Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

North Dakota Comprehensive Program Integrity Review

Final Report

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Reviewers:
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Introduction and Executive Summary

The Centers for Medicare & Medicaid Services (CMS) regularly conducts reviews of each state's Medicaid program integrity activities to assess the state's effectiveness in combating Medicaid fraud, waste, and abuse. Through state comprehensive program integrity reviews, CMS identifies program integrity related risks in state operations and, in turn, helps states improve program integrity efforts. In addition, CMS uses these reviews to identify noteworthy program integrity practices worthy of being emulated by other states. Each year, CMS prepares and publishes a compendium of findings, vulnerabilities, and noteworthy practices culled from the state comprehensive review reports issued during the previous year in the *Annual Summary Report of Comprehensive Program Integrity Reviews.*

The purpose of this review was to determine whether North Dakota's program integrity procedures satisfy the requirements of federal regulations and applicable provisions of the Social Security Act. A related purpose of the review was to learn how the State Medicaid agency receives and uses information about potential fraud and abuse involving Medicaid providers and how the state works with law enforcement in coordinating efforts related to fraud and abuse issues. Other major focuses of the review include but are not limited to provider enrollment, disclosures, and reporting; pre-payment and post-payment review; methods for identifying, investigating, and referring fraud; appropriate use of payment suspensions; and False Claims Act education and monitoring.

During this review, the team found inadequate program integrity controls in many parts of the state's Medicaid program, including: not conducting fundamental program integrity activities, lack of program integrity oversight of the Persons with Developmental Disabilities waiver program, inadequate payment suspension procedures, and insufficient provider enrollment practices and reporting. All the issues identified and CMS's recommendations for improvement are described in detail in this report. CMS is concerned that several of the issues described in this report were also identified in CMS's 2011 review and are still uncorrected. CMS will work closely with the state to ensure that these issues are satisfactorily resolved as soon as possible.

Background

In fiscal year (FY) 2012, North Dakota's Medicaid enrollment was approximately 83,000 beneficiaries and expenditures exceeded $744 million, which at the time of the review were all paid on a fee-for-service basis. The State Medicaid agency, known as the Medical Services Division, is part of North Dakota's Department of Human Services (DHS). The Medical Services Division houses the the Program Integrity Unit (PIU), which is responsible for Medicaid program integrity and provider enrollment in North Dakota for all services provided under the state plan. The Medical Services Division's Long Term Care Division is responsible for program integrity and provider enrollment for the state's Home and Community Based Services (HCBS) waiver programs. The Developmental Disabilities Division, which is part of DHS, oversees services provided under the state's Persons with Developmental Disabilities waiver. The limited program integrity coordination in these three components of the Medicaid program will be seen in the discussion which follows.

North Dakota does not have a Medicaid Fraud Control Unit, having obtained a waiver of this federal requirement in 1994. Instead, the PIU works with the United States Department of Health and Human Services Office of the Inspector General (HHS-OIG) and the Assistant United States Attorney (AUSA) for North Dakota on issues related to provider fraud.

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, and relationship with law enforcement. A four-person team reviewed the responses and materials that the state provided in advance of the onsite visit. The review team also conducted an in-depth telephone interview with a representative from the AUSA's office.

During the week of August 26, 2013, the CMS review team visited the DHS and conducted interviews with numerous DHS officials, including representatives of the PIU, Long Term Care Division, and the Developmental Disabilities Division. The team also conducted sampling of provider enrollment applications, program integrity cases, and other primary data to validate North Dakota's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of the PIU within DHS but also considered the work of other components responsible for a range of program integrity functions. North Dakota operates its Children's Health Insurance Program (CHIP) as a Title XIX Medicaid expansion program. The expansion program operates under the same billing and provider enrollment policies as North Dakota's Title XIX program. The same risks discussed in relation to the Medicaid program also apply to the CHIP expansion program. 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 that the DHS provided.

