Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

North Dakota Focused Program Integrity Review

Final Report

July 2019

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Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) is committed to performing program integrity reviews with states in order to identify risks and vulnerabilities to the Medicaid program and assist states with strengthening program integrity operations. The significance/value of performing onsite program integrity reviews include: (1) provides states with effective tools/strategies to improve program integrity operations and performance, (2) provides the opportunity for technical assistance related to program integrity trends, (3) assist CMS in determining/identifying future guidance that would be beneficial to states, and (4) assists with identifying and sharing promising practices related to program integrity.

The CMS conducted a focused review of the North Dakota Medicaid personal care services (PCS). The objective of the review was to assess the level of program integrity oversight of Medicaid PCS at the state level. A secondary objective of the review was to provide the state with useful feedback, discussions and technical assistance resources that may be used to enhance program integrity in the delivery of these services. The review also included a follow up on the state's progress in implementing corrective actions related to CMS's previous program integrity review conducted in calendar year 2013.

Medicaid PCS (sometimes referred to as personal attendant or personal assistance services) includes a range of assistance services provided to beneficiaries with disabilities and chronic conditions, of all ages. Provision of these services in the beneficiary's home is intended to serve as an alternative to institutionalization. Assistance may either be in the form of direct provision of a task by the personal care attendant (PCA) or cuing/prompting by the PCA so that the beneficiary may perform the task. Such assistance most often involves activities of daily living (ADLs) such as eating, drinking, bathing, dressing, grooming, toileting, transferring, and mobility. Services offered under Medicaid PCS are an optional benefit, except when they are medically necessary for children who are eligible for the Early and Periodic Screening, Diagnostic, and Treatment benefit that provides comprehensive and preventive health care services.

Pursuant to the regulations found at 42 C.F.R. § 440.167, PCS is a Medicaid benefit furnished to eligible beneficiaries according to an approved Medicaid State Plan, waiver, or section 1115 demonstration. States administer their Medicaid programs within broad federal rules and according to requirements of the specific authority approved by CMS. Services must be approved by a physician, or some other authority recognized by the state. Personal care beneficiaries cannot be inpatients or residents of a hospital, nursing facility, intermediate care facility for the developmentally disabled or institution for mental disease. Services can only be rendered by qualified individuals, as designated by each state.

During the week of April 8-12, 2019, the CMS review team visited North Dakota's Department of Human Services (DHS). They conducted interviews with numerous state staff involved in program integrity and administration of PCS to validate the state's program integrity practices with regard to PCS.

Summary of Recommendations

The CMS review team identified a total of 10 recommendations based upon the completed focused review modules and supporting documentation, as well as discussions and/or interviews with key stakeholders. The recommendations were in the following areas: Overview of the State's PCS, State Oversight of PCS Program Integrity Activities and Expenditures in regards to written policies and procedures, Personal Care Services Provider Enrollment, Oversight of Personal Care Services Providers, Program Integrity Post Payment Actions Taken – PCS Providers, and Electronic Visit Verification (EVV). The recommendations will be detailed further in the next section of the report.

Overview of the North Dakota Medicaid Personal Care Services

- In FFY18, North Dakota's Medicaid expenditures totaled approximately $1,240,743,305, while the number of beneficiaries served via Medicaid totaled approximately 91,072.
- In FFY18, North Dakota's Medicaid personal care services expenditures totaled approximately $20,249,024, while the number of beneficiaries receiving personal care services totaled approximately 1,276.
- PCS are a covered benefit under North Dakota's State Plan and 1915 (c) HCBS (Aged and Disabled) Waiver.
- PCS Providers are enrolled by North Dakota's DHS as Qualified Service Providers (QSP). The QSP can be an agency or an individual such as a family member, neighbor or friend that has met the standards set by the DHS.
- The North Dakota DHS operates eight regional human service centers and each serves a designated multi-county area, providing counseling and mental health services, substance abuse treatment, disability services, case management and other human services.

