Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

South Dakota Comprehensive Program Integrity Review

Final Report

January 2015

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Executive Summary and Introduction

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 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 South 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 the Medicaid Fraud Control Unit (MFCU) 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.

In South Dakota, program integrity activities are principally performed by the Surveillance and Utilization Review System (SURS) unit. The SURS unit is located within the Division of Medical Services (DMS), which falls under the umbrella of the Department of Social Services (DSS). The Department of Human Services (DHS) has oversight of waiver services. In 2013, South Dakota had approximately 116,000 beneficiaries enrolled in the Medicaid program with a budget of approximately $817 million.

The review team noted the state's Medicaid program has a number of vulnerabilities and instances of regulatory non-compliance in its program integrity activities, thereby creating risks to the Medicaid program. These risks are related to program integrity operations and oversight; suspension of payments in cases of credible allegations of fraud; and provider enrollment practices and reporting. Several of the issues described in this review were also identified in CMS's 2008 review and are still uncorrected. CMS will work closely with the state to ensure that all issues, particularly those that remain from the earlier review, are satisfactorily resolved as soon as possible. CMS's recommendations for improvement are described in detail in this report.

Methodology of the Review

In advance of the onsite visit, the review team requested that South Dakota complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as program integrity and provider enrollment/disclosures. A five-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 representatives from the MFCU.

During the week of April 16, 2013, the CMS review team conducted on-site interviews with numerous DSS and DHS officials as well as with staff from the dental contractor, who is responsible for processing and paying fee-for-service (FFS) dental claims. The team also sampled provider enrollment applications, program integrity cases, and other primary data to validate South Dakota's program integrity practices.

Scope and Limitations of the Review

This review focused on the program integrity activities of the SURS unit, but also considered the work of other components, agencies, and contractors responsible for a range of program integrity functions, including provider enrollment and contract management. South Dakota operates its Children's Health Insurance Program (CHIP) as both a Title XXI Medicaid expansion program and a stand-alone Title XXI program. The expansion program operates under the same billing and provider enrollment policies as South Dakota's Title XIX program. The same effective practices and risks discussed in relation to the Medicaid program also apply to the CHIP expansion program. The stand-alone CHIP program operates under the authority of Title XXI and is beyond the scope of this review. Unless otherwise noted, South 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 SURS unit provided.

Medicaid Program Integrity Unit

In South Dakota, the SURS unit is the organizational component dedicated to anti-fraud and abuse activities for Medicaid. The payment control officer, who supervises the SURS unit, serves as the South Dakota program integrity director. At the time of this review, the SURS unit had four full-time equivalent positions allocated to Medicaid program integrity functions. The table below presents the total number of preliminary and administrative cases, the number of cases referred to the MFCU, and the amount of identified and collected overpayments related to program integrity activities in the last four state fiscal years (SFYs).

Table 1

SFY	Number of Preliminary Investigations Initiated*	Number of Cases Referred to MFCU	Number of Administrative Cases**	Amount of Overpayments Identified***	Amount of Overpayments Collected***
2010	49	3	32	$388,850	$385,297
2011	30	8	19	$154,943	$153,710
2012	20	4	6	$368,520	$163,115
2013	22	0	10	$26,990	$26,990

*Preliminary investigations of suspected fraud or abuse complaints are conducted by investigative staff within the SURS unit to determine if there is sufficient basis to warrant a referral to the MFCU or administrative actions.
** Consists of cases developed by SURS staff through data analysis and preliminary investigations.
***The amount of overpayments identified and collected varies from year to year based on data mining and preliminary investigations. These figures do not include global settlements.

Results of the Review

The CMS review team found regulatory compliance issues and vulnerabilities related to program integrity in South Dakota's Medicaid program. Several of the issues represent risks to the integrity of the state's Medicaid program. These issues fall into three areas of risk and are outlined below. To address them, South Dakota should improve oversight and build more robust program safeguards.

Risk Area 1: Risks were identified in the state's program integrity operations and oversight.

