17.0617.02000

FISCAL NOTE

Requested by Legislative Council
02/08/2017

Amendment to: HB 1226

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2015-2017 Biennium		2017-2019 Biennium		2019-2021 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures						
Appropriations						

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2015-2017 Biennium	2017-2019 Biennium	2019-2021 Biennium
Counties			
Cities			
School Districts			
Townships			

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

This bill provides for a study of a Medicaid Fraud Control Unit (MFCU). For a decade the US Department of Health and Human Services (DHHS) has given North Dakota, the only remaining state, a waiver from having a MFCU.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

On January 6, 2017, the Governor received a letter from the federal DHHS informing North Dakota it would no longer operate under a MFCU waiver. This bill originally established a MFCU in the Office of Attorney General, where it is located in most other states. This bill has now been made into a study. A similar bill for a MFCU study passed in the 2015 and was not prioritized for study.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

N/A

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

N/A

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

N/A

Name: Kathy Roll
Agency: Office of Attorney General
Telephone: 328-3622
Date Prepared: 02/08/2017

17.0617.01000

FISCAL NOTE

Requested by Legislative Council
01/10/2017

Bill/Resolution No.: HB 1226

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2015-2017 Biennium		2017-2019 Biennium		2019-2021 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues					$1,000,000	
Expenditures			$156,160	$1,405,444	$261,346	$1,232,059
Appropriations			$156,160	$1,405,444	$261,346	$1,232,059

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2015-2017 Biennium	2017-2019 Biennium	2019-2021 Biennium
Counties			
Cities			
School Districts			
Townships			

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

This bill establishes a Medicaid Fraud Control Unit (MFCU) division in the Office of Attorney General. For a decade the US Department of Health and Human Services (DHHS)has given North Dakota, the only remaining state, a waiver from having a MFCU.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

On January 6, 2017, the Governor received a letter from the DHHS informing North Dakota it would no longer operate under a MFCU waiver. This bill establishes a MFCU in the Office of Attorney General, where it is located in most other states. The MFCU investigates and prosecutes Medicaid fraud activities and false claims by medical service providers, as established in House Bill Nos. 1174 and 1227.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

Although not known at this time for North Dakota, neighboring states with similar populations and Medicaid expenditures have seen recoveries ranging between $9-23 million over a six year period. North Dakota may see Medicaid recoveries at the least the lower part of the range although that is really unknown at this time. It is assumed the recoveries will likely be seen in the 2019-21 biennium given the startup time needed for investigations and adjudication. The estimated general fund revenue for the 2019-21 biennium is $1 million.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

For the first three years the federal government pays 90% of the unit costs and the general fund is responsible for 10% of the costs. After three years, the federal government pays 75% of the cost and the general fund pays 25% of the cost.

As requested, the MFCU consists of 6 staff members - 2 assistant attorneys general, 2 investigators, 1 auditor and 1 administrative assistant. The estimated cost for the staff and related expenses totals $1,561,604 for the 2017-19 biennium of which $1,405,444 is from federal funds and $156,160 is from the general fund. For the 2019-21 biennium, the estimated costs of the unit total $1,493,405, of which $1,232,059 is from federal funds and $261,346 is from the general fund. The request for 2 assistant attorneys general and 2 investigators results from the unit handling both criminal and civil forfeiture cases. Based on information from other like states this is the number of staff members needed to adequately staff the unit and manage the unit's workload.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

The Executive budget did not include funding for the unit.

For the 2017-19 biennium, the amount needed for the unit totals $1,561,604 of which $1,405,444 is from federal funds and $156,160 is from the general fund. For the 2019-21 biennium, the estimated costs of the unit total $1,493,405, of which $1,232,059 is from federal funds and $261,346 is from the general fund.

Name: Kathy Roll

Agency: Office of Attorney General

Telephone: 328-3622

Date Prepared: 01/17/2017

2017 HOUSE HUMAN SERVICES

HB 1226

2017 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB 1226
1/23/2017
27210

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Judy Kepple

Explanation or reason for introduction of bill/resolution:
Relating to the creation of a Medicaid fraud control unit in the attorney general's office

Minutes: 1, 2,

Chairman Weisz: called the committee to order.

Attendance taken

Chairman Weisz: Opened hearing on HB 1226

Rep. Hogan
(Attachment 1)

Chairman Weisz: questions from the committee?

Further testimony in support of HB 1226

Testimony in opposition of HB1226?

Neutral testimony on HB 1226
6:00
Shelly Peterson, President of NDLTCA
(Attachment 2)
15:11
Chairman Weisz: Are there any questions from the committee?

Representative Devlin: I can't remember Shelly ever testifying in a neutral position. So you feel that this is an absolute duplication of federal law that is already in place? Is that what the short version of your summary would be?

S. Peterson: My neutral testimony is that in the letter Governor Dalrymple received in December it is indicated that a new waiver was not approved. We are still operating under the existing1994 waiver, so the waiver is in place. We further believe that when you look at the letter it says that CMS is requesting ND to submit an implementation plan within 60

days of the receipt of the letter. It says that the implementation plan should be a time table for establishing it. ND has to develop an implementation plan with a time table. It doesn't say that we have to do it now. It says the governor establishes the time frame. We believe there is an enormous amount going on at this time and would it be prudent and good to look at how should we best develop a fraud unit, where is it necessary, what are we doing right now, what are the various entities required to do, where do we maybe have gaps and what would be the best process of implementing a unit? I know the vast majority put it in the Attorney General's office, but should we truly have maybe a neutral place. We have time at all of that. It is kind of like kicking the can down the road to give us time and thought on what is necessary. The other thing is, we have had this waiver since 1994 and they just received the letter in December. Is that something that should be appealed? We have had the waiver. It was circumstances that the state brought the issue to the feds. I would say let's just take time. The $156,000 in general funds in my opinion is to put that money back into the allotment cuts.
18:51

Representative Seibel: Do you have any idea how long we can operate under this waiver? So if we don't do something they may just pull our funding?

S. Peterson: What funding? I guess that is a question for Maggie. We have an existing waiver, they haven't said that it is not effective, they didn't like the new one, but we are still operating under the existing waiver if you look at the letter. It said submitting implementation plan with a time frame. So to me that says that it is in our court now. What do we as a state want to do. They didn't tell us what our time frame has to be.

Representative Seibel: Can we get a copy of that letter?

Maggie Anderson, Department of Human Services.

Representative Representative Seibel: How long can we operate under the old waiver?

M. Anderson: I will answer that by going back and giving a little bit of history. So what Shelly indicated is that we do have a letter from 1994 that at the time it indicated that the federal government had approved the state's request for a waiver from having a Medicaid fraud control unit. My earliest recollection of then there being a disagreement with that was in 2010 when the department had a performance audit. It was a finding or recommendation that the state move forward to establish a Medicaid fraud control unit. Part of the department's response was that we have a waiver in place. There are Medicaid waivers that are time limited. On this type of waiver there was no time limit to it. Subsequently this has been an ongoing audit finding of the department on the single audit since 2010. There have been variations of the actual recommendations some were that the waiver had expired and we should seek a new one, or we should ask the federal government what conditions would need to change in order for us to seek a new waiver. There were a lot of communications back and forth from our office and the federal government. Between 2010 and the spring of 2016, there were various emails and sometimes those things would have turnaround quickly and sometimes not. In May of 2016 Gov. Dalrymple received a letter from CMS basically saying you have been operating under this long standing waiver since 1994 and they asked

us several questions and the they asked the governor that ND provide notification on it's intent to establish a Medicaid fraud control unit or that the state submit a new waiver request justifying the continued absence of a unit based on current information. On September 12 Gov. Dalrymple sent a letter back asking for an extension to the waiver. On January 6, 2017 we received a letter from CMS and this is what they said. CMS is requesting that ND submit an implementation plan within 60 days of this letter including a time table including the earliest feasible by which ND will submit an application for certification of a Medicaid fraud control unit. These 3 bills are introduced. There are 3 bills 1174 which is the false claims act, 1227 the Medicaid fraud, and then the one in front of you right now. Essentially the planned approach is that there are 3 bills in play right now and we need to see what happens in the legislative session. If the bills are adopted and the money is appropriated to start a Medicaid fraud control unit then that timetable has been set by the legislature. If the bills are not passed or the appropriations are not provided, then the governor would have to submit a plan with a timetable at that time.

Representative Devlin: Is there a plan that could be submitted that would allow us to continue with the waiver we have now for a while?