Overview of North Dakota's Administration of Personal Care Services

- The DHS is the single state Medicaid agency which includes the Aging Services Division (ASD) and Medical Services Division (MSD).
- The ASD is responsible for the daily administration and supervision of the waiver, as well as issues, policies, rules and regulations related to the waiver. The ASD also conducts complaint investigations, which may include a financial audit component.
- The MSD which includes the Program Integrity (PI) unit and the Home and Community Based Services (HCBS) unit are responsible for assisting ASD with PCS program oversight.
- The PI unit provides education and updates other staff with trends among the provider community and the HCBS unit conducts PCS provider enrollment, training, and formal and focused audits of services.

Summary of PCS in North Dakota

The North Dakota DHS administers Medicaid PCS to eligible beneficiaries under the State Plan and under 1915 (c) HCBS waiver authority. The provision of PCS in the beneficiaries' homes or community settings is intended to serve as an alternative for individuals who would otherwise require institutional care. The Table 1 below provides details of the programs.

Table1.

Program Name /Federal Authority	**Administered By**	**Description of the Program**
Medicaid State Plan Personal Care Services (MSP-PC)	Aging Services Division	Implemented 9/1/2003 Personal care services assist eligible recipients with activities of daily living (ADLS). A case manager will assess how much help is needed with ADLS and determine the recipient's eligibility. Once a recipient is deemed eligible the recipient is placed into one of the three levels: Level A- up to 120 hours of help per month; Level B- up to 240 hours of help per month; and Level C- up to 300 hours of help per month.
Section 1915 (c) HCBS(Aged and Disabled) Waiver: Section 1915 (c) HCBS(Aged and Disabled) Waiver:	Aging Services Division Aging Services Division	Implemented 4/1/1993 Medicaid Waiver for HCBS serves aged and disabled. Recipient must be receiving Medicaid State Plan services, and be age 18 or older and physically disabled as determined by the Social Security Administration or the State Review Team or be at least 65 years of age. Eligible to receive care in a skilled nursing facility. Participate to the best of their ability in a comprehensive assessment to determine what services are needed and the feasibility of receiving HCBS as an alternative to institutional care. Have Person Centered Plan of Care State Form Number, (SFN) 404, developed and approved by the applicant/client or legal representative and HCBS case manager that adequately meets the health, safety, and personal care needs of the recipient. Voluntarily choose to participate in the HCBS program after discussion of available options. Service/care is delivered in the recipient's private family dwelling or the recipient is receiving a community-based service of adult foster care, adult day care, non-medical transportation, or adult resident service.

Program Name /Federal Authority	Administered By	Description of the Program
		Must receive services on a monthly basis. Not eligible for and/or receiving services through other Medicaid waivers or private funding sources. The applicant/client(s) impairment is not the result of a mental illness, intellectual disability or a closely related condition.

Summary of PCS Expenditures and Beneficiary Data

Table 2.

Program Name /Federal Authority	FFY 2016	FFY 2017	FFY 2018
Medicaid State Plan Personal Care	$19,928,524	$19,855,072	$19,468,132
Medicaid Waiver for Home and Community-Based Services (serves aged and disabled)	$973,311	$883,731	$780,892
Total Expenditures	**$20,901,835**	**$20,738,803**	**$20,249,024**

The PCS expenditures in the State Plan overall remained consistent with some gradual decrease demonstrated during the FFYs reviewed. The PCS expenditures in the HCBS waiver saw a decrease due to a change in beneficiary enrollment.

Table 3.

	FFY 2016	FFY 2017	FFY 2018
Total PCS Expenditures	$20,901,835	$20,738,803	$20,249,024
% Agency QSP-PCS Expenditures	61.50%	66.49%	72.27%
% Individual QSP-PCS Expenditures	38.50%	33.51%	27.73%

The percentage of Agency QSP-PCS expenditures increased over the three-year period. This increase was due to new agencies enrolling over the past few years due to an increase in beneficiaries with significant care needs. The majority of the beneficiaries were receiving PCS through QSP Agencies when compared to QSP Individual providers.

Table 4-A.

Table 4-A.

Medicaid State Plan PCS	**FFY 2016**	**FFY 2017**	**FFY 2018**
Medicaid State Plan PCS	1,135	1,083	1,050
Total Agency Directed Unduplicated Beneficiaries	**1,135**	**1,083**	**1,050**

*Unduplicated beneficiary count is the number of individuals receiving services, not units of service.