The SURS unit's limited number of staff affected its ability to pursue investigations and other core program integrity functions. The unit is comprised of the payment control officer, a nurse, and two data analysts, who, together, conduct prepayment reviews, analyze surveillance and utilization reports to identify outliers, and follow up on complaints and concerns that require a preliminary investigation. An analysis of other comparable state Medicaid programs revealed that South Dakota's SURS unit had the smallest number of full-time equivalent positions among similarly sized programs. Further, a comparison of South Dakota with Wyoming is illustrative. While Wyoming's Medicaid expenditures in federal fiscal year 2012 were not quite 75% of South Dakota's, Wyoming had 9.5 staff assigned to program integrity activities and averaged nearly twice as much in overpayment recoveries and over twice as many MFCU referrals per year as South Dakota in the four years preceding each state's last CMS review. Further, the SURS unit staff informed the review team that their internal review process did not always ensure a referral to the MFCU or recoupment of the identified overpayment when appropriate.

In addition, the SURS unit, in coordination with a contract liaison, is responsible for program integrity oversight of the dental contractor. The SURS unit was not performing any data analysis of dental claims nor providing program integrity oversight of the contractor or dental providers.

At the time of the review, written policies and procedures for key program integrity and provider enrollment functions were not available for review in a centralized location. These include: conducting prepayment reviews, payment suspensions, referrals to the MFCU, intra-agency program integrity coordination with DHS, or many key provider screening and enrollment requirements as described further in Risk Area 3.

Permissive Exclusion Authority

South Dakota's policy manual *Integrity Review Procedures* permits the state to suspend or exclude providers in accordance with the permissive exclusion authority at 42 CFR 1002.210. However, the SURS unit was not using this exclusionary authority and did not have procedures to exclude a provider for any reason for which the U.S. Department of Health and Human Services – Office of Inspector General (HHS-OIG) could exclude providers under 42 CFR Parts 1001 and 1003. The SURS unit indicated that the only actions imposed against providers were administrative recoupments and prepayment reviews. In the last 13 years, the SURS unit has not issued any warning letters or terminated any providers or contracts for fraud, integrity, or quality.

Some providers have been on prepayment review for several years and continue to be a risk to the Medicaid program, yet the state has chosen not to exercise its permissive exclusion authority.

Case Tracking System

The SURS unit's case tracking process has limitations that impact the effectiveness of program integrity operations. The unit maintains a spreadsheet log primarily to track events during case development and a database log for case tracking during the preliminary investigation, however, if the preliminary investigation concludes with no findings, the complaint is not recorded in either log as having been processed by the SURS unit. The tracking system also does not show whether the case was accepted by the MFCU, the applicable dates, or the outcome.

The lack of information prevents the SURS unit from accurately reporting how many issues related to fraud, waste, and abuse have been received from internal and external sources, the outcome of the preliminary investigations, or the length of time from identifying a case to resolution.

Recommendations:

- To ensure program integrity activities are handled efficiently across the entire State Medicaid agency and ensure effective communication on program integrity issues and oversight of funds, the state should establish an inter-agency or other formalized agreement between DSS and DHS.
- Determine an appropriate staffing level to ensure necessary oversight of program integrity operations and dental contractor performance. Consider the various factors that would influence staffing levels, such as program spending, level of overpayment recoveries, number of enrolled providers, and number of enrolled providers in the moderate and high risk categories.
- Ensure ongoing training for staff with an emphasis on developing program knowledge to increase the number of case investigations and referrals, and to improve oversight responsibilities. The Medicaid Integrity Institute is an available resource to the state; its curriculum includes courses related to fraud detection.
- Examine the state's process for reviewing suspected fraud cases at the state agency to ensure that the SURS unit is moving cases of suspected fraud through the process to a successful administrative action or fraud referral to the MFCU.
- The state should inventory existing policies and procedures to determine gaps, and develop and implement new policies and procedures to address the full range of program integrity and provider enrollment operations including but not limited to conducting prepayment review, payment suspension, referrals to the MFCU, intra-agency program integrity coordination, and many key provider screening and enrollment requirements to ensure continuity of program integrity operations.
- Develop procedures to utilize the state's permissive exclusion authority to remove providers who are a risk to the program and consider implementing other methods such as a lock-out and a self-audit program.
- Improve the SURS case tracking system to document all program activities such as preliminary investigations, referrals to the MFCU, and associated recoveries.

