OFFICE OF THE STATE AUDITOR

PERFORMANCE AUDIT FOLLOW-UP REPORT

Status of Recommendations

Medicaid Provider and Recipient Fraud and Abuse

September 26, 2014

Report No. 3029.1

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September 26, 2014

Honorable Jack Dalrymple, Governor

Members of the North Dakota Legislative Assembly

A fundamental objective of the Office of the State Auditor's work is to bring about improvements through recommendations. To achieve this, our recommendations need to be timely and effectively implemented. The Legislative Audit and Fiscal Review Committee (LAFRC) has requested the Office of the State Auditor to perform follow-up work after presentation of performance audit reports to the Committee and to report those agencies which have not implemented audit recommendations.

The Office of the State Auditor conducted an audit follow-up on the performance audit of Medicaid Provider and Recipient Fraud and Abuse (report #3029) dated September 2, 2010. The objective of this follow-up audit was to determine the status of the 21 recommendations included in the performance audit report. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our conclusions based on our audit objectives. The audit period for which information was collected and reviewed was July 1, 2012 through May 31, 2014.

Included in the report are the conclusions we made regarding the status of the recommendations included in the performance audit. Management's responses are included for partially implemented and not implemented recommendations.

Sincerely,

Robert R. Peterson
State Auditor

OFFICE OF THE STATE AUDITOR

Performance Audit Follow-Up
Medicaid Provider and Recipient Fraud and Abuse
Summary of Recommendations

The objectives of the performance audit conducted on the Department of Human Services were to answer the following questions:

> Does the Department of Human Services adequately identify and pursue indications of potential Medicaid provider fraud and/or abuse?
>
> Does the Department of Human Services adequately identify and pursue indications of potential Medicaid recipient fraud and/or abuse?

A summary of our conclusions made during this follow-up regarding the status of the 21 recommendations is as follows:

Status of Recommendation	Number	Percentage
Fully Implemented	8	38%
Partially Implemented	11	52%
Not Implemented	2	10%

There are no Office of the State Auditor's concluding remarks in this report.

Partially Implemented

Not Implemented

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Surveillance and Utilization Review Process

Recommendation 1-1

We recommend the Department of Human Services promote a culture of identifying potential Medicaid fraud and abuse. At a minimum, the Department should:

a) Establish adequate policies and procedures for identifying potential Medicaid fraud and abuse including definitions and steps to take when indications of potential Medicaid fraud and abuse are identified;
b) Clearly define employees' responsibilities of identifying potential Medicaid fraud and abuse;
c) Communicate such responsibilities to employees; and
d) Provide adequate training for identifying potential fraud and abuse to employees.

Action Taken

The Department of Human Services (DHS) made efforts to promote a culture of identifying potential Medicaid fraud and abuse. However, based on the number of partially implemented recommendations, improvements are still needed.

While DHS established policies and procedures for identifying potential Medicaid fraud and abuse, we identified certain changes could be made for improvement. We also identified improvements were needed to ensure responsibilities of identifying potential Medicaid fraud and abuse are communicated to employees. DHS appears to have provided adequate training to employees in 2012 and 2013.

Status

Partially Implemented.

Management's Response

The Department agrees with the status. The Department will continue to require staff to annually view the Medicaid Fraud and Abuse training video and will enhance procedures to ensure staff is aware of their responsibilities of identifying and reporting potential Medicaid fraud, waste and abuse.

Recommendation 1-2

We recommend the Department of Human Services comply with federal requirements and ensure an effective surveillance and review process is established to protect the integrity of the Medicaid program.

Action Taken

DHS established a process for conducting analytical reviews of data to identify areas for further review. However, improvements are still needed as indications of potential fraud and abuse were not properly pursued.

Status

Partially Implemented.

Management's Response

The Department agrees with the status. The Department will ensure that all instances of potential fraud or abuse are pursued, followed up on and properly documented.

Recommendation 1-3

We recommend the Department of Human Services ensure the Surveillance and Utilization Review System Unit is sufficiently organized outside the control of the other Medicaid operations so the Unit can objectively perform its functions.

Action Taken

DHS reorganized the Surveillance and Utilization Review System (SURS) Unit within the Medical Services Division of DHS within the Program Integrity Unit (PIU). The Administrator of the SURS Unit now reports to the Program Integrity Administrator, who in turn reports to the Medical Services Division Director.