Table 4-B.

Medicaid State Plan and 1915(c) HCBS (Aged and Disabled) PCS Waiver	**FFY 2016**	**FFY 2017**	**FFY 2018**
Medicaid State Plan PCS	387	251	187
HCBS (Aged and Disabled) PCS Waiver	61	45	39
Total Individual Unduplicated Beneficiaries	**448**	**296**	**226**

*Unduplicated beneficiary count is the number of individuals receiving services, not units of service.

Results of the Review

The CMS team identified areas of concern with North Dakota's PCS program integrity oversight, thereby creating a potential risk to the Medicaid program. CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved as soon as possible. These issues and the CMS recommendations for improvement are described in detail in this report. In addition, CMS has included technical assistance resources for the state to consider utilizing in its provision of PCS.

Overview of the State's PCS

The State Plan and 1915(c) HCBS waiver is administered by the DHS's ASD. Under this authority, the PCS benefit is administered to eligible beneficiaries under a traditional fee-for-service (FFS) methodology for those enrolled in the State Plan and HCBS waiver program PCS benefit. The PCS program does not include a consumer-directed benefit; however, the DHS allows the recipient to choose both agency and individual QSPs to provide PCS.

State Oversight of PCS Program Integrity Activities and Expenditures

The MSD, which includes the PI unit and the HCBS unit, is responsible for assisting ASD with PCS program oversight. The PI unit does not conduct data mining on PCS providers, however program, enrollment, and auditing staff meet with PI staff twice per month regarding findings of audits and complaints. These same staff also meet monthly to discuss trends found in audits. The PI unit has not directly audited any PCS providers because the HCBS unit is assigned to this task. The HCBS staff is responsible for conducting quarterly provider audits on agency and individual QSPs, however even though audits are being conducted neither the PI unit nor the HCBS unit conducted any in-person compliance site visits on the QSPs. The audits can be both formal and focused in nature. If a staff member receives any type of fraud or abuse complaint, regardless of the communication mode, from a QSP or regarding a QSP, it is forwarded to the HCBS Program Administrator responsible for QSP complaints. The HCBS Program Administrator will investigate the complaint. If a complaint involves an allegation of fraud, a review of the facts of the case and the relevant findings is completed with the Fraud, Waste, and

Abuse (FWA) Administrator. The FWA Administrator will determine if there is a credible allegation of fraud and determine if the case must be referred to law enforcement. The FWA Administrator will work with the HCBS Program Administrator to gather the information to submit to law enforcement. During the review process, DHS disclosed that there was no intra-agency agreement between the ASD and MSD, detailing program integrity oversight responsibilities.

The DHS's Medicaid Management Information System is currently going through certification with CMS and anticipates that the certification will occur in June 2019.

Recommendation #1

The state should consider developing a standard operating procedure that clearly describes the oversight/administrative roles and responsibilities of each DHS unit related to PCS.

Recommendation #2

The state should consider conducting onsite visits to the QSP provider agencies in order to monitor PCAs and/or agency activities.

State Oversight of Self- Directed Services

The DHS allows the beneficiaries to choose both agency and individual QSPs to provide PCS services.

Personal Care Services Provider Enrollment

The MSD provider enrollment administrator enrolls PCS providers. The DHS requires all providers to complete an application to enroll as a QSP and sign a provider agreement. Once the application is approved all providers are issued a Medicaid identification number regardless of whether they enrolled as an agency or individual QSP provider. Additionally, all enrolled QSPs receive a QSP Agency or Individual Handbook to ensure they are delivering service in accordance with DHS rules and regulations. All providers must complete the following forms: SFN 1606 - Agency Request to be a Qualified Service Provider, SFN 615 - Medicaid Program Provider Agreement, SFN 1168 - Ownership/Controlling Interest and Conviction Information, W-9 - Request for Taxpayer Identification Number and Certification, valid form of ID, official photo identification card that must be sent to DHS for each individual with an ownership or controlling interest in the agency to include current agents and/or managing employees.

