Testimony
Senate Bill Number 2114 - Department of Human Services
Senate Human Services Committee
Senator Judy Lee, Chairman
January 21, 2013

Chairman Lee, and members of the Senate Human Services Committee, I am Jon Alm with the Department of Human Services. I appear before you to support Senate Bill 2114, which was introduced on behalf of the Department of Human Services Department.

The State Auditor's office, in its October 2010 Performance Audit, recommended that North Dakota Medicaid ensure the implementation of Medicaid civil sanctions and other sanctions are imposed, as applicable, following investigations of providers which identify inappropriate billings, fraud, and/or abuse. Over the past two years, the Medicaid Program Integrity staff have enhanced the fraud and abuse policies and procedures, strengthened audit activities, updated North Dakota Administrative Code chapter 75-02-05 on Provider Integrity (chapter 75-02-05), developed a suspected fraud reporting mechanism for ease of reporting, and have been proactively engaging in the identification of suspected Medicaid fraud and abuse. In an effort to further enhance program integrity efforts, the Department is proposing to implement civil monetary sanctions to deter providers from engaging in fraud and abuse activities. I have attached a copy of chapter 75-02-05 to my testimony for your reference.

The language in this bill addressing the Department's ability to issue civil monetary sanctions begins on page 1, line 15, which says, [A] provider, an affiliate of a provider, or any combination of provider and affiliates, is liable to the department for up to $10,000 for each act of fraud or abuse.

This sanction is in addition to the applicable rules established by the department. An act is something done intentionally, voluntarily, or with a purpose. For example, each act may pertain to each false or abuse claim. The act or number of acts will be determined by the Department. The act must meet the definition of "fraud" or "abuse" set forth in chapter 75-02-05 before civil monetary sanctions may be considered. Page 1, line 18, requires a provider, an affiliate of a provider, or any combination of provider and affiliates, to reimburse the Department for investigation fees, costs, and expenses for any investigation and action brought in connection with a civil monetary sanction. Page 3, line 14, details that the State's share of all civil sanctions, investigative fees, costs, expenses, and interest received by the Department from issuing a civil monetary sanction must be deposited into the State's general fund.

The Department would use chapter 75-02-05 in carrying out the civil monetary sanctions provided in this bill. Chapter 75-02-05 outlines a provider's responsibilities to the Department, grounds for sanctions, how the Department investigates providers, and activities leading to and including sanctions. Providers' responsibilities include ensuring that services are medically necessary, retaining appropriate documentation, accepting payment as full, filing claims in a timely manner, and complying with all applicable Centers for Medicare and Medicaid Services (CMS) regulations. The Department may sanction a provider or a provider's affiliate for a number of reasons including when the provider or provider's affiliate presents a false or fraudulent claim or information, fails to disclose records, fails to comply with the terms of the provider agreement, defrauds any health care benefit program, and when a provider or provider's affiliate is suspended or excluded from other Medicaid programs or by Medicare. The Department is able to impose

sanctions, including requiring a provider to attend educational programs, implementing of a business integrity agreement, suspending Medicaid payments, imposing pre-payment or post-payment review of claims, recovering costs of the investigation, requiring a provider self-audit, making referrals to the appropriate state regulatory agency or licensing agency, suspending a provider from participation in the Medicaid program, and imposing prior authorization of all services and a peer review at the provider's expense.

As established by chapter 75-02-05, the Department will evaluate the severity of the fraud or abuse before imposing a civil monetary sanction. In evaluating the severity of the fraud or abuse, the Department may consider the seriousness of the offense, the extent of the violations, prior violations, prior imposition of sanctions against the provider, the provider's agreement to make restitution to the Department, or actions taken or recommended by peer groups or licensing boards, access to care for recipients, whether the provider self-disclosed the finding, and the provider's willingness to participate in a performance improvement plan.