Medicaid Program Integrity Unit

In North Dakota, program integrity operations are principally located in the PIU within the DHS. The Long Term Care Division and the Developmental Disabilities Division are also responsible for program integrity activities within their respective waiver programs, but there is limited coordination with or oversight from the PIU as discussed in Risk Areas 1 and 2. In total, the PIU had 9 full-time equivalent (FTE) positions allocated to Medicaid program integrity functions at the time of this review.

The table below represents the total number of preliminary investigations, number of cases referred to the HHS-OIG, and the amount of identified and collected overpayments related to program integrity activities in the last four complete state fiscal years (SFYs) conducted by the PIU and the Long Term Care Division. It should be noted that the majority of the activity reflected in the chart was conducted by the Long Term Care Division.

Table 1

SFY	Number of Preliminary Investigations Initiated*	Number of Cases Referred to HHS-OIG**	Amount of Overpayments Identified***	Amount of Overpayments Collected***
2009	136	0	$92,820	$80,371
2010	120	1	$57,240	$39,498
2011	171	5	$152,233	$98,907
2012	106	2	$76,786	$51,881

* 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. The PIU indicated that full investigations are conducted by the HHS-OIG. As a proxy for full investigations by the state agency, this report has listed the number of referrals made annually to the HHS-OIG.
***Overpayments collected do not include global settlements.

Results of the Review

The CMS review team found a number of risks related to program integrity in North Dakota's Medicaid program. These issues fall into four areas and are discussed below. To address these issues, North Dakota should improve oversight and build more robust program safeguards.

Risk Area 1: Risks were identified in the state's implementation of core program integrity activities.

Policies and Procedures

The PIU does not have written policies and procedures for key program integrity functions which include claims payment review, monitoring the work of the Recovery Audit Contractor (RAC), terminating a participating provider who has been excluded by HHS-OIG, or suspending payments in cases of credible allegations of fraud in accordance with the provisions of 42 CFR 455.23.

The PIU indicated that it is developing policies and procedures for the functions listed above but is waiting for the new Medicaid Management Information System (MMIS) to be fully operational to finalize and enter the new policies and procedures into the system. The absence of these policies and procedures and the lack of an interim plan to address the identified areas until the new MMIS is fully implemented leave the state vulnerable to inconsistent operations and ineffective functioning in the event of the loss of experienced program integrity or provider enrollment staff.

Methods for the identification, investigation, and referral of suspected provider fraud cases

During the 2011 CMS review, the team noted that North Dakota's PIU was not performing fundamental program integrity functions for identification, investigation, and referral of suspected fraud cases required under 42 CFR 455.13 through 42 CFR 455.15.
To address this issue, the PIU added three positions which include a Surveillance Utilization Review System (SURS) analyst, an audit coordinator, and one provider enrollment staff. The addition of these new staff members could bolster the PIU's ability to perform data analysis and identify and investigate provider fraud, waste, and abuse in the state's Medicaid program. However, staff members are assigned tasks that are primarily related to beneficiary fraud

issues. Additionally, the SURS administrator is responsible for conducting preliminary investigations of provider fraud, but this function was secondary to researching matters relating to third party liability.

The state indicated that the PIU does not conduct a significant number of preliminary investigations of suspected provider fraud because there are not enough provider fraud complaints referred through the state fraud hotline and other mechanisms that are used for individuals to report Medicaid fraud. The PIU staff estimated that there is one complaint of provider fraud for every twenty cases of beneficiary fraud. The allocation of existing resources toward beneficiary fraud also prevents the PIU from identifying and developing provider fraud cases itself and instead puts them in a reactive position. The state's practice of prominently pursuing beneficiary fraud over provider fraud was noted in the previous CMS review and is a practice that continues as evidenced by the 724 beneficiaries placed in the state lock-in program over the last 4 federal fiscal years.