The DHS implemented the screening level provisions, including fingerprinting, based on the assigned level of risk for directly enrolled PCS providers, however providers enrolling as QSPs are currently classified as limited risk and are only required to conduct limited state background checks and database checks upon enrollment, and every two years after **enrollment. Agency** providers are directed to check the following sites for each individual employee and acknowledge that the checks have been completed upon enrollment and reenrollment every two years: State exclusion list, HHS-OIG exclusion list, and criminal background checklists. During the interview with the state the team observed that SFN 615 - Medicaid Program Provider Agreement and the QSP Handbook had inconsistencies in the required frequency of federal database checks. One document showed the frequency for federal database checks should occur

every 30 days and the other showed these checks should occur every two years. The DHS staff also disclosed that they have not uploaded a terminated provider into TIBCO/DEX since 2018 due to a change in staff, but they are currently working with CMS's Provider Enrollment and Oversight Group (PEOG) to get access and training on the new DEX system to start uploading terminated providers again.

Recommendation #3

The state should ensure that all document language and forms are consistent with federal requirements of 42 CFR 455.436.

Recommendation #4

The state should continue taking actions to ensure that PCS provider agencies do not employ individual PCAs who have been terminated by another Medicaid program or convicted of a health-care related criminal offense. Continue working with PEOG to restore DEX credentials and continue utilizing database as required by uploading and downloading terminated providers.

Oversight of Personal Care Services Providers

Providers of PCS deliver supports to Medicaid eligible beneficiaries in their own home or communities who would otherwise require care in a medical institution. These non-medical services assist beneficiaries who have limited ability to care for themselves because of physical, developmental, or intellectual disabilities or conditions. These non-medical services assist beneficiaries with ADLs.

As part of the onsite review, CMS's review team selected four provider agencies to be interviewed. Those agencies were Circle of Life Kola Home Care, Easter Seals Goodwill ND Inc., Tami's Angels Inc., and Pro Health Home Care. During the interview with all four of the providers they all disclosed that they have never had a site visit from DHS for compliance and have received limited to no training from DHS on PCS topics related to fraud, waste, and abuse. The review team also determined from the interviews with the providers that three out of the four providers had either no policy and procedures referencing compliance or policy and procedures that were over 20 years old. Additionally, only one out of the four providers had a compliance process and reported employee terminations to DHS.

Recommendation #5

The state should provide additional training to QSP PCS providers on relevant rules and regulations related to Medicaid fraud, waste and abuse (including identifying, investigating and referring potential fraudulent billing practices to the state program integrity unit). In addition, the state should ensure a method for informing QSP PCS providers of any changes and/or updates to rules and regulations on a regular basis.

Recommendation #6

The state should establish guidance on the basic requirements for all QSP PCS providers regarding compliance program structure to ensure continuity within the Medicaid PCS program.

Recommendation #7

The state should ensure PCS providers are reporting to the state instances where PCAs are terminated for possible fraudulent behaviors.

Table 5.

Agency QSP and Individual QSP Combined	FFY 2016	FFY 2017	FFY 2018
Identified Overpayments	$170,015	$322,495	$131,164
Recovered Overpayments**	$29,180	$54,429	$58,846
Terminated Providers	33	24	26
Suspected Fraud Referrals***	4	1	2
# of Fraud Referrals Made to MFCU****	N/A	N/A	N/A

*Overpayments identified and recovered in FFY 2016, FFY 2017, and FFY 2018 include fraud, waste, and abuse.

*Includes Medicaid State Plan personal care and HCBS Aged/Disabled waiver providers. Identified and recovered overpayments are based on when the overpayment was discovered in FFY16, FFY17, and FFY18.
** If a provider has not fulfilled their repayment obligation and a repayment plan has not been established with the Department, overpayments are sent to collections.
***Includes suspected fraud referrals sent to OIG.
**** ND does not currently have a MFCU.