M. Anderson: Ultimately that would be the governor's discretion. I know that Gov. Burgum has submitted a letter to congressional leadership, not specific to Medicaid fraud control, but a letter did go out to all the governors and all the state insurance commissioners asking for global input on affordable care act and requirements and things like that. It is kind of the one size fits all approach whether it be Medicaid fraud control unit or something else. Are there varying degrees of how those things should be done. I can't speak for the governor though.

Chairman Weisz: Further questions?

Representative McWilliams: With there being somebody new in the position in Washington D.C. would it be an option to go to the new person and ask if we can continue with the waiver or is the previous decision of the predecessor stand.

M. Anderson: I think that is always an option. They can always say no. There is a requirement. There is a proposed rule that came out Sept. 2016. The administration issued a proposed rule. This is really the first time they have made policy and practice changes since the regulation was initially issued in1978. One of the things they speak to in here is the state plan requirement, so while the unit will be outside of the state Medicaid agency, the state Medicaid agency would still then have to have a state plan amendment if these rules are finalized as proposed speaking to a Medicaid fraud control unit. I don't know then if that state plan piece will afford an opportunity for a waiver. All of this has to play out. Simply to answer your question, a person can always ask.
Lots has to play out.

Representative Skroch: What the cost and loss would be to the state of ND if we were considered noncompliant by the federal government?

M. Anderson: Medicaid grants for 2017 - 2019 is 2.4 billion so about half of that amount would be federal. Some would be Medicaid expansion at a much higher federal match, so

ultimately if we disagree or whatever and we are not going to do all of that. There would be a corrective action plan, we would have a series of conversations and letters. It is not like the governor's letter back says we want to have them reconsider, it would not be the next day that they would pull our funding. We can talk about a number, but I don't believe the state would place that entire federal financing in jeopardy, but it is probably about 1 billion dollars or more than that per biennium.

Representative Skroch: So this is not something that has to be done in 60 days. We could take some time to appeal and resubmit to the new administration.

M. Anderson: Clearly it does not have to be implemented in 60 days. That I don't even believe would be possible. What the letter clearly says is that the governor needs to submit an implementation plan within 60 days of receipt of the letter. The implementation plan should include a time table, including the earliest feasible date by which the Medicaid fraud unit could be certified.

Chairman Weisz: Further questions?

Any more neutral testimony? Seeing none.

Closed Hearing on HB 1226.

2017 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB 1226
2/7/2017
27995

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Judy Kopp

Explanation or reason for introduction of bill/resolution:

Relating to the creation of a Medicaid fraud control unit in the attorney general's office.

Minutes:

Chairman Weisz: Opened the discussion on HB 1226.

Representative P. Anderson: If we have a government that is not going to renew our waiver so we pretty much have to do something.

Chairman Weisz: There are also going to be some amendment floating around that give us the opportunity to take a look at this and delay it for two years. We have had this in front of us at least twice before or maybe even three times. That is why I say that the discussion needs to be whether we want to move forward and just add Medicaid fraud, do we want to give some opportunity to appeal the decision by CMS and see if the new administration has a change in their policy. That is the discussion this committee needs to have. If we want the Medicaid fraud unit then we certainly need to look at the language and how we make this. That was the amendment provided by Rep. Hogan. I want to know where the committee is at on this.

Representative Devlin: I am not convinced that we need it at this time. I would be more willing to study it and see what happens with the new administration and see what happens with the CMS appeal. I do have an amendment to change the bill into a study, but if you are going to deal with Rep. Hogan's amendment first either way works.

Chairman Weisz: I think we need to have the discussion as to which direction we want to go.

Representative Schneider: Can we ask M. Anderson what the implications are to having our waiver frozen into the future, because that would be the difference from the last time this bill came before the committee I am assuming.

Chairman Weisz: That question was asked in the hearing too, but she can restate it for us here.

M. Anderson, Department of Human Services.
The letter the federal government sent to the governor's office in early January indicated that they were not going to approve the request to extend the waiver or renew the waiver. There has been no end date that says your waiver ends this date. What they requested in that letter then was within 60 days for the governor to submit a plan for next steps. So on January 31 Gov. Burgum did respond to the letter. The letter says we received your letter, we have a biennial session, and this was not included in the executive request. However, there are three bills. Should those bills pass, the governor would sign them and if they don't pass then the governor will submit a plan as to how he will do this within the 60 -day time frame. So essentially it was there are these 3 bills, let's see what happens with them. If the bills do not pass, then he will submit a plan for how we will be doing this within the 60 days.

Representative Schneider: Are there programs that are going to be eliminated or hurt because we don't get our waiver approved.

M. Anderson: There has been no speaking of that in the communication that has come from the federal government at this time. Where these types of things are falling in the priorities of the new people in the federal government is difficult to know, but they have not threatened the Medicaid program or the Medicaid funding. They have indicated to the governor that he needs to submit a plan. The current waiver that we have does not have an end date to it. All they indicated in response to the letter was that they are not going to give us a new waiver, but they did not say that the current one ends. So let's just say that all 3 bills fail then I will keep the centers for Medicare and Medicaid services updated, so I would notify them of that and then we would start working on what that plan looks like. If they all pass, then the AG's office or whoever the governor's office designates would design that.

Representative Porter: Great explanation from M. Anderson and going forward. I think that just brings it more into light that what Representative Devlin was presenting in regards to a study and to look at this and make sure that we are moving this in the right direction. These bills all have a huge fiscal effect in the future as the federal funding weans off and then we are stuck with the program that now has to meet their requirements for the waiver. We also have a brand new MMIS system, but we don't even know if it is tracking utilizations and if the department is using it to call people up and saying that they double billed us or billed us for services that weren't part of it, so I think it even points more toward the study. Since we have all of the new things in the federal

Vice Chairman Rohr: I was not here when we had the hearing for this, so I see that LTC was here and talked about Medicaid fraud and how well the system works to detect that. There are other factions. Did we hear from anyone else? I think of hospitals, clinics, etc. and I just wondered if they had any data.

Chairman Weisz: Vice Chairman Rohr, the letter that we received from CMS seemed to argue that certain states were getting a return on their investment. I think it was Wyoming, Montana and one other state were the ones. One state didn't. I think it was SD. I guess it was Montana that had a negative return. Wyoming recovered 1.3 million and expended 1.4 million. Supposedly SD recovered $7 million and spend $1.2 million. That was always the debate we had before. I know prior to my term in office, counties did it. It was always the counties job to investigate fraud and they got a cut out of what they recovered and basically

in the end they said it wasn't worth it. We eliminated that after the 97 session. I guess the committee would have to look at whether they think there is major fraud going on with our providers. If we do, then a fraud unit will help, but it certainly is going to cost us money up front.

Representative P. Anderson: I think we need to be proactive. We are the only state that isn't doing it. I can't believe they are going to say take two years to study it and then another 2 years to put it in a bill. The way I understand it is that if we don't do something the governor's office will put together a fraud unit.

Chairman Weisz: Maybe you should hand out the proposed amendments, Representative Devlin. The governor would have to forward a plan to CMS about how they are going to comply. He can't do a lot without legislative authority, so there still has to be in conjunction with legislative authority. He could show a plan of what we plan to do. The amendment says that the department will report to legislative management together with any legislation required to implement the recommendations. Basically the department of human services along with the governor and the attorney general shall study the feasibility of establishing a Medicaid fraud unit. Then they need to put together the legislation that they feel is necessary to make it happen.

Representative B. Anderson: I was just going to say that I would be in favor of the amendment.

Representative Westlind: I would be in favor of the motion to do a study. I think if you are going to see fraud it will be in private practice. I think the study would be the way to go.

Representative Porter: The other consideration the study brings into play is the size and the complexity of the unit. Right now we are talking about 6 FPEs inside of this bill. Is it too big or too small? I think we need to answer these questions before we commit the state of ND to the unit and I think that is part of what the study does. The federal funds only last so long and then it becomes the responsibility of the state of ND. It then becomes a general fund obligation.

Chairman Weisz: Maggie, I have a question. Whatever is recovered in fraud is split 50/50? Do we get any extra kick from it? The feds get there's and we get ours?

M. Anderson: It would depend on the particular service or eligibility group. So if the fraud say was found in Medicaid expansion, where it is a higher match more of it could be returned to the feds, but that would also have to be worked back through the actuarial rates, because that is a managed care product. Another straight example would be family planning services. The federal government reimburses Medicaid at 90% for family planning service. Straight fee for service, forget managed care for a minute. If you found fraud in managed care situation and it was family planning, then you would have to return 90% to the federal government. So it would really depend on the category of individuals in the services as to what %. The other piece is HB 1174 which is over in Rep. Koppelman's committee which is the false claims act. It does add that extra piece and then if you have a false claims act the state you are allowed to keep an extra 10%. That is what it was when we introduced the bill in 2007. My understanding is that with the provisions of a false

claims act is that you are allowed to keep an addition 10% if you have a false claims act in place along with a Medicaid fraud control unit.