Civil sanctions will be applied in cases where the provider has not improved practices after the Department has addressed repeated concerns with them and there has been no improvement or resolution in their practice, or if the provider has not complied with the remedies determined by the Department pursuant to the sanction. For example, if a Qualified Service Provider (QSP) supplies an incorrect date for payment for services in error, and it is not a systemic pattern; a civil sanction would not be imposed. However, a civil sanction may be applied if a medical provider had been sanctioned with a pre-payment review of claims due to erroneous billing practices and the same billing practices do

not improve over the course of 12 months. The civil sanction will be used with providers who have consistent, severe, and repetitive concerns; the Department will use civil sanctions as a last resort in restricting adverse provider practices.

If the Department issues a civil monetary sanction on a provider or affiliate, the provider's and affiliate's review and appeal rights are set forth on page 2, starting on line 3 through page 3, line 10. A provider or affiliate who is assessed a sanction may request a review of the sanction by filing a statement of dispute with the Department within 30 days of the date of the Department's written notice of the sanction. Page 2, line 7, states that a provider or an affiliate may not request a review if the sanction imposed is termination or suspension, including failure to meet standards of licensure, certification, or registration, or if the provider or affiliate has been sanctioned by the Medicare program or by another state's Medicaid program. After the Department receives a provider's or affiliate's request for review and documentation that supports the request for review, the Department will assign the request for review to someone other than an individual who was involved in imposing the sanction. A provider or affiliate, if timely, can also request an informal conference regarding a review. As stated on page 2, line 25, a provider or affiliate may appeal the final decision of the Department to the district court in the manner provided in section 28-32-46 which can be further reviewed by the North Dakota Supreme Court as provided in section 28-32-49. The Department's written notice of sanction to the provider or affiliate will include language informing the provider or affiliate of its right to review and appeal.

The Department recognizes the importance of ensuring providers are aware of updates to North Dakota Century Code, Administrative Rules, or policies. As a result, the Department will provide training on fraud and abuse efforts and program changes by sending the information to providers in a provider newsletter and publishing the information on the 'Provider Updates' section on the Department's website. Additionally, Department staff are available to answer questions providers may have about the process.

This concludes my testimony. I would be happy to answer any questions the committee may have. Thank you.

CHAPTER 75-02-05
PROVIDER INTEGRITY

75-02-05-01. Purpose. The purpose underlying administrative remedies and sanctions in the medical assistance (medicaid) program is to ensure the proper and efficient utilization of medicaid funds by those individuals providing medical and other health services and goods to recipients of medical assistance.

History: Effective July 1, 1980; amended effective July 1, 2012.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-05-02. Authority and objective. Under authority of North Dakota Century Code chapter 50-24.1, the department of human services is empowered to promulgate such rules and regulations necessary to qualify for federal funds under section 1901 specifically, and title XIX generally of the Social Security Act. These rules are subject to the medical assistance state plan and to applicable federal regulation and state law.

History: Effective July 1, 1980; amended effective July 1, 2012.
General Authority: NDCC 50-06-05.1, 50-24.1-04
Law Implemented: NDCC 50-24.1-04

75-02-05-03. Definitions. In this chapter, unless the context or subject matter otherwise requires:

1. "Abuse" means practices that:

   a. Are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to medicaid;

   b. Elicit reimbursement for services that are not medically necessary;

   c. Are in violation of an agreement or certificate of coverage; or

   d. Fail to meet professionally recognized standards for health care.

2. "Administrative or fiscal agent" means an organization which processes and pays provider claims on behalf of the department.

3. "Affiliates" means persons having an overt or covert relationship each with the other such that any one of them directly or indirectly controls or has the power to control another.

4. "Business integrity agreement" means an agreement between the department and the provider that addresses the concerns of the department and recognizes essential elements of required compliance for the provider to preempt further sanction, exclusion from participation, or termination.

5. "Client share" means the amount of monthly net income remaining after all appropriate deductions, disregards, and medicaid income levels have been allowed. This is also referred to as recipient liability.

6. "Closed-end medicaid provider agreement" means an agreement that is for a specified period of time not to exceed twelve months.