Overall, North Dakota's activity regarding post payment actions taken seems low, when compared to expenditures. There were only seven fraud referrals made in the last three FFYs to law enforcement. During FFYs 16, 17 and 18, there were overpayments identified and recovered. However, in FFYs 16, 17 and 18 the recoveries from overpayments were low when compared to the identified overpayment amounts. During the interview with DHS the review team learned that DHS's overpayment policy was still in draft form. Additionally, all four providers interviewed did not identify any overpayments during the last three FFYs. Given the limited number of investigations and referrals along with the low number of overpayments and terminations that the PCS agencies reported, the state should ensure that they are allocating sufficient resources to the prevention, detection, investigation, and referral of suspected provider fraud. The DHS also disclosed during the interview that they do not currently have a suspension policy.

Recommendation #8

The state should ensure that they are allocating sufficient resources to the prevention, detection, investigation, and referral of suspected provider fraud.

Recommendation #9

The state should finalize its draft overpayment policy and verify that identified and collected overpayments are fully reported by the QSPs.

Electronic Visit Verification (EVV)

An EVV system is a telephonic and computer-based in-home scheduling, tracking, and billing system. Currently, DHS does not utilize an EVV system for in-home scheduling, tracking and billing, but is in the process of procuring a system that will comply with Section 12006 of the 21st Century Cures Act.

Pursuant to Section 12006 of the 21st Century Cures Act, all states are required to implement an EVV system for PCS by January 1, 2020.

Recommendation #10

The state should require the use of an EVV system as a method to verify visit activity for Medicaid-provided PCS as required under Section 12006 of the 21st Century Cures Act. The EVV system should verify the date of service, location of service, individual providing the service, type of service, individual receiving the service, and the time the service begins/ends.

Status of Corrective Action Plan from Year 2013 Review

North Dakota's last CMS program integrity review was in August 2013, and the report for that review was issued in January 2015. The report contained four recommendations relative to implementation of core program integrity activities, lack of program integrity oversight of the Persons with Developmental Disabilities Waiver programs, payment suspensions, and provider enrollment practices. During the onsite review in April 2019, the CMS review team conducted a thorough review of the corrective actions taken by North Dakota to address all issues reported in calendar year 2013. The findings from the 2013 review have been satisfied by the state and are described below.

Risk Areas -

1. **A risk was identified in the state implementation of core program integrity activities.**

   Status at time of the review: Corrected

The Department developed P&P for Payment Suspensions Initiated by the PIU that were initiated on November 12, 2013. On March 10, 2015 the state responded to a request for additional information and provided a copy of documents titled: Coordinated Services Program (Lock-In), Provider Screening and Enrollment by the PIU, Statewide Surveillance and Utilization Program Integrity Unit and Establishing a Compliance Program- Providers and Suppliers Enrolled in ND Medicaid and CHIP. The Department has a RAC waiver from April 21, 2017 through March 31, 2019 and was granted an extension through March 31, 2021. The Department participated in the CMS on-site, MMIS certification the week of February 25, 2019. The CMS has 60 days from their onsite visit to determine if the Department met all the certification requirements. The department has provided the following attachments: Pre-payment Review policy, Audit Overview Oversight, Sampling and Extrapolation Plan, Civil Monetary Penalties, CSP 8-19-2015 Coordinated Services program, PI Unit Training Info from 2015 to current and PI Meeting agenda/minute documents to satisfy implementation of core program integrity activities. Additionally, no cases were referred to law enforcement as a result of these meetings. Tools used would be the Audit Overview Oversight document and the Sampling and Extrapolation plan.

2. **A risk was identified in the state's lack of program integrity oversight of the Persons with Developmental Disabilities waiver programs**.

   Status at time of the review: Corrected

The Department worked with the DD Division to ensure policies and procedures are established relative to program integrity. The DD provider integrity manual can be found at: http://www.nd.gov/dhs/services/disabilities/docs/dd-provider-integrity-manual.pdf. The DD Division, along with the PIU, currently refer all credible allegations of fraud and abuse to law enforcement. The PIU, in collaboration with the DD Division, will implement a compliance

program that ensures providers, staff, and beneficiaries of the DD area are trained to report fraud and abuse. The PIU will ensure that DD Division staff members continue to watch the annual fraud and abuse training video on an annual basis. On 9/18/18 training was provided for all interested DD providers. The training document can be found at: http://www.nd.gov/dhs/services/disabilities/docs/dd-provider-integrity-training-2018.pdf. Currently, the PIU hold monthly meetings with the DD Division to evaluate and collaborate on potential fraud and abuse cases, assist with audit activities, and provide program integrity oversight within the DD Division, to include meetings with the provider audit area to discuss their audit process, and areas of concern.