Chairman Weisz: That way you can keep 10% of the feds share.

M. Anderson: Correct. That would impact the global drug settlements that the state currently receives. We would be able to keep an additional 10% of that too.

Chairman Weisz: What does the committee want to do?

Representative Devlin: I move the amendment I submitted, 1001 to turn it into a study,

Representative B. Anderson: second

Chairman Weisz: Discussion now committee. This is basically philosophical whether we do it now or do it later. Ok I will try a voice vote.

Voice vote taken.
Carried to accept the amendment, 01001 to turn it into a study.
Motion carried.

Chairman Weisz: We have an amended bill in front of us. What are the committee's wishes?

Representative Damschen: I move a do pass as amended on HB 1226

Vice Chairman Rohr: second

Chairman Weisz: discussion?

Clerk will call the roll on a do pass as amended on HB 1226.

Roll call taken. Yes 9 No 1 Absent 4

Motion carried.

Chairman Weisz will carry this bill.

2/7/17 DP

17.0617.01001
Title.02000

Prepared by the Legislative Council staff for
Representative Weisz
February 7, 2017

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1226

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for a study of establishment of a medicaid fraud control unit and a report to the legislative management.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. MEDICAID FRAUD CONTROL UNIT STUDY - REPORT TO LEGISLATIVE MANAGEMENT. During the 2017-18 interim, the department of human services, with the cooperation of the governor and the attorney general, shall study the feasibility and desirability of establishing a medicaid fraud control unit. Before August 1, 2018, the department of human services shall report to the legislative management the outcome of this study, together with any legislation required to implement the recommendations."

Renumber accordingly

Date: 2/7/17
Roll Call Vote #: 1

2017 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1226

House Human Services 17.0617.01001 Committee

☐ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☑ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Rep. Devlin Seconded By Rep. B. Anderson

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz			Rep. P. Anderson		
Vice Chairman Rohr			Rep. Schneider		
Rep. B. Anderson					
Rep. D. Anderson					
Rep. Damschen					
Rep. Devlin					
Rep. Kiefert					
Rep. McWilliams					
Rep. Porter					
Rep. Seibel					
Rep. Skroch					
Rep. Westlind					

Voice Vote Carried to adopt amendment.

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2/7/17
Roll Call Vote #: 2

2017 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1226

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☐ Adopt Amendment
☑ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☑ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Rep. Damschen Seconded By Rep. Rohr

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz	✓		Rep. P. Anderson		✓
Vice Chairman Rohr	✓		Rep. Schneider	abs.	
Rep. B. Anderson	abs.				
Rep. D. Anderson	✓				
Rep. Damschen	✓				
Rep. Devlin	✓				
Rep. Kiefert	✓				
Rep. McWilliams	✓				
Rep. Porter	✓				
Rep. Seibel	abs.				
Rep. Skroch	abs.				
Rep. Westlind	✓				

Total (Yes) 9 No 1

Absent 4

Floor Assignment Rep. Weisz

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1226: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (9 YEAS, 1 NAYS, 4 ABSENT AND NOT VOTING). HB 1226 was placed on the Sixth order on the calendar.

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for a study of establishment of a medicaid fraud control unit and a report to the legislative management.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. MEDICAID FRAUD CONTROL UNIT STUDY - REPORT TO LEGISLATIVE MANAGEMENT. During the 2017-18 interim, the department of human services, with the cooperation of the governor and the attorney general, shall study the feasibility and desirability of establishing a medicaid fraud control unit. Before August 1, 2018, the department of human services shall report to the legislative management the outcome of this study, together with any legislation required to implement the recommendations."

Renumber accordingly

2017 SENATE HUMAN SERVICES

HB 1226

2017 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1226
3/6/2017
Job Number 28733

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Marie Johnson

Explanation or reason for introduction of bill/resolution:

A bill to provide for a study of establishment of a Medicaid fraud control unit and a report to the legislative management.

Minutes: 2 attachments

Chair J. Lee: Brought the hearing to order, Sen. Kreun was absent.

Rep. Kathy Hogan, District 21 (0:30-4:20) Introduced the bill, please see attachments #1, 2. The original cost is 90% federal, 10% state match. There are 2 states without Medicaid fraud programs. The collections collected from fraud investigations more than equals the cost. The difficulty is the money that's collected has to go to the general fund, and the expenditures have to come out of the general fund, you can't link them, there are Federal rules that say you can't link them. The income from collections after about two years outweighs the cost. This is a program that's targeted at provider fraud, I gave you a report given out by the National Association of Medicaid Fraud Control Units (please see attachment #2), which gives you some examples. This is a reference point for you.

Chair J. Lee: But nothing bad ever happens in North Dakota. We don't have any financial abuse of adults or Medicaid fraud, do we?

Rep. Hogan: The answer to that is that some of the things are national trends are things like medical equipment online, scooters for example, those are the kinds of things that generate significant fraud, those have had big collections in some states. Those are examples, I don't believe that the majority of providers are committing fraud, but I think that we as a state need to assure that our funds being used appropriately.

Chair J. Lee: It isn't targeted at individual consumers. The provider fraud is where the money is.

No opposition, or neutral testimony.

Senator Anderson: I've had experience with Medicaid fraud in the past, the Department had procedures in place to take care of that, explain what Medicaid does now when they perceive fraud?

Maggie Anderson, Director, DHS: we have a program integrity unit within the medical services division that unit does provider enrollment, survey and utilization review, the federal auditors, the payment error rate measurement audits, the recovery audit contractors; and they also do 3rd party liability, as well as our fraud waste and abuse efforts. We also have medical staff, throughout the Department, so if someone notices something in claims, they may then seek additional data, if they found an issue, they work with our program integrity staff to investigate, if it leads to belief for need for prosecution, we turn those items over to the regional office of the Inspector General. The piece that's different with the Medicaid Fraud Control Unit, is the Department doesn't have prosecution authority, the Medicaid Fraud Control Unit has authority, the program integrity unit within the medical services division instead of turning over to States attorney or the OIG office, they would turn it over to the Medicaid Fraud Control Unit, who would complete the investigation, and prosecute if necessary.

Senator Anderson: How do you perceive the Medicaid Fraud Unit to be different from your integrity unit?

Ms. Anderson: Our Medicaid Program Integrity Unit doesn't have the same staffing; the staffing required for a Medicaid Control Fraud Unit, must include 1 or more attorneys, 1 or more experienced auditors, we have staff who maintain certification for fraud examiners, a senior investigator with substantial experience in commercial or financial investigations, who is capable of supervising and directing the investigation activities of the Unit. We don't have anybody tagged as an investigator, our staff do investigations as part of their work. What is different, our staff do audits and recoveries, often times those are people who misunderstood policy, or they fat fingered a claim; it's when we find that's there's a problem within that review; that seems to be indicative of something greater than human error. In those situations, we would investigate and today we would turn it over to other individuals to prosecute, if there was a Medicaid Fraud Control Units, we would turn it over to them.

Senator Anderson: But that's not good enough for the feds, is that what we're hearing here?

Ms. Anderson: The Medicaid Fraud Control Units, our waiver dates back to the mid-1990s, and the Medicaid Fraud Control Units came before that, that was before we had Payment Error Rates Measurements audits, Recovery Audit Contractors (RAC) audits, before many Medicaid programs even thought about having a Medicaid Program Integrity Unit. It was 2009 when the agency approached the Director at the time, this is where programs need to go to review claims and establish appropriate overpayments; we established a Medicaid Program Integrity Unit within the Medical Services Division. The feds are saying yes, you need both, what you are doing within your agency and then Medicaid Fraud Control Unit; keeping in mind the Medicaid Fraud Control Units, by regulation has to be distinct. There would be an agreement between the two entities, if they found over claims; those would need to come back to us to process the claims, the referrals would come from us to them. They would do their own data mining of our system. They would have user access into NMIS.

Senator Heckaman: When I look at the letter from Mr. Slavitt, it says you have 60 days to prepare your reply, but then it says you should include a timetable and the earliest feasible date. Can you do that without having authority to do that? Is this study going to keep you in the timeframe? Do we need an appropriation for this?