According to the Fraud and Abuse Unit and SURS Manual, prior approval is required from the Director of Medical Services and DHS Cabinet for quarterly provider reviews and six month analytical reviews. While the manual specifically states prior approval is not required from the Director of Medical Services for six month analytical recipient analysis, the Director continues to be approving the reviews. Also, we identified policy requires suspected provider fraud or abuse between $5,000 and $14,999 be discussed with legal and the Director of Medical Services for further analysis and direction. We conclude requiring prior approval of work plans from the Director of Medical Services and DHS Cabinet and the involvement of the Director of Medical Services when fraud or abuse is identified does not allow the SURS Unit to objectively perform its functions.

Status

Not Implemented.

Management's Response

The Department disagrees with the status. The Department however will review the reporting structure to ensure that SURS functions are objectively performed.

Recommendation 1-4

We recommend the Department of Human Services review staffing of the Surveillance and Utilization Review System Unit and the Fraud and Abuse Unit. At a minimum, the review should:

a) Identify duties/responsibilities of the units' employees which are not a responsibility of the units;
b) Determine whether duties can be reassigned; and
c) Ensure adequate resources exist for fulfilling mandatory responsibilities of the units.

Action Taken

While DHS has reviewed staffing of the SURS and the Fraud and Abuse Unit and appears to have implemented parts a) and b) of the recommendation, improvements are still needed to ensure adequate resources exist for fulfilling mandatory responsibilities of the units. A Program Integrity Unit (PIU) was created within the Medical Services Division. The unit includes Medicaid Provider Enrollment, SURS, and Third Party Liability (TPL). DHS obtained three additional full-time employee positions within PIU: an Audit Coordinator, a SURS Analyst, and a Provider Enrollment Specialist. We reviewed job duty questionnaires for SURS and PIU employees. All employees seemed to

be assigned tasks relevant to their responsibilities within the units. However, it appears the new MMIS project and provider enrollment backlog has consumed staff time during the last year for employees within PIU. This has reduced the amount of resources available for fulfilling the mandatory responsibilities of the units.

Status Partially Implemented.

Management's Response The Department agrees with the status.

Recommendation 1-5

We recommend the Department of Human Services ensure the administrator of the Surveillance and Utilization Review System Unit has the necessary knowledge and skills to conduct utilization reviews and identify suspected fraud by requiring the administrator to have the necessary qualifications as required by the Medicaid program.

Action Taken The SURS administrator referred to in the original audit is no longer employed at DHS. The SURS Administrator has an appropriate professional certification and experience in performing investigations.

Status Fully Implemented.

Recommendation 1-6

We recommend the Department of Human Services provide appropriate and convenient methods to report potential Medicaid fraud and abuse. The Department should:

a) Establish a dedicated 1-800 number for reporting fraud and abuse and/or add an option to the current Medical Services Division number dedicated to reporting fraud and abuse; and/or

b) Have an online form which can be submitted electronically.

Action Taken DHS created the SURS Referral form and provided an email address to report fraud and abuse electronically. In addition, DHS added an option to the current Medical Services Division number dedicated to reporting fraud and abuse. The DHS website also contains information on how to report fraud.

Status Fully Implemented.

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Medicaid Providers

Recommendation 2-1

We recommend the Department of Human Services submit a new request to the federal government for a Medicaid Fraud Control Unit waiver. Based on the determination from the federal government, the Department should:

a) Take appropriate action to establish a Medicaid Fraud Control Unit in the state of North Dakota; or

b) Ensure adequate resources are made available to efficiently and effectively investigate and refer Medicaid provider fraud and abuse.

Action Taken

DHS's response in the original audit stated it did not agree with the recommendation. The response stated DHS would contact the federal government to inquire to what extent conditions needed to change to require a new waiver request to be submitted and appropriate action would then be taken after information was provided by the federal government.

On November 5, 2010, DHS sent a letter to the Director of Medicaid Fraud Control Unit Oversight Division requesting guidance regarding to what extent conditions need to change to require North Dakota to request a new waiver. Nearly a year later (September 2011) DHS received a letter from the Director of the Medicaid Integrity Group. The letter stated recent events suggest a need to discuss the continuation of the waiver. DHS is still waiting for the Centers for Medicare and Medicaid Services (CMS) to provide guidance. While DHS took the action it said it would, this action did not implement the recommendation.

Status

Not Implemented.