7. "Credible allegation of fraud" means an allegation which has been verified by the department.

8. "Department" means the department of human services.

9. "Division" means the medical services division of the department.

10. "Exclusion from participation" means permanent removal from provider participation in the North Dakota medical assistance program.

11. "Fraud" means deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or another and includes an act that constitutes fraud under applicable federal or state law.

12. "Licensed practitioner" means an individual, other than a physician who is licensed pursuant to North Dakota Century Code chapter 43-17, or otherwise authorized by the state to provide health care services.

13. "Medicaid" means "medical assistance" and is a term precisely equivalent thereto.

14. "Offsetting of payments" means a reduction or other adjustment of the amounts paid to a provider on pending and future bills for purposes of offsetting overpayments previously made to the provider.

15. "Open-end medicaid provider agreement" means an agreement that has no specific termination date and continues in force as long as it is agreeable to both parties.

16. "Person" means any natural person, company, firm, association, corporation, or other legal entity.

17. "Provider" means any individual or entity furnishing medicaid services under a provider agreement with the division of medical services.

18. "Sanction" means an action taken by the division against a provider for noncompliance with a federal or state law, rule, or policy, or with the provisions of the North Dakota medicaid provider agreement.

19. "Suspension from participation" means temporary suspension of provider participation in the North Dakota medicaid program for a specified period of time.

20. "Suspension of payments" means the withholding of payments due a provider until the matter in dispute between the provider and the division is resolved.

21. "Termination" means determining a provider to be indefinitely ineligible to be a medicaid provider.

History: Effective July 1, 1980; amended effective July 1, 2012.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 CFR 431.107

75-02-05-04. Provider responsibility. To assure quality medical care and services, medicaid payments may be made only to providers meeting established standards. Providers who are certified for participation in medicare are eligible for participation, providing no sanction has been imposed as provided for in section 75-02-05-08. Comparable standards for providers who do not participate in medicare are established by state law and appropriate licensing and standard-setting authorities in the health and mental health fields.

1. Payment for covered services under medicaid is limited to those services that are medically necessary for the proper management, control, or treatment of an individual's medical problem and provided under the physician's or licensed practitioner's direction and supervision.

2. Each provider agrees to retain documentation to support medical services rendered for a minimum of seven years and, upon request, to make the documentation available to persons acting on behalf of the department and the United States department of health and human services. A provider shall provide the records at no charge.

3. A provider must accept, as payment in full, the amounts paid in accordance with the payment structure established by the department. A provider performing a procedure or service may not request or receive any payment, in addition to the amounts established by the

department, from the recipient, or anyone acting on the recipient's behalf, for the same procedure or service. In cases where a client share has been properly determined by a county social service board, the provider may hold the recipient responsible for the client share.

4. No medicaid payment will be made for claims received by the department later than twelve months following the date the service was provided.

5. The department will process claims six months past the medicare explanation of benefits date if the provider followed medicare's timely filing policy.

6. In all joint medicare/medicaid cases, a provider must accept assignment of medicare payment to receive payment from medicaid for amounts not covered by medicare.

7. When the recipient has other medical insurance, all benefits available due from that other insurance must be applied prior to the provider accepting payment by medicaid.

8. A provider may not offer or accept a fee, portion of a fee, charge, rebate, or kickback for a medicaid patient referral.

9. Claims for payment and documentation must be submitted as required by the department or its designee.

10. A provider shall comply with all accepted standards of professional conduct and practice in dealing with recipients and the department.

11. A provider may not bill a recipient for services that are allowable under medicaid, but not paid due to the provider's lack of adherence to medicaid requirements.

12. Each provider shall comply with all applicable centers for medicare and medicaid services regulations.

History: Effective July 1, 1980; amended effective July 1, 2012.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 CFR 431.107

75-02-05-05. Grounds for sanctioning providers. Sanctions may be imposed by the division against a provider who:

1. Presents or causes to be presented for payment any false or fraudulent claim for care or services.

2. Submits or causes to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

3. Submits or causes to be submitted false information for the purpose of meeting prior authorization requirements.

4. Submits a false or fraudulent application to obtain provider status.

5. Fails to disclose or make available to the department or its authorized agent records of services provided to medicaid recipients and records of payments received for those services.