Ms. Anderson: If you look Governor Burgum's letter, it reads essentially to let the acting administrator at CMS; we address the letter to Tim Hill, and at the point where this legislation was final, whichever pieces we told them there were 3 different bills; we indicated that I would keep the Centers for Medicaid Services updated on the status of those bills, at the end of the session, we would see what that 60-day plan looked like, if all 3 bills had passed in there amended form, then that would have addressed the timeline, at this point with the 1174 and 1227 being defeated, and the study in place, then our plan to the federal government would be that the department has been directed to conduct this study along with the Attorney General's office and that our end goal would be a proposal for the 2019 biennium.

Senator Heckaman: So actually we could be out 4-5 years to implementation?

Ms. Anderson: I don't think you'd be out more than 2 years for a plan, coming out of the next session would be the speed at which a Unit could be up and running.

Senator Heckaman: What happens if you get a reply saying that no, that's too long, you have to do this ahead of time, can you handle that?

Ms. Anderson: There would be no appropriation to the DHS for this bill, I'd have to ask the AG if they're comfortable answering that question, absent an appropriation and an FTE, then you would be looking at a unit with temps, what I will say is that this area, the Department's had audit finding in this area since prior to 2010 surge performance audit, we have been having conversations with CMS for that entire duration, where we ask different questions, has the waiver expired, do we need a new waiver, throughout all those conversations I have reminded the federal government that we have a biennial session. This conversation has been ongoing; it's not like it started on January 6th, the communication has been back and forth for at least a decade.

Senator Piepkorn: Looking at stories, it goes from $2,000 to $750,000 fine. Fraud ranges quite expansively, with that in mind, Rep. Hogan stated that our income will exceed the cost, do you think that's the case, describe the situation, is there major fraud in North Dakota?

Ms. Anderson: So currently, we recoup overpayments on a routine basis. In the example of a home care provider, who did five days of work and billed us for seven. We have staff doing audits all the time in various areas, when we find that, we recoup the funds. If we find that it's more than just a human error, we will investigate, sometimes we terminate provider agreements. We may refer that person for prosecution, I can't speculate. We have found some things. The Program Integrity Unit meets on a regular basis, find audit topics to focus on, work with staff to pull review information. Cross system there have been audits that have netted couple $100,000 funds, where we noticed in within a particular provider type. In regards to covering the costs, that's really difficult for me to answer because we don't have a Medicaid Fraud Control Unit, there's a lot of data out there that the Unit publishes in an

annual report that shows the amount of federal and state dollars going into those, and the recoveries, I can send a link to the committee.

Chair J. Lee: Closed the Public hearing.

2017 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1226
3/6/2017
Job Number 28737

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Maine Johnson

Explanation or reason for introduction of bill/resolution:

A bill to provide for a study of establishment of a Medicaid fraud control unit and a report to the legislative management.

Minutes: No Attachments

Chair J. Lee: Brought the hearing to order, all members were present.

Senator Heckaman: I move Do Pass.

Senator Piepkorn: Second.

V-Chair Larsen: This is growing government, I don't support it, we're already doing it.

Chair J. Lee: If the Feds didn't say we had to do it, we wouldn't be doing it.

Senator Anderson: If you read the letter from the governor (attachment #2, Minutes from 3/6; Job Number 28733), he was pretty strong about saying just what Sen. Larsen just indicated, you don't need a Fraud Unit if there's not that much fraud, we have some in the state, I'm dealing with some of those cases right now; but it isn't as big a deal in North Dakota as it is other places. Medicaid doesn't do a lot of business with out of state people. Medicare is a bigger problem.

Roll call vote was taken.

Motion passes 6-1-0.

Senator Kreun will carry.

Chair J. Lee: Closed the hearing.

Date: 3/6 2017

Roll Call Vote #: 1

2017 SENATE STANDING COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. 1226

Senate Human Services Committee

☐ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Sen. Heckaman Seconded By Sen. Piepkorn

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)	X		Senator Joan Heckaman	X	
Senator Oley Larsen (Vice-Chair)		X	Senator Merrill Piepkorn	X	
Senator Howard C. Anderson, Jr.	X				
Senator David A. Clemens	X				
Senator Curt Kreun	X				

Total (Yes) 6 No 1

Absent 0

Floor Assignment Sen. Kreun

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1226, as engrossed: Human Services Committee (Sen. J. Lee, Chairman) recommends **DO PASS** (6 YEAS, 1 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1226 was placed on the Fourteenth order on the calendar.

2017 TESTIMONY

HB 1226

Att. 1
HB 1226
1-23-17

TESTIMONY
HB 1226
House Human Services Committee
January 23, 2017
Representative Kathy Hogan

Chairman Weisz and member of the House Human Service Committee, for the record, my name is Kathy Hogan and I represent District 21, the heart of Fargo.

HB Bill 1226 is the third of the Welfare Fraud bills. This is the bill that will establish a Medicaid fraud unit in the Attorney General's office.

There has been some discussion regarding placing the unit in the ND Department of Human Services. For your information, here is the federal regulation regarding the relationship between Medicaid and the fraud unit.

42 CFR § 1007.9

Relationship to, and agreement with, the Medicaid agency.

(a) The unit must be separate and distinct from the Medicaid agency.

(b) No official of the Medicaid agency will have authority to review the activities of the unit or to review or overrule the referral of a suspected criminal violation to an appropriate prosecuting authority.

(c) The unit will not receive funds paid under this part either from or through the Medicaid agency.

(d) The unit will enter into an agreement with the Medicaid agency under which the Medicaid agency will agree to comply with all requirements of § 455.21(a)(2) of this title.

This bill was drafted in collaboration with the Attorney General's office. The proposed staffing pattern and structure was based on the South Dakota model because it is a parallel state regarding size and organization. As you will note, the funding for this unit is 90% federal for the first three years and then it is 75% federal. The first years of funding are incentive because typically, states are able to retain their share of Medicaid fraud claims which can then cover the cost of the program and in the long run generate additional general fund revenue in Medicaid recovery.

Staff from the Attorney General's office are available to answer specific question and they have drafted amendments which I support.

Thank you for your consideration and I would be more than willing to answer any questions.

att. 2
HB1226
1-23-17

Testimony on HB 1226

House Human Services Committee

January 23, 2017

Good afternoon Chairman Weisz and members of House Human Services Committee. My name is Shelly Peterson, President of the North Dakota Long Term Care Association (NDLTCA). We represent 210 assisted living, basic care and nursing facilities in North Dakota. I am here today to talk about abuse and neglect in nursing facilities and the extensive requirements in place to assure all residents in a nursing facility are free from abuse, neglect and exploitation.

Each facility has safe guards and practices in place to guard against abuse, neglect and exploitation. Should those safe guards fail and there is an allegation of abuse, neglect or exploitation, it is reported and investigated. We have state and federal statutes that govern the response time on reporting, investigation and follow-up. Having a role in the process could be the State Ombudsman, Adult Protective Services, the State Health Department, local Law Enforcement and the Department of Justice. I am only going to briefly cover three aspects, Nursing Facility State Licensing Rules, Federal Nursing Facility Regulations and the Elder Justice Act.

Regulation and oversight is extensive in this area; a lot has changed and improved since the implementation of Medicaid Fraud Units in the mid 90's. We believe North Dakota has a comprehensive approach to this issue.

I. STATE LICENSING

NDAC 33-07-03.2-07. Governing Body.

3. The governing body must ensure sufficient trained and competent staff is employed to meet the residents needs. The governing body shall approve and ensure implementation of written personnel policies and procedures including:

b. Provisions for checking state registries and licensing boards for current licensure or registry status and history of disciplinary actions prior to employment.

c. Procedures to ensure all personnel for whom licensure, certification, or registration is required have a valid and current license, certification, or registration.

d. Prohibitions on resident abuse, neglect, and misappropriation of resident property, and procedures for investigation, reporting and follow-up action.

II. FEDERAL REQUIREMENTS

CFR § 483.13 (b)(c)(1)(ii)(2)(3)(4)
The resident has the right to be free from:
-Verbal,
-Sexual,
-Physical, and
-Mental abuse,
-Corporal punishment, and
-Involuntary seclusion

-Residents must not be subjected to abuse by **anyone**, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property.

-This includes:
-Protecting residents from mistreatment, neglect & misappropriation of property
-Identify residents whose personal histories render them at risk for abusing other residents and those at risk for being abused
-Development of intervention strategies to prevent occurrences
-Monitor for changes that would trigger abusive behavior
-Reassessment of the intervention on a regular basis

-The facility must:

-Develop and operationalize policies and procedures for screening & training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property.

