Testimony
Senate Bill Number 2114 - Department of Human Services
House Human Services Committee
Representative Robin Weisz, Chairman
March 19, 2013

Chairman Weisz, and members of the House Human Services Committee, I am Jonathan Alm, an attorney with the Department of Human Services (Department). I appear before you to support Senate Bill 2114, which was introduced on behalf of the 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 Unit 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. To further enhance program integrity efforts, the Department is proposing the implementation of 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.

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 ten thousand dollars 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 or voluntarily or with a purpose. 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, requires that the State's share of all civil sanctions, investigative fees, costs, expenses, and interest received by the Department as a result of issuing a civil monetary sanction be deposited into the State's general fund.

The Department would use chapter 75-02-05 to carry out the imposition of civil monetary sanctions provided in this bill. Chapter 75-02-05 outlines a provider's responsibilities to the Department, the 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 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 a business integrity agreement, suspending Medicaid payments, imposing prepayment 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, 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.

An example of when civil monetary sanctions may be applied would be in a case where the provider has not improved practices after the Department has addressed repeated concerns with the provider and there has been no improvement or resolution in the practice or if the provider has not complied with the remedies imposed by the Department pursuant to a non-monetary sanction. For instance, if a Qualified Service Provider supplies an incorrect date for payment for services in error, and it is an occasional or one-time mistake; a civil monetary sanction would not be imposed. However, a civil monetary sanction may be imposed if a medical provider had been sanctioned under chapter 75-02-05 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 monetary sanction will be used with providers who have consistent, severe, and repetitive concerns.

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 if the provider or affiliate failed 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 intends to provide training on fraud and abuse deterrence efforts and on 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 try to answer any questions the committee may have. Thank you.