Risk Area 2: Risks were identified in the state's process for suspension of payments in cases of credible allegation of fraud.

The state is not always suspending payments to providers or documenting good cause exceptions not to suspend in cases where it determines that a credible allegation of fraud exists as required by the regulation at 42 CFR 455.23. Since March 25, 2011, SURS referred 10 credible allegation cases to the MFCU. Five of these cases did not have an associated payment suspension or a good cause exception not to suspend payments on file. In the other cases where a payment suspension was made, 61 days on average elapsed between the date of the MFCU referral and the date the suspension was imposed. Approximately $27,000 was paid to the providers during this period. These payments were potentially at risk.

In the 2008 CMS review, the state was cited for not notifying providers of payment suspensions in cases under investigation by the MFCU. While the state subsequently took steps to ensure that such notifications were made, it remained out of compliance at the time of this review because the notice of suspension was missing several key pieces of information. For example, the notice did not explain why payments were suspended or indicate the period of suspension. The notice also did not inform providers of their right to submit written evidence for consideration by the state or discuss the applicable administrative appeals process with corresponding citations to the state's statute as required at 42 CFR 455.23(b)(2).

Lastly, in those cases where payment suspensions were invoked, the state did not request nor did the MFCU provide quarterly certifications to continue the suspensions as the regulation further requires. The SURS unit indicated it had verbal directions from the MFCU to continue the suspension but did not document these discussions for each case.

Recommendations:

- Ensure that provider payments are suspended upon determination that a credible allegation of fraud exists with subsequent referral to the MFCU unless a good cause exception is exercised and documented by the state.
- Ensure that the provider notification letter includes all applicable elements as outlined in the regulation at 42 CFR 455.23(b)(2).
- On a quarterly basis, request a certification from the MFCU that any matter accepted on the basis of a referral continues to be under investigation thus warranting continuation of the suspension. Document each case to reflect such quarterly certification.

Risk Area 3: Risks were identified in the state's provider enrollment practices and reporting.

Exclusion Searches

The regulation at 42 CFR 455.436 requires that the State Medicaid agency must check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider on the HHS-OIG's List of Excluded Individuals and Entities (LEIE), the Excluded Parties List System (EPLS) on the System for

Award Management (SAM)[1], the Social Security Administration Death Master File (SSA DMF), and the National Plan and Provider Enumeration System (NPPES) upon enrollment and reenrollment; and check the LEIE and EPLS no less frequently than monthly.

South Dakota's State Plan Amendment implementing the Affordable Care Act's provider screening and enrollment requirements became effective on April 1, 2013; however, at the time of the review, South Dakota was not conducting federal database searches of providers and any person with an ownership or control interest or who is an agent or managing employee of the provider at enrollment, reenrollment, or monthly as required by the regulation. The state anticipated that when its new MMIS was fully operational, it would have the capability to perform automated federal database checks at the required frequency, but the state did not have a completion date for the new MMIS at the time of the review. In addition, the team noted that the disclosure of information about managing employees is optional during the state's provider enrollment process. This represents a partial improvement from the 2008 CMS review, which found that the state was not soliciting any information on managing employees. However, as the disclosure remains optional, it prevents the state from searching all the required affiliated parties during its required database checks at enrollment and monthly thereafter.

Ownership and Control Disclosures

The 2008 CMS review found that the state was not capturing all required ownership and control disclosures as required by the regulation at 42 CFR 455.104. While the state improved in this review, it was not fully compliant in capturing all required disclosures at enrollment from FFS providers or from the dental contractor. The state's web-based enrollment process does not collect the date of birth of each person or entity with an ownership or control interest in the provider or subcontractor, or the enhanced business address information from corporate entities. In addition, as noted above, collecting the names of managing employees is incomplete because disclosure is optional. Furthermore, the state was not collecting disclosures from the board of directors and all applicable managing employees of the dental contractor which, in addition to providing services to beneficiaries, is also responsible for processing and paying all dental claims from FFS providers.