-Assure the facility is doing all that is within its control to prevent occurrences

-Not employ individuals who have been

- A) Found guilty of abusing, neglecting, or mistreating residents by a court of law; or
- B) Have a finding entered into the state nurse aide registry.
- Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a CNA or other facility staff to the state nurse aide registry or licensing authorities.

-The facility must ensure all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with

federal and state law. If the events that cause the allegation involve abuse or result in serious bodily injury, you must report immediately, (within 2 hours) to the administrator, State Health Department and Law Enforcement (EJA).

-The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

-Results of all investigations must be reported to the administrator or his designated representative and to the Health Department within 5 working days of the incident, and if the alleged violation is verified, appropriate corrective action must be taken.

REPORTING

Immediately (2 hours or 24 hours) by:
-DoH Website submission; or
-Email; or
-Telephone; or
-Facsimile

Purpose of Facility Investigations

To determine:
-If abuse & neglect have occurred
-The causative factors
-Interventions to prevent further injury of harm
-Utilize findings & conclusions to ensure future safety & compliance

Training

The facility upon hire and annually must inform staff of the requirement to report abuse, neglect and exploration to their supervisor and to Law Enforcement.

III. FEDERAL LAW – ELDER JUSTICE ACT

The Elder Justice Act is a federal law passed as part of the ACA. The goal was to further combat abuse, neglect and exploitation of elders by promoting the discovery of crimes against residents of long term care facilities. This law requires all owners, employees, managers, agents or contractors of a nursing facility to report any reasonable suspicion of a crime against a resident in a nursing facility.

If the event that causes the reasonable suspicion results in serious bodily injury to a resident, you must report the suspicion within 2 hours of forming the suspicion. All other events raising a reasonable suspicion of a crime must be reported within 24 hours.

The report must be submitted to at least one local Law Enforcement Agency and the State Health Department. Any person who is required to report the suspicion of a crime and fails to do so, may be subject to a civil money penalty of up to $200,000 and up to $300,000 if additional harm results to a victim or another person; and may be excluded from participation in any federal health care program.

Thank you for the opportunity to provide information on this important issue. If you have any questions, I would be happy to answer them.

Shelly Peterson, President
North Dakota Long Term Care Association
1900 North 11th Street
Bismarck, ND 58501
(701) 222-0660

THE ELDER JUSTICE COALITION

A NATIONAL ADVOCACY VOICE FOR ELDER JUSTICE IN AMERICA

JOHN B. BREAUX, HONORARY CHAIR ◆ ROBERT B. BLANCATO, NATIONAL COORDINATOR

ELDER JUSTICE ACT SUMMARY

The Elder Justice Act (EJA), was passed by both the Senate and the House in the health care reform bill, H.R.3590 and signed into law by President Obama.

The main provisions are listed below:

Authorizes $777 million over 4 years for the Elder Justice Act.

Establishes an Elder Justice Coordinating Council to make recommendations to the Secretary of HHS on the coordination of activities of federal, state, local and private agencies and entities relating to elder abuse, neglect and exploitation. Recommendations contained in report are due in 2 years.

Establishes a 27-member Advisory Board on Elder Abuse, Neglect and Exploitation. They are to submit a report within 18 months to create a short and long-term multidisciplinary strategic plan for the developing field of elder justice.

Adult Protective Services (APS) funding. Provides $400 million ($100 million per year) in first-time dedicated funding for adult protective services. Provides $100 million ($25 million annually) for state demonstration grants to test a variety of methods to improve APS.

Provides $26 million for establishment and support of Elder Abuse, Neglect and Exploitation Forensic Centers to develop forensic expertise regarding and providing services relating to, elder abuse, neglect and exploitation.

Provides $32.5 million (over 4 years) in grants to support the Long-Term Care Ombudsman Program and an additional $40 million ($10 million annually) in training programs for national organizations and State long-term care ombudsman programs.

Authorizes $67.5 million (over 4 years) in grants to enhance long-term care staffing through training and recruitment and incentives for individuals seeking or maintaining employment in long-term care, either in a facility or a community-based long-term care entity.

Authorizes $48 million ($12 million annually) for a National Training Institute for Surveyors.

Requires the immediate reporting to law enforcement of crimes in a long-term care facility and establishes civil monetary penalties for failure to report.

Provides for penalties for long-term care facilities that retaliate against an employee for filing a complaint against or reporting a long-term care facility that violates reporting requirements.

Authorizes a $500,000 study on establishing a national nurse aide registry.

Authorizes $15 million (over 4 years) for the Department of Health and Human Services to improve data collection and dissemination, develop and disseminate information related to best practices related to adult protective services and to conduct research related to APS.

Authorizes the Secretary to make grants to long-term care facilities for the purpose of assisting such entitites in off-setting the costs related to purchasing, leasing, developing and implementing certified HER technology.

Related Provisions

Provisions in S.795 related to additional reporting of data on CMS's Nursing Home Compare (e.g. crimes in facilities) were moved to the section of the bill dealing with nursing home transparency requirements (S.647.) These provisions appear in the health care reform bill.

Provisions in S.631, to create a national program of criminal background checks for nursing home employees (a part of the original Elder Justice Act) were included in the health care reform bill.

1612 K STREET, NW SUITE 400 WASHINGTON, D.C. 20006

PHONE: 202-682-4140 ◆ FAX: 202-223-2099

WWW.ELDERJUSTICECOALITION.COM ◆ ELDERJUSTICE@VERIZON.NET

THE UNITED STATES
DEPARTMENT of JUSTICE

FOR IMMEDIATE RELEASE
Wednesday, March 30, 2016

Department of Justice Launches 10 Regional Elder Justice Task Forces

Today, the Department of Justice announced the launch of 10 regional Elder Justice Task Forces. These teams will bring together federal, state and local prosecutors, law enforcement, and agencies that provide services to the elderly, to coordinate and enhance efforts to pursue nursing homes that provide grossly substandard care to their residents.

"Millions of seniors count on nursing homes to provide them with quality care and to treat them with dignity and respect when they are most vulnerable," said Acting Associate Attorney General Stuart F. Delery. "Yet, all too often we have found nursing home owners or operators who put their own economic gain before the needs of their residents. These task forces will help ensure that we are working closely with all relevant parties to protect the elderly."

The Elder Justice Task Forces will include representatives from the U.S. Attorneys' Offices, state Medicaid Fraud Control Units, state and local prosecutors' offices, the Department of Health and Human Services (HHS), state Adult Protective Services agencies, Long-Term Care Ombudsman programs and law enforcement.

"The Department of Justice has a long history of holding nursing homes and long-term care providers accountable when they fail to provide their Medicare and Medicaid residents with even the most basic nursing services to which they were entitled," said Principal Deputy Assistant Attorney General Benjamin C. Mizer, head of the Justice Department's Civil Division. "By bringing everyone to the table, we will be able to more effectively and quickly pursue nursing homes that are jeopardizing the health and well-being of their residents."

The 10 Elder Justice Task Forces will be launched in the following Districts: Northern District of California, Northern District of Georgia, District of Kansas, Western District of Kentucky, Northern District of Iowa, District of Maryland, Southern District of Ohio, Eastern District of Pennsylvania, Middle District of Tennessee and the Western District of Washington.

"We believe that by actively participating in the Elder Justice Task Forces announced today through joint investigations, sharing information and regular meetings; we will strengthen our efforts nationally to protect the most vulnerable of our population who reside in our nursing

homes and other care facilities," said Keesha Mitchell, President of the National Association of Medicaid Fraud Control Units and the Director of the Ohio Medicaid Fraud Control Unit.

"The HHS Office of Inspector General (OIG) continues to pursue nursing home operators who provide potentially harmful care to residents who are often unable to protect themselves," said Chief Counsel to the Inspector General Gregory Demske of HHS. "Creating these task forces sends a message to those in charge of caring for these beneficiaries that grossly substandard care will not be tolerated."

"The Administration for Community Living was created to help ensure that older adults and people with disabilities are able to live the lives they want, with the people they choose, fully participating in their communities," said Becky Kurtz, Director of the Office of Long-Term Care Ombudsman Programs at the Administration for Community Living. "Our mission includes supporting their basic right to live with dignity, free from abuse. We appreciate the Department of Justice's leadership on this important initiative and applaud its long-standing commitment to elder justice efforts."

"Our most vulnerable citizens deserve the highest quality care and attention," said Executive Director Kathleen Quinn of the National Adult Protective Services Association. "This initiative will help insure that long-term care facilities provide it. The Department of Justice is to be commended for this, and indeed all its efforts, to protect the millions of elder abuse victims in this country."