Since the last CMS review, the PIU developed a SURS manual, but the PIU staff still did not have the in-depth training, tools, and institutional experience needed to undertake ongoing provider review activities such as a systematic peer review or analysis of outliers that would otherwise be conducted with an active surveillance and utilization control program. The lack of proactive measures to detect provider fraud, waste, and abuse leaves the PIU dependent on referrals from outside sources and sister agencies.

Referrals to Law Enforcement

As noted above, the PIU conducts very few preliminary investigations of provider fraud and abuse. It reported a total of 11 preliminary investigations of suspected provider fraud over the last four state fiscal years and only five of those cases were referred to the HHS-OIG.

The Office of the State Auditor (OSA) in North Dakota, which regularly evaluates Medicaid policies and activities, wrote in its latest report that there is room for improvement in conducting preliminary investigations. In its *Single Audit Report [for] Fiscal Years Ended June 30, 2012 and 2011* [1], OSA noted that they reviewed all nine cases of suspected provider fraud that the PIU had investigated during the period of the audit, and they identified four instances where the SURS unit "did not conduct appropriate preliminary investigations" or "where actions taken in the case were not properly documented." The audit report also noted that of these cases, the SURS unit forwarded five cases of suspected fraud or abuse to HHS-OIG for prosecution and recouped just $19,231 as a result of fraud investigations.

In contrast, the Long Term Care Division of the State Medicaid agency conducted 522 preliminary investigations of suspected provider fraud over the last four federal fiscal years. Providers identified for preliminary investigation are personal care attendants, which in North Dakota are referred to as Qualified Service Providers. The PIU staff indicated that law enforcement will decline to prosecute these cases based the low dollar amounts involved.

[1] State of North Dakota Office of State Auditor: *Single Audit Report Fiscal Years Ended June 30, 2012 and 2011* http://www.nd.gov/auditor/reports/SA_12.pdf

Program integrity activities by the Long Term Care Division were performed autonomously with little coordination with or oversight from the PIU. Only the most egregious cases were brought to the attention of the PIU. The state would benefit from coordinating the fraud and abuse prevention activities performed by the Long Term Care Division with the PIU so that central oversight is possible.

Audit Activity

The PIU's Fraud and Abuse Manual contains a work plan which includes an audit plan. The SFY 2013 master audit list provided to the review team consisted of 4 audits: one annual service after death audit that produced a recovery of $395; one audit of services for maternal depression generating a recovery of $152; one ad-hoc audit of a non-emergency medical transportation provider that was on-going; and an audit of new psychiatric treatment codes that did not identify any overpayments. Conversely, the staff from the Long Term Care Division indicated that they plan 47 audits of facilities per year and a minimum of 85 audits of qualified service providers per year.

In addition, the state has not been able to gain traction with its RAC to identify and recoup provider overpayments due to the limited scope of the RAC's investigations. Since its inception in June of 2011, the RAC in North Dakota has only recovered $385 from five years of MMIS claims data. According to the state, the effort that goes into training the RAC on state policies and procedures is labor intensive and time consuming.

Further hindering the audit endeavors of the state agency is the lack of an adequate sampling plan and associated staff with sampling skills. The OSA audit found that the SURS staff lacked policies and procedures to carry out a sampling plan since the SURS manual was not completed until after the audit period in June 2012. According to the OSA, the sampling plan submitted by the PIU contained the following deficiencies:

- Sampling activities are not properly documented;
- Sampling periods include short time frames;
- Samples are not expanded when errors are detected;
- Additional samples are not created when the initial data probe yields no results;
- Sampling results are not tracked in a manner to identify patterns that may indicate fraud or abuse; and
- Errors detected are not investigated further to determine if fraud or abuse exists.

The CMS review team, statistician, and audit staff reviewed the state's sampling plan and concurred with OSA's findings. The lack of a comprehensive sampling plan limits the state's ability to identify improper payments and effectively recoup them from providers.

Recommendations: To address risks related to the implementation and oversight of fundamental program integrity activities, the state should:

- Complete policies and procedures that address all program integrity functions, and develop an interim plan to ensure adherence until the new MMIS is implemented.