Business Transaction Disclosures

Neither the standard nor modified provider agreement contained language that the provider agrees to furnish information related to business transactions within 35 days of a request by the State Medicaid agency or the Secretary of the Department of Health and Human Services as required by 42 CFR 455.105. This issue remains uncorrected from the 2008 CMS review.

Criminal Offense Disclosures

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 since the

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

inception of those programs for each person with ownership or control interest in the provider, or who is an agent or managing employee of the provider. Such information must be furnished at the time providers 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 within 20 working days from the date it receives the information.

At the time of the 2008 CMS review, the state was not capturing all criminal conviction disclosures on the provider and dental enrollment forms as required by 42 CFR 455.106. Since 2008, the state revised its dental enrollment form to collect the required criminal conviction disclosures. However, the state is still not capturing health care criminal conviction disclosures during the enrollment or reenrollment process from FFS providers on persons with an ownership or control interest in the provider or agents or managing employees of the provider as required by the regulation.

Notification of Adverse Actions to HHS-OIG

At the time of the 2008 CMS review, the state did not require its dental contractor to report adverse actions during credentialing of dental providers as specified by 42 CFR 1002.3 so that the state could report these actions to HHS-OIG. The state improved in this review by updating the dental contract to require adverse action reporting to the state, but was still not fully compliant in reporting all denials of provider enrollment based on fraud, integrity, and quality concerns to HHS-OIG. In addition, when DHS takes adverse action to terminate providers in the developmental disabilities program, it does not report these actions to the SURS unit nor directly to HHS-OIG. During sampling, the review team noted instances of adverse actions, such as license revocation and a provider voluntarily withdrawing from the Medicaid program to avoid a sanction, and no subsequent reporting to HHS-OIG.

Provider Screening and Enrollment

The regulation at 42 CFR 455.410(b) requires the state to enroll all ordering and referring physicians or other professionals as participating providers. South Dakota's State Plan Amendment implementing the Affordable Care Act's provider screening and enrollment requirements became effective on April 1, 2013. However, at the time of the review the state was not requiring all ordering and referring physicians or other professionals to be enrolled as participating providers in the Medicaid program.

Verification of Provider Licenses

The regulation at 42 CFR 455.412 requires states to have a method for verifying that a provider is licensed in accordance with state law and ensure that the license has not expired and that there are no limitations on the license. The state did not have any methods in place to conduct primary source verifications of in-state or out-of-state provider licenses to confirm that the license had not expired and that there are no current limitations on the provider's license.

National Provider Identifier

The regulation at 42 CFR 455.440 requires all claims for payment for items and services that are ordered or referred contain the National Provider Identifier (NPI) of the physician or other professional who ordered or referred such items or services. The state's claim form for primary care case management providers does not capture the NPI number for ordering and referring providers. The state indicated that the NPI will be captured on claim forms during claim processing once the new MMIS is fully operational.

Screening Levels for Medicaid Providers

The regulation at 42 CFR 455.450 requires that the state screen all initial applications, including applications for a new practice location and any applications received in response to a re-enrollment or revalidation of enrollment request based on a categorical risk level of "limited", "moderate", or "high". The state has not established categorical risk levels for provider types to conduct the appropriate screening based on the applicant's risk level in accordance with the regulation. According to the State Plan, this requirement was to be implemented by April 1, 2013; however, the state does not expect to be fully compliant until the new MMIS is fully operational.

Application Fee

South Dakota's State Plan Amendment implementing the Affordable Care Act's provider screening and enrollment requirements became effective on April 1, 2013; however, at the time of the review, South Dakota has not begun collecting application fees from certain Medicaid-only providers prior to executing a provider agreement in accordance with the regulation at 42 CFR 455.460.