3. **The state does not suspend payments in cases involving a credible allegation of fraud**.

   Status at time of the review: Corrected

The Department updated and continue to follow state administrative code relative to program integrity activities and suspending payments and passed bill 50-24.1-36 to implement civil penalties. The Department developed, and continues to use, the Payment Suspension policy; the policy will be re-evaluated to include the authority of the PIU Administrator to suspend payments. The PIU included the definition of a credible allegation of fraud pursuant to 42 CFR 455.23 and reference the Payment Suspension policy in the Fraud and Abuse manual. The Department suspend payments for, based on the PI Administrators discretion, any Medicaid provider when it is determined there is a credible allegation of fraud pursuant to 42 CFR 455.23. The Department re-analyze the case filing system and made the appropriate changes relative to the CMS Fraud Referral Performance Standards. The Department developed Reporting Provider Sanctions to HHS-OIG policy dated April 17, 2013. The Department updated, and continue to use, the Memorandum of Understanding with the US Attorney's office completed January, 2015. The Department's provider suspension numbers from 2013 to present are attached in an excel spreadsheet. The Department does not have an executed MOU with HHS-OIG, however the Department is negotiating a MOU with the ND Attorney General's Office where a Medicaid Fraud Control Unit (MFCU) will be established once the application is approved by HHS/OIG. The ND Legislative branch gave final approval to establish a six person MFCU unit.

4. **A risk was identified in the state's provider enrollment practices**.

   Status at time of the review: Corrected

The Department revised form DHS 1168 (JAN 2015) to include the requirements at 42 CFR 455.104(b)(2), (b)(3), (b)(4), and (c)(2). All providers to include waiver provider use form DHS 1168. Trained staff in PIU and Medicaid funded areas on all pertinent policies and policy updates. Executed a contract with a vendor in 2013 to verify provider licenses. Establish a system to verify terminations or denials of enrollment via Medicare, CHIP, or another state Medicaid program as required by 42 CFR 455.416. Executed a contract with a vendor in 2013 to conduct site visits according to risk levels. Executed a contract with a vendor in 2013 to conduct monthly exclusion searches at enrollment, reenrollment, and monthly. The vendor confirms the exclusion status of employees or contracts, for the Medical Services providers, on a monthly

basis; this vendor also confirms the exclusion for the DD program. The North Dakota PIU was going to request a waiver from CMS for provider application fees pursuant to 42 CFR 455.460, however no request for application waivers was submitted. The Department require LTC facilities to be enrolled with Medicare, therefore Medicare will always be in receipt of the application fee and we'd never ask for it. The DD providers that meet "institutional" level of care have not been assessed application fees. This waiver will also include Long Term Care and Developmental Disabilities programs. The Department provided the following additional attachments SFN 1168 Ownership Controlling Interest and Conviction Information Form and Provider Enrollment Desktop Procedures includes licensure verification, site visits and data base checks.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for North Dakota to consider utilizing:

- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute, which can help, address the risk areas identified in this report. Courses that may be helpful to Wyoming are based on its identified risks include those related to managed care. More information can be found at http://www.justice.gov/usao/training/mii/.
- Review the document titled "Vulnerabilities and Mitigation Strategies in Medicaid Personal Care Services". This document can be accessed at the following link https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/MedicaidGuidance.html
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Visit and utilize the information found on the CMS' Medicaid Program Integrity Education site. More information can be found at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html.
- Consult with other states that have PCS programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of staff in program integrity.

Conclusion

The CMS focused review identified areas of concern and instances of non-compliance with federal regulations which should be addressed immediately.

We require the state to provide a CAP for each of the recommendations within 30 calendar days from the date of the final report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction along with the specific steps the state expects will take place, and identify which area of the state Medicaid agency is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the CAP such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of the letter. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the CAP should identify those corrections as well.

CMS looks forward to working with North Dakota to build an effective and strengthened program integrity function.