- Evaluate the PIU's process for developing provider reviews to ensure it is yielding adequate oversight. Develop tools and seek training opportunities to ensure PIU staff are capable of conducting preliminary investigations, pre-payment reviews, site visits, data mining, and other key fraud detection activities. The PIU should improve coordination and oversight of the program integrity activities performed by the Long Term Care Division and ensure central oversight.
- Design a comprehensive audit plan that includes high-risk provider targets that will result in high-value returns for the state agency. Consider including the RAC in the development of the audit plan and utilize its expertise to help identify audit opportunities.
- Ensure that the deficiencies identified in the sampling plan are addressed and provide training to PIU staff to enhance their sampling skills.

Risk Area 2: Risks were identified in the state's lack of program integrity oversight of the Persons with Developmental Disabilities waiver programs.

The Developmental Disabilities Division administers two waiver programs (comprehensive traditional waiver and autism waiver) that provide services which include but are not limited to early intervention, residential habilitation, day support habilitation, environmental, and in home support to Medicaid beneficiaries. The division operates outside of the Medical Services umbrella and has an annual budget of approximately $200 million (of which 52% is federally funded) that is paid to 35 provider entities who provide services to approximately 4200 beneficiaries. North Dakota must incorporate fraud and abuse oversight into waiver programs of this size.

The CMS review team observed that there is no program integrity oversight of the Persons with Developmental Disabilities waiver programs or the provider audit unit responsible for performing retrospective reviews of paid claims. Although the Developmental Disabilities Division staff indicated that one program integrity issue was identified and reported to the PIU in the past several years, the PIU is not actively involved to prevent provider or beneficiary fraud, nor ensure that adequate disclosures or required database searches are performed on provider entities or associated providers, which is detailed in Risk Area 4.

The developmental disability provider entities are paid by using a cost-based retrospective method. The providers are reimbursed an interim, previously established rate as they submit claims for services through MMIS. Each claim for services will pay up to the authorized limit entered into MMIS. A provider audit unit, which operates outside of the Developmental Disabilities Division, reviews the provider entity's cost on an annual basis to determine a final payment rate. Once a final payment rate is established, a reconciliation process is initiated to recover overpayments or to make additional payments, but the PIU does not perform any look-behind of paid claims.

In addition, the Developmental Disabilities Division does not have a compliance officer who ensures that providers and staff are trained how to report fraud. Nor is there information in the Patient Bill of Rights or any other documentation provided to the beneficiary how to report fraud.

Recommendations: To address the lack of program integrity controls in the Persons with Developmental Disabilities waiver programs, the state should:

- Develop and implement policies and procedures to ensure program integrity oversight of the Persons with Developmental Disabilities waiver programs.
- Establish processes among the PIU, the Developmental Disabilities Division, and the provider audit unit to coordinate the identification, investigation, and referral of suspected provider fraud in the Persons with Developmental Disabilities waiver programs to law enforcement.
- Implement a compliance program that ensures providers, staff, and beneficiaries of the Persons with Developmental Disabilities waiver programs are trained how to report fraud.

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

North Dakota indicated that it exercises wide latitude to withhold provider payments as a sanction when it appears that the provider is not complying with Medicaid policies, but the state does not have a written policy to suspend payments when it determines that a credible allegation of fraud exists in accordance with 42 CFR 455.23. Since the 2011 CMS review, the state created a *Fraud and Abuse Unit and Surveillance Utilization Review Section Manual* that outlines a process for investigating potential provider and beneficiary fraud and making referrals to law enforcement. However, the manual did not indicate the steps necessary to suspend payments or document good cause not to suspend payments upon determining a credible allegation of fraud.

During and subsequent to the onsite review, the team attempted to review provider case files submitted to HHS-OIG since March 25, 2011 to determine compliance with the regulation. Based on information provided by the state, four provider cases were referred to HHS-OIG by the PIU. An informal case file existed for one provider and the PIU indicated that case files were not organized for the other cases. Payments were not suspended in any of the cases.