Recommendations:

- Search all federal databases to determine the status of providers, persons with an ownership or control interest in the provider, agents, and managing employees of the provider at enrollment and reenrollment as required by 42 CFR 455.436. Check these names against the EPLS and the LEIE (or the equivalent CMS-generated Medicare Exclusion Database) monthly to ensure that the state does not pay federal funds to excluded persons or entities.
- Collect the full range of ownership and control disclosures from FFS providers and the dental contractor during the enrollment process as required by 42 CFR 455.104. Update the enrollment forms to require FFS providers to disclose any health care related criminal convictions during the enrollment or reenrollment process.
- Modify all provider agreements to require providers to disclose business transactions upon request in accordance with 42 CFR 455.105.
- Develop procedures to ensure that all adverse actions and provider terminations resulting from fraud, integrity, and quality are reported to HHS-OIG.
- Develop policies and procedures to implement the new provider enrollment and screening requirements as described by 42 CFR 455 Subpart E with specific reference to the following:

- enrollment of all ordering and referring physicians or other professionals as participating providers,
- inclusion of the ordering or referring provider's NPI on claim forms,
- verification of all provider licenses prior to enrollment or reenrollment,
- establishment of provider risk levels for screening purposes, and
- collection of application fees from certain Medicaid-only providers during enrollment.

Effective Practices

As part of its comprehensive review process, CMS also invites each state to self-report practices that it believes are effective and demonstrate its commitment to program integrity. CMS does not conduct a detailed assessment of each state-reported effective practice. South Dakota reported the operation of a Telephone Service Unit to answer calls from providers regarding claims.

Implementation of a Telephone Service Unit

The state established a Telephone Service Unit to answer calls from providers regarding questions related to claims submissions. The unit has expanded and now includes 15 claims processors who have the knowledge to answer questions regarding claims submissions, reasons for denial of claims, eligibility issues, and coverage policy rules. The state observed that there is a close working relationship with the provider community, with many of the providers and claims processors on a first name basis. The state believes that this close working relationship and ongoing impromptu education about proper submission of claims has contributed to its low Payment Error Rate Measurement (PERM) rate for the past two cycles. The state had the second lowest and lowest payment error rates, respectively, among all states in its PERM cycle for the past two reviews. In addition, the Telephone Service Unit serves as a source for complaints of possible fraud, waste, and abuse which are sent to the SURS unit for further review.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for South 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. Specific courses that may be helpful to South Dakota based on its identified risks include the *Program Integrity Fundamentals Seminar and the Medicaid Provider Enrollment Seminar*. More information can be found at http://www.justice.gov/usao/training/mii/training.html.
- Use the program integrity review guides posted in the Regional Information Sharing Systems as a self-assessment tool to help strengthen the state's program integrity efforts and to identify best practices to develop a case tracking tool and to address areas of risk outlined in Risk Area 1.
- 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 South Dakota to states that are further along in this process to address the areas of non-compliance identified is Risk Area 2.

- 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.
- 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 South Dakota review the noteworthy practices on provider enrollment and disclosures and the effective practices in program integrity and consider emulating these practices as appropriate.

Summary

The risks identified in this report, particularly those that are uncorrected, repeat risks that remain from the time of the agency's last comprehensive program integrity review should be addressed immediately.

To that end, we require that the state provide a corrective action plan (CAP) 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 South Dakota to strengthen the effectiveness of its program integrity function.

Official Response from South Dakota
February 2015

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DSS
Strong Families - South Dakota's Foundation and Our Future

February 27, 2015

Mark Majestic
Director
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop AR-18-50
Baltimore, Maryland 212441850

Dear Mr. Majestic:

Please find enclosed South Dakota Department of Social Services' formal response and Corrective Action Plans (CAPs) in reply to the Medicaid Integrity Group's comprehensive review of South Dakota's Medicaid program integrity procedures and processes.

The state recognizes the three risk areas identified in the report and have objectively approached our action plans to mitigate those areas. In the nearly two years since the program integrity review was completed there has been much improvement in the areas identified. Updates to the program functions and processes are called out in the CAPs with supporting documentation.

Thank you for your continued support and guidance in all matters.

Sincerely,

Lori Lawson
Deputy Director
Division of Medical Services
SD Department of Social Services