Management's Response

The Department agrees with the status; however, the Department did what we said we would do, which is to contact the Centers for Medicare and Medicaid Services (CMS) inquiring to what extent conditions needed to change to require a new waiver request be submitted. The most recent information was requested by and sent to CMS in November 2011 and the Department has received no further response. Recently, the Health and Human Services (HHS) Office of Inspector General (OIG) announced their audit work plan for 2015. Included in the HHS OIG Work Plan for 2015 is "….We will also determine whether North Dakota, the only State that does not have a MFCU and that received an exemption in 1994, continues to operate under the conditions that support the State's exemption." Because HHS OIG will be reviewing the North Dakota MFCU exemption, we will allow their office to issue their findings before taking further action.

Recommendation 2-2

We recommend the Department of Human Services comply with federal requirements and take appropriate action when a provider is suspected of fraud or abuse following a preliminary investigation. When applicable, the Department should:

a) Conduct full investigations; or
b) Refer the case to an appropriate law enforcement agency

Action Taken

Through a review of information associated with preliminary investigations, it appears DHS is in compliance with federal requirements.

Status

Fully Implemented.

Recommendation 2-3

We recommend the Department of Human Services make improvements with the denied claims information received from the Quality Improvement Organization. At a minimum, the Department should:

a) Effectively monitor and identify patterns of inappropriate billings; and
b) Ensure inappropriate billing information is provided to the Surveillance and Utilization Review System Unit.

Action Taken

DHS has made improvements with the denied claims information received from the Quality Improvement Organization (QIO) by providing the information to the Program Integrity Administrator and having three SURS coders attend Utilization Review meetings. However, due to the sporadic receipt of denied claims information from QIO, the fact DHS held four quarterly meetings in a two-year period, and an apparent lack of utilization of the information provided by QIO, improvements are still needed related to monitoring and identifying patterns of inappropriate billings.

Status

Partially Implemented.

Management's Response

The Department agrees with the status and will ensure that the quarterly meetings are held and that additional information is provided when necessary (from the QIO), in order to better utilize the data. The Department will analyze all of the denied claims data received and determine if there are areas that warrant an audit or additional data analysis.

Recommendation 2-4

We recommend the Department of Human Services improve the post-payment review process of Medicaid providers to ensure fraud and abuse are effectively identified.

Action Taken

DHS has made improvements to the post-payment review process of Medicaid providers to ensure fraud and abuse are effectively identified. We judgmentally selected for review 4 of 25 provider audits started between July 1, 2012 and May 31, 2014. In three of the four audits reviewed, DHS either expanded testing, requested providers with errors to conduct provider self-audits, or referred the audit to a Recovery Audit

Contractor for further audit recoveries. The fourth audit reviewed, was put on hold by DHS management while alleged policy differences of the provider group are resolved. However, we identified improvements are still needed related to calculating and documenting audit error rates to identify whether expanded testing is required by DHS policy.

Status

Partially Implemented.

Management's Response

The Department agrees with the status and will take measures to continually improve the post payment review process. The Department has made changes to the audit coversheet to document audit error rates and to also specifically document if fraud, waste or abuse was identified. The Department will develop consistent methodology for the calculation and documentation of audit error rates. The Department will also expand its utilization of the Recovery Audit Contractor (RAC).

Recommendation 2-5

We recommend the Department of Human Services take appropriate action with ambulance provider claims to ensure Medicaid funds are properly expended. At a minimum, the Department should:

a) Ensure recovery of inappropriately paid claims;
b) Perform an analytical review of ambulance provider claims; and
c) Conduct necessary investigations of suspected provider fraud or abuse.

Action Taken

DHS has taken action with ambulance provider claims to ensure Medicaid funds are properly expended. DHS management stated the amounts identified as inappropriately paid during the original audit have been recovered. DHS had also established a prepayment review process for auditing ambulance claims. This process was discontinued in April 2014. Improvements needed with the prepayment review process include:

- Even though the review process identified claims were in need of being denied or downcoded, DHS did not take appropriate action to do so. In April 2014, DHS performed a review of the prepayment review process. Of 530 claims reviewed, DHS identified 173 (33%) claims were to be downcoded or denied due to the review and no appropriate action was taken. Thus, while DHS was aware certain claims were to be adjusted, no action was taken. As a result, Medicaid funds appear to have been improperly expended.
- Potential ambulance provider fraud and/or abuse was not being recognized and investigated as claims were only reviewed to determine whether they were to be denied or downcoded.
- The average number of monthly ambulance claims sampled was less than what was required by DHS policy (approximately 7% vs 10%, respectively).
- No expanding of the review was done even though approximately 5% of claims reviewed were to be denied and 50% of the claims were to be downcoded.