Additionally, the state does not have a written policy to notify a provider that their payments have been suspended as required by 42 CFR 455.23(b)(1). The PIU indicated that per North Dakota Administrative Code § 75-02-05-09, a provider under investigation may not appeal a temporary payment withholding sanction until the investigation is completed. This was also identified as a risk during the 2011 CMS review. The Long Term Care Division staff reported that the unit also does not notify providers when suspending payments due to a credible allegation of fraud in accordance with 42 CFR 455.23(b)(1).

The CMS review team also interviewed the AUSA with whom the state evaluates potential and on-going cases. The AUSA confirmed that the PIU focuses its limited resources on beneficiary fraud rather than provider fraud. The team also noted that a Memorandum of Understanding between the State Medicaid agency and the AUSA dates back to 1995 and does not reflect the state's current process of referring cases to law enforcement.

Recommendations: To address the risks identified in the state's procedures to suspend payments in cases involving a credible allegation of fraud, the state should:

- Revise the state's *Fraud and Abuse Unit and Surveillance Utilization Review Section Manual* to include procedures for suspending payments in cases of credible allegations of fraud and ensure that the written notification to providers of the suspension is consistent with 42 CFR 455.23.
- Make sure the state is suspending payments for any Medicaid provider when it determines that there is a credible allegation of fraud.
- Develop procedures to organize case files for tracking and review, and ensure that case files are developed using CMS Fraud Referral Performance Standards[2].
- Develop and implement formal policies and procedures and revise the outdated Memorandum of Understanding with the AUSA and HHS-OIG that specifies each party's responsibilities with regard to cases associated with a credible allegation of fraud**.**

Risk Area 4: Risks were identified in the state's provider enrollment and reporting practices.

The PIU is responsible for enrolling all Medicaid FFS providers under the state plan. This unit does not enroll waiver providers; rather, they are enrolled directly by the staff that oversee the waiver. For example, providers in the HCBS waiver programs for seniors are enrolled by the Long Term Care Division. Similarly, providers in the Persons with Developmental Disabilities waiver program are enrolled by the Developmental Disabilities Division. This fragmented enrollment process has resulted in inconsistent collection of required disclosures as well as inconsistent provider screening practices and federal database checks. These issues are discussed in greater detail below.

Ownership and Control Disclosures

In North Dakota, the *Ownership/Controlling Interest and Conviction Information* form (SFN 1168) must be submitted by all billing providers who provide services under the state plan and all HCBS waiver providers. This form is not fully compliant with 42 CFR 455.104. The form does not solicit the required relationship information as described at 42 CFR 455.104(b)(2). In addition, the form 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 (b)(3). The form only asks about ownership or controlling interest in another North Dakota Medicaid provider. Finally, the form does not solicit the address of the managing employees of the disclosing entity as required by 42 CFR 455.104(b)(4).

The required disclosures by the fiscal agent were not on file at the time it responded to the Request for Proposals or prior to contracting with the state. The fiscal agent also did not submit disclosures when it had a change in ownership in February 2013 as required by the regulation at

[2] http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/downloads/fraudreferralperformancestandardsstateagencytomfcu.pdf

42 CFR 455.104(c)(2). The state provided the review team with a SFN 1168 disclosure form completed by the fiscal agent dated August 1, 2013. The form is missing the same elements as described above. In addition, the fiscal agent form appears to contain contradictory and incomplete information. For example, there are two entities listed as owners, with one having 100% ownership and the other having 50%. In addition, the second owner only provided a name. It listed no address or tax identification number. This issue was also identified in CMS's 2011 review.

In the Persons with Developmental Disabilities waiver program, the state is out of compliance with all of the requirements of the regulation. The division does not collect any of the disclosures from disclosing entities required by 42 CFR 455.104.