The Elder Justice Task Forces reflect the department's larger strategy and commitment to protecting our nation's seniors, spearheaded by the department's Elder Justice Initiative. The Elder Justice Initiative coordinates and supports the Department's law enforcement efforts and policy activities on elder justice issues. It plays an integral role in the department's investigative and enforcement efforts against nursing homes and other long-term care entities that deliver grossly substandard care to Medicare and Medicaid beneficiaries. The Elder Justice Initiative will be providing litigation support and training to the Elder Justice Task Forces. Learn more about the Justice Department's Elder Justice Initiative at http://www.justice.gov/elderjustice.

TESTIMONY
HB 1226
Senate Human Services Committee
March 6, 2017
Representative Kathy Hogan

Chairman Lee and member of the Senate Human Service Committee, for the record, my name is Kathy Hogan and I represent District 21, the heart of Fargo.

During the 2015 legislative session, the House Appropriations committee had serious discussions regarding the need for and structure of a Medicaid fraud unit. These hearings and discussion were in the Government Operations Division of Appropriations. In the end we agreed that there were a number of related issues that needed to be considered before beginning and so it was not funded at that point in time.

During the interim, several of us have worked to address this issue and we have prepared three bills related to Medicaid Fraud. HB 1227 identified what Medicaid fraud is. HB 1174 defined civil liability in false claims. The HB 1226 originally established a Medicaid Fraud Unit in the Attorney General's Office. The first two bills were defeated and this bill became a study resolution in the House.

Two significant events have happened in the last 6 weeks. During the organizational session, a major meeting was held with providers, DHS and other key partners to review this issue and idea of Medicaid Fraud. Secondly, the ND Department had requested an exemption to the federal Medicaid Fraud requirements which we have had in place since about 1997. On January 6, the Governor was notified that that exemption was denied and the state had 60 days to submit a plan to implement a Medicaid Fraud unit. Attached is the letter. The Governor's office responded to the CMS regarding these pieces of legislation and the states plan to meet the Medicaid fraud mandate. Attached is that response.

I hope that your committee will consider the establishment of a Medicaid Fraud Unit to meet the federal requirements, to assure the program integrity of the Medicaid unit and to collect dollars that were inappropriately spent.

These bills have been drafted in collaboration with the Attorney General's office. Staff from the Attorney General's office are available to answer specific question and they have drafted amendments which I support.

1226
#1
3/6
pg.2

Thank you for your consideration and I would be more than willing to answer any questions.

1226
#1
3/6
pg 3

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

JAN - 6 2017

Administrator
Washington, DC 20201

The Honorable Jack Dalrymple
Governor of North Dakota
600 East Boulevard Avenue
Bismarck, ND 58505

Dear Governor Dalrymple:

Thank you for your letter dated September 12, 2016, in which you requested that the State of North Dakota be granted a new waiver from the requirement that it operate a Medicaid Fraud Control Unit (MFCU). Along with your letter, you enclosed several documents in support of the state's waiver request, including those that address fraud and abuse efforts in its managed care program; expenditure summaries; corrective actions taken related to various state and federal program integrity reviews: and state abuse and neglect processes.

As you are aware, section 1902(a)(61) of the Social Security Act outlines two criteria, which must co-exist, under which a state may be granted a waiver from the requirement to operate a MFCU. To qualify for a waiver, a state must demonstrate to the satisfaction of the Department of Health and Human Services' (HHS) Secretary: (1) that the effective operation of a MFCU would not be cost-effective because minimal fraud exists in connection with the provision of covered services to eligible individuals under the state plan, and (2) that beneficiaries under the plan are protected from abuse and neglect in connection with the provision of services under the plan without the existence of a MFCU. The Centers for Medicare & Medicaid Services (CMS) has carefully reviewed the information you provided and determined that the state's waiver request does not meet these criteria.

We appreciate the analysis outlined in your letter of MFCUs in similar sized states that had years in which operational costs exceeded their recoveries. However, we do not believe that this observation is indicative of a MFCU's cost-effectiveness. Monetary recoveries are only one factor in measuring the success and impact of an effective MFCU. MFCUs primarily conduct criminal prosecutions that result in criminal indictments and convictions, in addition to the recovery of criminal restitution. MFCUs' deterrent value, and the sentinel effect of their successful criminal and civil cases, cannot be measured in dollars. This is especially so for prosecutions of patient abuse or neglect that occur in North Dakota health facilities, which typically do not involve a Medicaid overpayment and result in criminal outcomes with no monetary recovery.

Moreover, in reviewing the recovery information in similar states, while in a single year MFCU operational costs may exceed recoveries when analyzing MFCUs over a longer period of time, such as a 3-year period (2013-2015), recoveries in similar sized states often exceeded the operational costs of operating a MFCU. Wyoming, for example, recovered roughly $3.1 million and expended $1.4 million, and South Dakota recovered roughly $7 million and expended $1.2 million. While Montana had a negative return on investment for this time period, during the prior 3-year period (2010-2012), Montana had recoveries of $3.2 million and expenditures of

1226
#1
3/6
Pg. 4

$697,345. Overall, the data suggest that MFCUs are cost-effective in the similar sized states, and there is insufficient reason to believe that a MFCU operating in North Dakota will be an exception.

Your letter offers an analysis conducted by Optum related to Professional Provider Specialty Peer Outliers suggesting that minimal fraud exists in North Dakota's Medicaid program and that beneficiaries are protected from abuse and neglect without the existence of a MFCU. This Optum analysis was only for Sanford Health Plan, and therefore, covers only North Dakota's Medicaid expansion population and represents only about 25 percent of the state's Medicaid budget. CMS does not believe this information persuasively argues that the operation of a MFCU would not be cost-effective because minimal fraud exists in North Dakota and that beneficiaries under the plan would be protected from abuse and neglect without the existence of a MFCU.

Finally, the enclosures to your letter include a description of the affirmative steps taken by HHS in response to program integrity-related deficiencies identified by CMS and other agencies. CMS appreciates these actions, but none of them are germane to our determination that the state has not demonstrated in its request that minimal fraud exists or that, absent a MFCU, all beneficiaries under the plan are fully protected from abuse and neglect. In sum, upon carefully reviewing the information provided, CMS has determined that North Dakota has not demonstrated that operating a MFCU would not be cost-effective because minimal fraud exists and that all beneficiaries under the plan are fully protected from abuse and neglect without the existence of a MFCU.

As such, CMS is requesting that North Dakota submit an implementation plan within 60 days of receipt of this letter. The implementation plan should include a timetable for establishing a MFCU, including the earliest feasible date by which North Dakota will submit an application for certification of a MFCU to the Office of Inspector General (OIG). Please submit the implementation plan to the CMS Administrator and provide a copy of your reply to Daniel R. Levinson, Inspector General, 330 Independence Ave., SW, Washington DC 20201.

Should you or your staff have questions about this letter, please contact Jonathan Morse, Deputy Director, Center for Program Integrity, Centers for Medicare & Medicaid Services, at 410-786-1892, Jonathan.Morse@cms.hhs.gov, while questions about requirements of the MFCU program may be directed to Richard Stern, Director, OIG Medicaid Fraud Policy and Oversight Division, at 202-205-0572, Richard.Stern@oig.hhs.gov. Mr. Stern's OIG division would be pleased to provide North Dakota with technical assistance regarding establishing a MFCU, and CMS looks forward to continuing to work with you to protect North Dakota's Medicaid program against fraud and abuse, and its beneficiaries against abuse and neglect.

Sincerely,

Andrew M. Slavitt
Acting Administrator

1226
#1
3/6
Pg.5

State of
North Dakota
Office of the Governor

Doug Burgum
Governor

January 31, 2017

Tim Hill, Acting CMS Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Blvd
Baltimore MD 21244

RE: North Dakota Medicaid Fraud Control Unit

Dear Ms. Verma:

I am in receipt of the January 6, 2017 letter from Acting Administrator Andrew Slavitt to Governor Dalrymple requesting the submission of an implementation plan for North Dakota to establish a Medicaid Fraud Control Unit. I took office on December 15, 2016.

North Dakota has a biennial legislative session, which convenes on odd-numbered years. The 2017 Legislative Session began earlier this month and neither my Executive budget nor the previous Executive Budget included the establishment of the MFCU.

Even though funding to establish a Unit was not included in the Executive Budget Recommendation, there are three Legislatively-sponsored bills that, if approved by the legislative assembly, would contain the required components for North Dakota to establish a Medicaid Fraud Control Unit. The bills that have been introduced are: House Bill 1174 – False Claims Act; House Bill 1226 – Medicaid Fraud Control Unit; and 1227 – Medicaid Fraud. The bills, as introduced, are attached for your reference.