Status Partially Implemented.

Management's Response The Department agrees with the status. The Department discontinued auditing ambulance claims in April of 2014 in order to seek guidance from Medicare regarding ground ambulance auditing. Based on the guidance received, the state will create an ambulance review policy that will cover both the pre-payment layperson reviews and post payment reviews. The Department will expand any reviews if it is identified that a large number of claims were down coded or denied. All potential recoveries will be pursued.

Recommendation 2-6

We recommend the Department of Human Services make improvements with the audits/reviews conducted on Qualified Service Providers. At a minimum, the Department should:

a) Conduct analytical reviews of data to identify areas to audit/review;
b) Ensure adequate resources exist to conduct audits/reviews of Qualified Service Providers; and
c) Forward indications of Medicaid fraud and abuse to the Surveillance and Utilization Review System Unit, as applicable.

Action Taken DHS has made improvements with audits/reviews conducted on Qualified Service Providers (QSPs). Analytical reviews of data are performed to identify areas to audit/review. Also, Home and Community Based Services (HCBS) has added a new full-time employee to assist with county case management audits. Another employee now spends approximately 30-40% of their time auditing rural differentials (new rate went into effect January 2014 and has unique audit requirements). While DHS has forwarded indications of Medicaid fraud and abuse to the SURS Unit, we identified all indications of Medicaid fraud and abuse were not consistently being forwarded.

Status Partially Implemented.

Management's Response The Department agrees with the status. HCBS staff will forward all indications of fraud and abuse to the SURS unit per policy.

Recommendation 2-7

We recommend the Department of Human Services establish policies and procedures for conducting investigations of potential Medicaid provider fraud and/or abuse.

Action Taken DHS established policies and procedures for conducting investigations of suspected Medicaid provider fraud.

Status Fully Implemented.

Recommendation 2-8

We recommend the Department of Human Services establish policies and procedures for referring suspected Medicaid provider fraud.

Action Taken

DHS established policies and procedures for referring suspected Medicaid provider fraud.

Status

Fully Implemented.

Recommendation 2-9

We recommend the Department of Human Services review practices related to sanctions of Medicaid providers and make appropriate changes to use such options when applicable. At a minimum, the Department should:

a) Review and update North Dakota Administrative Code Chapter 75-02-05 and ensure rules are consistent with the Code of Federal Regulations requirements; and

b) Ensure civil penalties and other sanctions are imposed, as applicable, following investigations of providers which identify inappropriate billings, fraud, and/or abuse.

Action Taken

We identified appropriate changes have been made to update North Dakota Administrative Code (NDAC). DHS has made changes for sanctioning or terminating providers. However, we identified limited to no controls being established in DHS policy or procedure for ensuring civil penalties and other sanctions are imposed as applicable.

Status

Partially Implemented.

Management's Response

The Department agrees with the status. For the 2013 Legislative Session, and in response to the 2010 audit report, the Department introduced SB 2114, to allow the Department to impose sanctions to Medicaid providers. With the changes in NDCC & NDAC, the Department will develop a process to ensure that civil monetary penalties or other sanction activity are considered and imposed as applicable.

Chapter 2
Recommendations Medicaid Providers

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Medicaid Recipients

Recommendation 3-1

We recommend the Department of Human Services comply with federal requirements following preliminary investigations of Medicaid recipients. When applicable, the Department should:

a) Refer the case to an appropriate law enforcement agency if there is reason to believe a recipient has defrauded the Medicaid program; and

b) Conduct a full investigation of abuse if there is reason to believe a recipient has abused the Medicaid program.

Action Taken

We reviewed 9 cases related to preliminary investigations of Medicaid recipients. We identified appropriate action being taken by DHS following the preliminary investigation (4 cases were referred to law enforcement due to apparent fraudulent activity and 5 cases resulted in a full investigation). DHS has recouped approximately $80,000 of the $245,000 of Medicaid overpayments identified in the cases reviewed. DHS has either entered into an agreed upon payment plan with the recipients or turned the cases over to collections for the remaining balance.

Status

Fully Implemented.

Recommendation 3-2

We recommend the Department of Human Services make improvements communicating indications of fraud and/or abuse identified with any program recipient. At a minimum, the Department should:

a) Ensure the Surveillance and Utilization Review System Unit and/or Fraud and Abuse Unit are notified of all indications of potential Medicaid recipient fraud and/or abuse;

b) Communicate indications of fraud and/or abuse to other applicable program areas; and

c) Analyze the benefits of centralizing fraud and abuse information and work for all programs within the Department.