6. Fails to provide and maintain services to medicaid recipients within accepted medical and industry standards.

7. Fails to comply with the terms of the medicaid provider agreement or provider certification which is printed on the medicaid claim form.

8. Overutilizes the medicaid program by inducing, furnishing, or otherwise causing a recipient to receive care and services that are not medically necessary.

9. Rebates or accepts a fee or portion of a fee or charge for a medicaid patient referral.

10. Is convicted of a criminal offense arising out of the practice of medicine.

11. Fails to comply and to maintain compliance with all regulations and statutes, both state and federal, which are applicable to the provider's profession, business, or enterprise.

12. Is excluded from medicare.

13. Is suspended, excluded from participation, terminated, or sanctioned by any other state's medicaid program.

14. Is suspended or involuntarily terminated from participation in any governmentally sponsored medical program.

15. Bills or collects from the recipient any amount in violation of section 75-02-05-04.

16. Fails to correct deficient provider operations within a reasonable time, not to exceed thirty days, after receiving written notice of these deficiencies from the division, another responsible state agency, or their designees.

17. Is formally reprimanded or censured by an association of the provider's peers for unethical practices.

18. Fails to change or modify delivery patterns and services within a reasonable period after receipt of a request so to do by a peer review committee whose jurisdiction includes the provider.

19. Is convicted of a criminal offense arising out of the making of false or fraudulent statements or of an omission of fact for the purpose of securing any governmental benefit to which the provider is not entitled, or out of conspiring, soliciting, or attempting such an action.

20. Refuses to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments. A refusal of repayment exists if no repayment or arrangement for repayment is made within thirty days of the date written notice of discrepancy was sent.

21. Is served with a search warrant by a member of any law enforcement agency for the purpose of obtaining evidence of a crime of fraud committed by that provider against the medical assistance program, or is charged with such a crime, provided that no provider may be terminated from participation in the medical assistance program on such grounds.

22. Refuses to attend a division educational program or fails to agree to implement a business integrity agreement, if required by the division.

23. Defrauds any health care benefit program.

History: Effective July 1, 1980; amended effective November 1, 1983; July 1, 2012.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 12.1-11-02; 42 CFR 455.13, 42 CFR 455.16, 42 CFR 431.107

75-02-05-06. Reporting of violations and investigation.

1. Information from any source indicating that a provider has failed or is failing to fulfill the provider's responsibilities, as set forth in section 75-02-05-04; or that a provider has acted in a manner which forms a ground for sanction as set forth in section 75-02-05-05 must be transmitted to the division.

2. The division shall investigate the matter and, if the report is substantiated, shall take whatever action or impose whatever sanction is most appropriate. The taking of any action or the imposition of any sanction does not preclude subsequent or simultaneous civil or criminal court action.

3. a. The division may investigate suspected fraud or abuse. The division may conduct an investigation to determine whether:

(1) Fraud or abuse exists and can be substantiated;

(2) Sufficient evident exists to support the recovery of overpayments or the imposition of sanctions; or

(3) The matter should be referred for action by another agency, including a law enforcement agency, to determine whether sufficient evidence exists to pursue any other civil or criminal action permitted by law.

b. The division may undertake an investigation to:

(1) Examine a provider's medical, financial, or patient records;

(2) Interview a provider and a provider's associates, agents, or employees;

(3) Verify a provider's professional credentials and the credentials of the provider's associates, agents, and employees;

(4) Interview recipients;

(5) Examine equipment, prescriptions, supplies, or other items used in a recipient's treatment;

(6) Sample a random mix of paid claims, prior authorizations, and medical records;

(7) Determine whether services provided to a recipient were medically necessary;

(8) Examine insurance claims or records or records of any other source of payment, including recipient payments; or

(9) The division may refer the case to the appropriate authority for further investigation and prosecution.