Should the bills pass out of both chambers of the North Dakota Legislature, I will sign them. However, I recently made it clear in my January 13 letter to Congressional leadership that all federal agencies creating one-size-fits-all requirements for states that also act as unfunded mandates are not acceptable and must be reviewed. States are fully capable of effectively designing efficient systems scaled to their own needs.

If the North Dakota Legislature appropriates the funding and allocates the minimum-required staff resources, North Dakota will move forward to establish the Medicaid Fraud Control Unit. If the 2017 North Dakota Legislative Assembly does not authorize the Medicaid Fraud Control Unit, as well as the related legislative authority, appropriation and staffing, I will submit the requested implementation plan.

1226
#1
3/6
pg. 6

The North Dakota Legislative Assembly is scheduled to end no later than April 28, 2017. Because there is current legislation under consideration, I request an extension of the 60-day time frame for an implementation plan.

Maggie Anderson from the Department of Human Services will keep the Centers for Medicare and Medicaid Services staff informed regarding the status of the three bills under consideration in the current 2017 Legislative Session.

If you have questions, please contact Ms. Anderson at 701-328-1603 or via email at manderson@nd.gov.

Sincerely,

Doug Burgum
Governor

Encl

C:

Wayne Stenehjem, North Dakota Attorney General
Daniel Levinson, Inspector General
Maggie Anderson, North Dakota Department of Human Services Acting Director

MEDICAID FRAUD REPORT

National Association
of Medicaid Fraud Control Units

March/April 2015

INSIDE

Hallmark Health Systems
Agrees to Pay $1.75 Million 1
Cases 2
Case Updates 11

Hallmark Health Systems Agrees to Pay $1.75 Million

Attorney General Maura Healey announced on April 13 that Hallmark Health Systems has agreed to pay $1.75 million to settle allegations that it improperly billed the Massachusetts Medicaid Program (MassHealth) for certain inpatient admissions at its hospitals, resulting in overpayments by MassHealth.

The settlement alleges that from March 2008 to December 2013, Hallmark used a specific default code that classified MassHealth patients as having received short-stay inpatient services, when an observation or outpatient level of care would have been more appropriate. This protocol resulted in higher payments to Hallmark hospitals from MassHealth.

MassHealth reimburses acute hospitals at a flat rate that covers all non-physician inpatient services for the first 20 days of an admission. If a hospital provides outpatient services, MassHealth reimburses such services using a lower rate. To assist hospitals in determining whether to bill services as outpatient or inpatient, MassHealth promulgated guidelines that provide clear standards for allowing a hospital to bill MassHealth for an inpatient admission.

The AG's Office alleges that Hallmark's practice of billing and receiving reimbursement for certain inpatient stays violated MassHealth guidelines that inpatient admissions always require case-by-case review to determine a heightened need for care based on clinical criteria or physicians' orders.

The AG's Office alleges that Hallmark knew or should have known that the case management system did not properly rely on clinical criteria or physicians' orders, and therefore resulted in improper claims for inpatient admissions for MassHealth patients staying at Lawrence Memorial Hospital and Melrose-Wakefield Hospital, two of the acute hospitals Hallmark operates.

1226
#2
3/6
Pg.2

This matter was handled by Chief George Zachos and Deputy Chief Steven Hoffman, of AG Healey's Medicaid Fraud Division, and was investigated by Investigator Eric Panicucci, with assistance from MassHealth.

For further information contact George Zachos, Director (617) 727-2200.

CASES

Counselors: Ohio

Attorney General Mike DeWine announced on March 25 that a bill of information for one count of theft was filed against John J. Rehak, Jr. Subsequently, Rehak pleaded guilty to the theft, and was sentenced to one year of community control with the condition that he pay the stipulated restitution of $67,369.23 to the Ohio Department of Medicaid. The relatively short community control period is due to the defendant's attorney's representation to the judge that Rehak would be liquidating a retirement account to pay the bulk of the restitution within the next couple months and could come up with the rest of the money in a year. If Rehak violates his community control, he will serve six months in prison.

Rehak was a professional counselor who owned a counseling office called Clear Mind. After several undercover visits were done by MFCU special agents, it was determined that Rehak was billing Medicaid recipients for extra counseling sessions that did not occur. Special Agent (SA) Brett Myers determined from interviews that Rehak had done the same thing with at least 20 other recipients. After comparing office calendars and payment ledgers (obtained through a December 2013 search warrant) with the billings and interviews, SA Myers was able to calculate the theft amount of $67,369.23 for phantom office visits that did not occur but were billed and paid from July 7, 2006 to January 4, 2014.

For further information contact Keesha Mitchell, Director (614) 466-0722.

Dentists: Massachusetts

Attorney General Healey announced on March 31 that Dr. Jennifer Lee, a dentist, has agreed to pay $750,000 because of allegations of improperly billing MassHealth for emergency dental services, resulting in thousands of dollars of overpayments.

The settlement resolves allegations that from January 2005 to December 2013, Dr. Lee and her corporation, Wollaston Dental Care, fraudulently billed MassHealth using a specific code used to bill for palliative emergency treatment of minor dental pain. The investigation discovered that Dr. Lee was routinely billing this code at nearly every patient visit when the dental services provided did not meet the criteria for billing this code.

Dr. Lee currently operates both Wollaston Dental Care and Alpine Dental. According to the settlement, Dr. Lee and her practice have agreed to comply with all applicable state and federal statutes, and all applicable regulations governing their participation in MassHealth.

This matter was handled by Assistant Attorney General David M. Scheffler and Investigator Lisa Bailey with assistance from MassHealth.

For further information contact Assistant Attorney General David M. Scheffler (617) 727-2200.

1226 #2 3/6 Pg. 3

Home Health Care: Ohio

Attorney General DeWine announced on February 26 that Erika White was sentenced on her theft guilty plea. The judge sentenced her to two years of community control, with the condition that she pay $15,015.92 in restitution. If she violates the terms of her community control she will be sent to prison for eight months.

White was the home health care aide for her mother. Although White was billing for 12 hours a day, her mother stated that White left her alone for long periods during the day and did not feed her properly, bathe her, give her medication, or take her to doctor's appointments.

On November 19, 2013, an indictment was filed charging White with two counts of failure to provide for the functionally impaired and theft. On December 15, 2014, White pleaded guilty to theft.

* * * * *

Attorney General DeWine announced on March 4 that Angela Nelson was sentenced on her guilty plea of theft. Nelson was ordered to pay $2,000 in restitution which she provided to the clerk of courts.

Nelson was a home health care aide who billed for services not provided. Video surveillance showed that Nelson was only working 61% of the time she billed. The recipient confirmed that Nelson did not work all her hours. Nelson also admitted to billing for services not provided for two recipients.

* * * * *

Attorney General DeWine announced on March 5 that Brenda Mencer entered a guilty plea to one Medicaid fraud count. At the hearing, Mencer paid full restitution of $7,122.28. Mencer was sentenced to a six month suspended jail sentence, suspended costs, and placed her on two years of community control. She was also ordered to pay $3,500 in investigative costs to the Ohio Attorney General's Office.

Mencer, in her capacity as an independent home health care aide, billed for services not rendered to a Medicaid recipient. Video surveillance was conducted on the home of this Medicaid recipient. Special Agent Erin Brantley's video surveillance analysis compared to the billing records revealed that Mencer consistently billed for the full amount of authorized units, but failed to appear on the video for the entire duration or majority of the second shift. When Mencer was interviewed, she affirmed her knowledge of the Medicaid rules and regulations, claimed that her timesheets were accurate, and terminated the interview. During a second interview with the Medicaid recipient, she admitted that Mencer had not worked a second shift since April of 2014. Additionally, Special Agent Brantley obtained hospital records that showed Mencer billed while the Medicaid recipient was hospitalized.

* * * * *

Attorney General DeWine announced on March 6 that Dawn Shannon was sentenced to a prison term of 11 months on Medicaid fraud to run consecutively to 17 months on the theft from an elderly person. Both sentences are suspended for five years of community control. Shannon was ordered to pay restitution of $3,665.10 to ODM and $4,955.37 to the victim of her theft offense.

Shannon previously pleaded guilty to Medicaid fraud, a felony of the fifth degree and theft from an elderly person, a felony of the fourth degree.

Shannon was an independent home health care aide who billed for services not provided to a Medicaid recipient. Shannon also purchased items for herself with the recipient's debit card. The total amount of unauthorized purchases on the card was $4,955.37.