Action Taken

DHS made improvements communicating indications of fraud and/or abuse identified with program recipients. However, improvements are still needed.

It appears the SURS Unit is being notified of indications of potential Medicaid recipient fraud and/or abuse. DHS established policies and procedures for reporting improper payments and suspected fraud to the SURS Unit. Also, DHS established a new referral form for centralizing and sharing information related to recipient fraud and/or abuse. However, we identified the referral form was not being sent to Economic Assistance as required by DHS policy. Also, we identified the SURS Administrator was not communicating suspected fraud and abuse to at least two program administrators.

Status

Partially Implemented.

Management's Response The Department agrees with the status. The Department will share information specific to recipient fraud or abuse with other programs when allowed by federal regulation. The Department will consider including Child Care Assistance on the SFN 20 Referral Form.

Recommendation 3-3

We recommend the Department of Human Services establish policies and procedures for conducting investigations of potential Medicaid recipient fraud and/or abuse.

Action Taken DHS established policies and procedures for conducting investigations of potential Medicaid recipient fraud and/or abuse.

Status Fully Implemented.

Recommendation 3-4

We recommend the Department of Human Services establish policies and procedures for referring suspected Medicaid recipient fraud.

Action Taken DHS established policies and procedures for referring suspected Medicaid recipient fraud. However the referral requirements established by DHS are not consistent with the requirements in the Code of Federal Regulations (CFR). According to DHS policy, suspected Medicaid recipient fraud:

- Below $5,000 – is not referred to a law enforcement agency.
- Between $5,000 and $14,999 – is possibly referred to local law enforcement or a County State's Attorney's Office.
- Over $15,000 – will be referred to the Office of Inspector General and US Attorney's Office.

CFR requirements identify no dollar thresholds and state "If there is reason to believe that a recipient has defrauded the Medicaid program, the agency must refer the case to an appropriate law enforcement agency."

Status Partially Implemented.

Management's Response The Department agrees with the status and is developing procedures for ensuring instances of recipient fraud are referred to appropriate law enforcement agencies.

Recommendation 3-5

We recommend the Department of Human Services conduct a formal cost/benefit analysis to determine if the reestablishment of Welfare Fraud Units within North Dakota is warranted.

Action Taken While DHS conducted a welfare fraud unit analysis, the analysis contained no numerical measures or dollar values to approximate the costs of reestablishing Welfare Fraud Units or to estimate their associated benefits. As a result, the analysis conducted by DHS was not considered a "formal cost/benefit analysis." According to the analysis, DHS obtained various documents prepared by the Department surrounding the Welfare

Fraud units, read various newspaper articles on welfare fraud, discussed the topic with various County Social Service Board Directors, and spoke to eligibility workers interviewed by the Office of the State Auditor during the original audit.

Status Partially Implemented.

Management's Response The Department agrees with the status that a formal cost benefit analysis was not completed. A detailed cost benefit analysis of the Welfare Fraud Units was provided to the 1999 Legislative Assembly, who chose not to include the funding for these activities in the Department's 1999-2001 appropriation. Considering the unique relationship between each state and county government, and the resulting interaction with the state's attorney's, the Department did not believe contacting surrounding states would provide any substantiated monetary evidence to determine if the Welfare Fraud Units should be reestablished in North Dakota. Therefore the Department performed an in-depth analysis of the issues surrounding the identification, reporting and prosecution of economic assistance fraud in North Dakota. Based upon the analysis, the Department provided the counties access to tools to detect and report fraud, and also identified the need for and assisted the counties to cultivate relationships with local law enforcement agencies and state's attorney's to encourage the prosecuting of recipient fraud cases.

Recommendation 3-6

We recommend the Department of Human Services modify requirements in the Medicaid Program Policy Manual related to county social services offices referring all recipient errors to the State's Attorney's Office. At a minimum, the Department should:

a) Establish criteria for recipient errors which must be reported to the Surveillance and Utilization Review System Unit; and

b) No longer require counties to refer all recipient errors to the State's Attorney's Office.

Action Taken DHS modified requirements in policy and established criteria for recipient errors which must be reported to the SURS Unit. The revised policy requires the county social service offices to refer all recipient errors in which there is an overpayment or suspected fraud (regardless of overpayment) to the SURS Unit. In addition, DHS policy no longer requires counties to refer all recipient errors to the State Attorney's Office.

Status Fully Implemented.