4. The division may contract with specialists outside the department as part of the investigation.

History: Effective July 1, 1980; amended effective July 1, 2012.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 CFR 455.14; 42 CFR 455.15; 42 CFR 455.16

75-02-05-07. Activities leading to and including sanction.

1. a. When the division determines that a provider has been rendering care or services in a form or manner inconsistent with program requirements or rules, or has received payment for which the provider may not be properly entitled, the division shall notify the provider in writing of the discrepancy noted. The notice to the provider may set forth:

(1) The nature of the discrepancy or inconsistency.

(2) The dollar value, if any, of such discrepancy or inconsistency.

(3) The method of computing such dollar values.

(4) Further actions which the division may take.

(5) Any action which may be required of the provider.

b. When the division has notified the provider in writing of a discrepancy or inconsistency, it may withhold payments on pending and future claims awaiting a response from the provider.

2. If the department determines that a provider's claims were not submitted properly or that a provider has engaged in suspected fraud or abuse, the division may require the provider to participate in and complete an educational program.

a. If the division decides that a provider should participate in an educational program, the division shall provide written notice to the provider, by certified mail, setting forth the following:

(1) The reason the provider is being directed to attend the educational program;

(2) The educational program determined by the division; and

(3) That continued participation as a provider in medicaid is contingent upon completion of the educational program identified by the division.

b. An educational program may be presented by the department. The educational program may include:

(1) Instruction on the correct submission of claims;

(2) Instruction on the appropriate utilization of services;

(3) Instruction on the correct use of provider manuals;

(4) Instruction on the proper use of procedure codes;

(5) Education on statutes, rules, and regulations governing the medicaid program;

(6) Education on reimbursement rates and payment methodologies;

(7) Instructions on billing or submitting claims; and

(8) Other educational tools identified by the division.

3. If a provider who is required to participate in an educational program refuses to participate in that program, the department shall suspend the provider from participation in medicaid until the provider successfully completes the required program. The timeframe to successfully complete the educational program may be extended upon provider request and with department approval.

4. If the department determines that a provider's claims were not submitted properly or that a provider has engaged in suspected fraud or abuse, the division of medical services may require the provider to implement a business integrity agreement. If the department requires a provider to enter a business integrity agrement and the provider refuses, the department shall ensure the provider is suspended from participation in medicaid until the provider implements the required agreement.

5. The division shall suspend all medicaid payments to a provider after the division determines there is a credible allegation of fraud for which an investigation is pending under the medicaid program unless the provider has demonstrated good cause why the division should not suspend payments or should suspend payment only in part.

6. The director of the division, or the director's designee, shall determine the appropriate sanction for a provider under this chapter. The following may be considered in determining the sanction to be imposed:

a. Seriousness of the provider's offense.

b. Extent of the provider's violations.

c. Provider's history of prior violations.

d. Prior imposition of sanctions against the provider.

e. Prior provision of information and training to the provider.

f. Provider's agreement to make restitution to the department.

g. Actions taken or recommended by peer groups or licensing boards.

h. Access to care for recipients.

i. Provider's self-disclosure or self-audit discoveries.

j. Provider's willingness to enter a business integrity agreement.

7. When a provider has been excluded from the medicare program, the provider will also be terminated or excluded from participation.

8. If the division determines there is a credible allegation of fraud, the division may impose any one or a combination of the following temporary sanctions:

a. Prepayment review of claims;

b. Postpayment review of claims;

c. Recovery of costs associated with an investigation;

d. Requirement of a provider self-audit;

e. Notification and referral to the appropriate state regulatory agency or licensing agency;

f. Suspension from participation in the medicaid program and withholding of payments to a provider;

g. Prior authorization of all services; and

h. Peer review at the provider's expense.