Criminal Conviction Disclosures

The state's *Ownership/Controlling Interest and Conviction Information* form completed by providers enrolled by the PIU and HCBS, as well as the fiscal agent, captures the criminal conviction history of directors, officers, agents, managing employees, and subcontractors; however, it does not solicit conviction information on persons with an ownership or controlling interest in the provider as required by 42 CFR 455.106. It also does not include the identification of criminal conviction offenses related to Medicare and Title XX programs; it only solicits information on Medicaid and CHIP. Further, 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. This is a repeat risk from the CMS 2011 review.

In the Persons with Developmental Disabilities waiver program, the division does not solicit any of the criminal conviction disclosures required by 42 CFR 455.106 and is fully out of compliance with the regulation.

Verification of Provider Licenses

In North Dakota, enrolling providers are required to submit a copy of a valid license to the agency at enrollment, and the state has a process to verify that the license is active. However, during interviews a PIU representative said that due to staffing issues, the agency has no way of knowing if a provider loses their license or has their license terminated during the enrollment period. This places the state at risk of not complying with 42 CFR 455.412 and permitting providers with expired licenses, limitations, and other adverse actions against their licenses to remain in the Medicaid program.

The team also noted that North Dakota had an interagency agreement in effect that described a plan to form an interdepartmental survey team for the purpose of surveying facility compliance with applicable licensing requirements. This agreement dated back to 1975. Both the 2011 and 2013 CMS review teams observed that the interdepartmental team had never been formed. This raises the question of how effectively the licenses of facilities serving the Medicaid population were being monitored.

Termination or Denial of Enrollment

During a provider enrollment demonstration, the state did not verify and had not obtained access to the CMS provider termination database to identify providers who have been terminated by Medicare, CHIP, or another state Medicaid program as required by 42 CFR 455.416. Without such access, the state has limited means of determining if providers terminated by Medicare, CHIP, or another state Medicaid program are improperly enrolled in the North Dakota Medicaid program.

Site Visits

North Dakota has not conducted pre or post-enrollment site visits of moderate or high risk providers to verify that information submitted to the state is accurate in compliance with the requirements at 42 CFR 455.432. The state agency adopted the same risk categories defined by Medicare; however, the state did not have any plans in place to conduct the necessary site visits.

Exclusion Searches

North Dakota collects ownership and controlling interest information from all providers under the State Plan and from HCBS waiver providers by using the SFN 1168 form. The state checks all of the names disclosed on the form against the HHS-OIG List of Excluded Individuals and Entities (LEIE), Excluded Parties List System (EPLS)[3], and the National Plan and Provider Enumeration System (NPPES) databases at enrollment and reenrollment. However, it does not perform monthly checks of the LEIE or EPLS as required by the regulation at 42 CFR 455.436. The state also does not search the Social Security Administration Death Master File upon enrollment or reenrollment.

The North Dakota Developmental Disabilities Division contracts with a fiscal agent. The state collected the disclosures from the fiscal agent also by using the SFN 1168 form. However, the individuals disclosed by the fiscal agent are not checked against LEIE or EPLS as required by 42 CFR 455.436. Further, the state does not conduct any exclusion searches for providers in the Persons with Developmental Disabilities waiver program. Finally, the state does not require any of its providers to confirm the exclusion status of their employees or contractors on a monthly basis against the LEIE or EPLS. This does not comport with the guidance on exclusion checking issued by CMS in its State Medicaid Director Letter #09-001 dated January 16, 2009.

Application Fee

The State Medicaid agency is required to implement a written policy to collect or waive the applicable application fee prior to executing a provider agreement from certain prospective or re-enrolling Medicaid-only providers as stipulated by 42 CFR 455.460. The state does not have an associated policy and is not collecting application fees from providers who enroll through the

[3] In July 2012, the EPLS was migrated into the new System for Award Management (SAM). .

PIU, the Long Term Care Division, or the Persons with Developmental Disabilities waiver program.