9. After the completion of a further investigation, the division shall document its findings in writing and provide a copy of that documentation to the provider. Following a determination by the division that the provider has engaged in fraud or abuse; the division may terminate, exclude or impose sanctions with conditions, including the following:

a. Recovery of overpayments;

b. Recovery of excess payments;

c. Recovery of costs associated with an investigation;

d. Requirement of a provider self-audit;

e. Prepayment review of claims;

f. Postpayment review of claims;

g. Notification and referral to the appropriate state regulatory agency or licensing agency;

h. Prior authorization of all services;

i. Penalties as established by the department; and

j. Peer review at the provider's expense.

10. A sanction may be applied to all known affiliates of a provider, provided that each sanctioned affiliate knew or should have known of the violation.

11. A provider subject to termination or exclusion from participation may not submit claims for payment, either personally or through claims submitted by any clinic, group, corporation, or other association to the department or its fiscal agenct for any services or supplies provided under the medicaid program except for any services or supplies provided prior to the effective date of the termination or exclusion.

12. A clinic, group, corporation, or other organization which is a provider may not submit claims for payment to the department or its fiscal agent for any services or supplies provided by a person within the clinic, group, corporation, or organization who has been terminated or is under exclusion from participation in this state or any other state or who has been excluded from medicare except for those services or supplies provided prior to the effective date of the termination or exclusion.

13. When the division determines there is a need to sanction a provider, the director of the division, or the director's designee, shall notify the provider in writing of the sanction imposed. The notice must advise the provider of the right of appeal, when applicable.

14. After the division sanctions a provider, the director of the division may notify the applicable professional society, board of registration or licensure, and any appropriate federal, state, or county agency of the reasons for the sanctions and the sanctions imposed.

15. If the department sanctions a provider who also serves as a billing agent for other providers, the department may also impose sanctions against the other providers upon a finding that the actions performed as the billing agent fails to meet department standards.

History: Effective July 1, 1980; amended effective July 1, 2012.
General Authority: NDCC 50-24.1 04
Law Implemented: NDCC 50-24.1-04; 42 CFR 455.13, 42 CFR 455.14, 42 CFR 455.15, 42 CFR 455.16, 42 CFR 455.17, 42 CFR 455.23

75-02-05-08. Imposition and extent of sanction. Repealed effective July 1, 2012.

75-02-05-09. Appeal and reconsideration.

1. A provider may not appeal a temporary sanction until further investigation has been completed and the division has made a final decision.

2. After completion of further investigation, if there is an imposition of a subsequent sanction, the provider may appeal the decision to impose sanctions unless the sanction imposed is termination or suspension and the notice states that the basis for the sanction is:

   a. The provider's failure to meet standards of licensure, certification, or registration where those standards are imposed by state or federal law as a condition to participation in the medicaid program.

   b. Because the provider has been similarly sanctioned by the medicare program or by another state's medicaid program.

3. An appeal must be filed with the department within thirty days of the date the notice of sanction is mailed to the provider.

4. Appeals taken are governed by chapter 75-01-03, and providers will be treated as claimants under that chapter.

5. Without prejudice to any right of appeal, the provider, upon receipt of notice of decision may in writing, request reconsideration. The request for reconsideration must include a statement refuting the stated basis for the imposition of the sanction. The division shall, within ten days after receipt of a request for reconsideration, make written response to the request, stating that imposition of the sanction has been affirmed or reversed.

History: Effective July 1, 1980; amended effective July 1, 2012.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 23-01-03, 23-16-01, 23-17.1-01, 23-20.1-04, 23-27-01, 25-16-02, 26.1-18-02, 43-05-09, 43-06-08, 43-12.1-03, 43-13-15, 43-15-15, 43-17-34, 43-26-13, 43-28-10, 43-32-17, 43-33-02, 43-37-03, 50-11.1-03;NDAC 75-01-03; 42 USC 1396a(a)(39); 42 CFR 431.151; 42 CFR 455.13

75-02-05-10. Provider information sessions. Repealed effective July 1, 2012.