Notifications to HHS-OIG and State Agency Exclusion Notifications

The state does not notify HHS-OIG for any adverse action taken on a provider's participation in the Medicaid program for a program integrity reason as required by 42 CFR 1002.3(b)(2). This issue was also identified in the 2011 CMS review.

Recommendations: To address the risks identified in provider enrollment and reporting practices, the state should:

- Revise the state's *Ownership/Controlling Interest and Conviction Information* form (SFN 1168) to include the missing data elements outlined above as prescribed by 42 CFR 455.104 and 455.106. Ensure that the fiscal agent and disclosing entities associated with the Developmental Disabilities Division waiver programs submit complete disclosure information in accordance with these federal regulations at the required intervals. Ensure that every disclosed party affiliated with the state's program is checked against the EPLS, LEIE, NPPES, and Social Security Administration's Death Master File during the enrollment process and monthly thereafter against the LEIE and EPLS.
- Implement all provisions of the State Plan to conduct the screening and enrollment of providers as required by 42 CFR 455 Subpart E. Required elements of the screening process include verifying provider licenses, checking for providers terminated or denied enrollment for cause by Medicare or other states, conducting site visits for medium and high risk providers, performing all required federal database searches at the proper intervals, and collecting Medicaid application fees when appropriate.
- Ensure that adverse action reporting and provider notification requirements are met in accordance with the requirements of 42 CFR 1002.3.
- Develop a process to coordinate provider enrollment activities with sister agencies to ensure the same level of screening during the enrollment process is completed for their providers (for example, in terms of disclosure collection and federal database searches).

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:

- Consult with other states on methods of conducting site visits to provider applicants. Consider using other available state, county, and local government resources to assist in the provider screening process in order that the state can comply with the requirements of 42 CFR 455.432 as outlined in Risk Area 4.
- Consult CMS's Medicaid Payment Suspension Toolkit at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/MedicaidGuidance.html to develop a payment suspension process that is consistent with federal regulations and guidance. CMS can also refer North Dakota to states that are further along in this process to address the areas of non-compliance identified is Risk Area 3.

- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts by creating the policies and procedures necessary to provide effective oversight of the Persons with Developmental Disabilities waiver programs to address the concerns outlined in Risk Area 2.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute, such as those related to fraud detection techniques, which can help address the risk areas identified in this report. Specific course information can be found at http://www.justice.gov/usao/training/mii/training.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.
- Work with the assigned CMS State Liaison to discuss program integrity issues and request technical assistance as needed.
- Access the annual program integrity review summary reports on the CMS website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html. These reports contain information on noteworthy and effective program integrity practices in states. We recommend that North Dakota review the noteworthy practices on provider enrollment and disclosures and the effective practices in program integrity and consider emulating these practices as appropriate.
- Since North Dakota is a Medicaid expansion state we suggest working with the CMS State Liaison and CMS Center for Medicaid and CHIP Services to gain knowledge of Medicaid managed care programs and determine applicable program integrity language that should be placed in the model Medicaid managed care contract.

Summary

The instances of non-compliance with federal regulations should be addressed immediately. CMS is also concerned about uncorrected, repeat problems that remain from the time of the agency's last comprehensive program integrity review.

We require the state to provide a corrective action plan (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. Please 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 plan should identify those corrections as well.

CMS looks forward to working with North Dakota to strengthen the effectiveness of its program integrity function.

north dakota department of human services

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February 6, 2015

Peter Leonis, Director of Field Operations North
Department of Health and Human Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard, Mail Stop AR-18-50
Baltimore, Maryland 21244-1850

Dear Mr. Leonis:

I have enclosed North Dakota Medicaid's Corrective Action Response to the August 26, 2013 review by the Medicaid Integrity Group. As you see from the Corrective Action Plan, North Dakota Medicaid has made significant progress with program integrity efforts and we continue to move forward with additional action items.

We look forward to working with your agency with follow up activities. If you have any questions, I can be reached at 701.328.1603.

Sincerely,

Julie F. Schwab

Julie F. Schwab
Medical Services Division Director