* * * * *

Attorney General DeWine announced on March 10 that Tanisha Paige pleaded guilty to one count of theft by deception. The court sentenced her to five years of community control and ordered her to pay restitution of $55,746.98 to the Ohio Department of Medicaid (ODM). If she violates the terms of her community control, she will spend eight months in prison.

Paige was a home health care aide who billed for services not provided to her mother. Paige's mother complained that Paige failed to provide hygiene/incontinence care which resulted in frequent urinary tract infections. Another aide who worked for Paige's mother reported Paige left her mother sitting in the same clothes with "caked on feces." Video surveillance as well as hospital admission and discharge information revealed Paige was billing for services not provided. Ultimately, Paige admitted to billing for hours she did not work. Between January 1, 2009 and November 20, 2013, Paige billed ODM a total of $55,746.98 for services not provided.

* * * * *

Attorney General DeWine announced on March 12 that Makita Pope pleaded guilty to one count of Medicaid fraud. The court sentenced her to a four month suspended jail term and three years of community control, and ordered her to pay $3009.36 in restitution to the Ohio Department of Medicaid (ODM). Before the hearing, Pope paid $500 in restitution.

Pope, a home health care aide with ABC Healthcare Inc., billed for services not provided to a Medicaid recipient. Pope admitted to billing three hours daily while she only worked for two hours. Investigation showed she billed $3,009.36 for services not provided between January 11, 2013 to February 19, 2014.

* * * * *

Attorney General DeWine announced on March 19 that Julia Andrews paid $75,000 in restitution and pleaded guilty to Medicaid fraud. As a result, Andrews was sentenced to 18 months in prison, suspended for a five year period of community control. In addition, she was ordered to pay $15,000 in investigative cost, court cost, and $150,000 in restitution.

Andrews billed for nursing services not provided. During various periods of physical surveillance, Andrews failed to provide any services. In a review of GPS data, Andrews performed nine hours of home health services, yet she billed for 250 hours. Furthermore, search warrants were obtained to review cell phone data, and Facebook information. According to social media, Andrews was on vacation during periods that she billed for home health services. The mother of the Medicaid recipient discussed services performed by Andrews. Initially, she provided multiple stories to cover for Andrews, but eventually she

1226 #2 3/6 pg.5

cooperated with the MFCU. Typically, Andrews only worked 24 hours a month, in three shifts, instead of the 40 hours a week claimed in her billing documentation.

When confronted, Andrews admitted that she billed for services not provided, but she also provided many excuses. According to Andrews, she administered care at her house; days of care were administered and she chose not to bill; and she only billed 40 hours a week as a safeguard, in order to prevent any loss of services that were needed for the patient's care. Essentially, Andrews claimed that she worked the majority of the hours that she claimed during the week.

* * * * *

Attorney General DeWine announced on March 20 that Amy Neubacher was sentenced to a nine month suspended prison term, placed on probation for three years, and ordered to pay $18,000 in restitution to the Ohio Department of Medicaid (ODM). Neubacher, a licensed practical nurse who billed for services not provided to a Medicaid recipient, pleaded guilty to one count of Medicaid fraud, a felony of the fourth degree on January 26. Neubacher billed for many of the days that she did not work. She billed for services not provided while the recipient was being transported to doctor's appointments and while the recipient was in the hospital.

* * * * *

Attorney General DeWine announced on March 24 that Misty Barney pleaded guilty to Medicaid fraud. She was sentenced to five years of community control and ordered to pay $11,356.35 in restitution. If Barney violates the terms of her community control, she will be incarcerated for eight months.

From February 17, 2012 through November 21, 2012, Barney, an independent home health care aide, billed for services not rendered after she was removed from a Medicaid recipient's All Service Plan. Barney stated that she billed for services not rendered to pay her husband's drug-related debt. Barney received an overpayment of $11,356.35.

* * * * *

Attorney General DeWine announced on March 30 that Mohammed Abdi entered a guilty plea to one count of Medicaid fraud, a first degree misdemeanor. The court sentenced Abdi to 30 days, suspended, and six months of community control. Abdi was ordered to pay $404.30 in restitution and a $1,000 fine.

Abdi, a home health care aide, engaged in a kickback scheme with a Medicaid recipient. Abdi submitted false timesheets to his employer, Covenant Home Health, showing that he worked more hours than he actually provided. The recipient signed off on the timesheets. Based on the fraudulent timesheets, Covenant billed Medicaid for services not provided. Abdi then split his pay with the recipient.

* * * * *

Attorney General DeWine announced on April 8 that Jene Love pleaded guilty to Medicaid fraud, a felony of the fourth degree. She was sentenced to community control for a term of five years and ordered to pay $28,859.62 in restitution to the Ohio Department of Medicaid (ODM). If Love violates the terms of her community control, the court will impose a prison term of 11 months.

Love, a home health care aide with Horizon Health Services, billed for services not rendered to a Medicaid recipient. Love was scheduled to work two hours in the morning and four hours in the evening for a total of six hours daily. From November 4, 2011 to October 16, 2013, while Love never showed up for her evening shift, she billed for the entire 6 hours daily. Because Love only came for the morning shift, the recipient did not know that she was entitled to personal care aide services in the evening.

* * * * *

Attorney General DeWine announced on April 13 that Sharon Guei pleaded guilty to theft by deception, a misdemeanor of the first degree. The court sentenced her to a suspended jail-term of 180 days, placed her on community control for one year, and ordered her to pay $1221.50 in restitution to the Ohio Department of Medicaid (ODM). Guei, a home health care aide, billed for services rendered to Medicaid recipients while she was on the OIG's List of Excluded Individuals.

For further information on these cases contact Keesha Mitchell, Director (614) 466-0722.

Home Health Care: Vermont

Attorney General William Sorrell announced on March 23 that Theresa Ambrose was convicted on March 16 in Vermont Superior Court, Windsor Criminal Division, of two misdemeanor counts of false pretenses. The convictions stemmed from Ambrose's submission of false timesheets in order to obtain payment for services that she did not provide while she was employed as a home-based health care worker under the Choices for Care program, a Vermont Medicaid program.

Ambrose was sentenced to 12 to 24 months in jail, all suspended, and placed on 24 months of probation subject to standard conditions, and the additional conditions that she complete 40 hours of community service and not work as a care provider under any Vermont Medicaid waiver program. Ambrose was also ordered to pay $4,841 in restitution to Vermont Medicaid.

For further information contact Assistant Attorney General Jason Turner (802) 828-5332.

Home Health Care: Washington State

Attorney General Bob Ferguson announced on February 25 that Landon Michael Armani pleaded guilty and was sentenced to one count each of theft first degree, theft second degree, Medicaid false statement and false verification of application for public assistance.

Investigator Larry Carlier completed the investigation for the Washington State MFCU. The investigation revealed that Armani was contracted to provide in-home care for a Medicaid recipient and that between that between August 29, 2012 and October 27, 2013, he had billed for in-home medical care services for his mother while she was living in Vietnam and he was working in New York City, New York. Additionally, Armani falsified documents to continue his mother's EBT benefits and used the EBT card for purchases in Washington and New York. Assistant Attorney General Marty Raap prosecuted the case.

Armani was sentenced as a first-time offender and was ordered to pay over $15,000 in restitution and other financial obligations. He paid all costs at sentencing and entered into a "Voluntary Exclusion

1226 #2 3/6 pg 7

Agreement" with OIG which contained a five year prohibition on working as a Medicaid/Medicare provider.

For further information contact Assistant Attorney General Mike Pellicciotti (360) 586-8888.

Nurses: Ohio

Attorney General DeWine announced on March 2 that Sophia Mulle entered a guilty plea to one Medicaid fraud count, a first degree misdemeanor. The court sentenced Mulle to a 180 day suspended jail term and placed her on three years of probation. She was also ordered to pay $7,500 in restitution to Medicaid and $2,000 in investigative costs to the Ohio Department of Medicaid. Prior to the hearing, Mulle paid the full $7,500 restitution.

Mulle worked as a private duty nurse for a Medicaid recipient. It was learned that Mulle billed Medicaid for more service hours than she actually provided.

* * * * *

Attorney General DeWine announced on March 4 that Timnah Wills pleaded guilty to Medicaid fraud, a felony of the fourth degree. The judge placed her on community control for four years and ordered her to pay $11,944.71 in restitution to the Ohio Department of Medicaid. If she violates the terms of her community control, she will spend 12 months in prison.

Wills was an independent licensed practical nurse who admitted to billing for services that she did not provide to two Medicaid recipients. Wills also falsified nursing notes. On the date Wills's case was scheduled for Grand Jury, Wills arrived with a large stack of nursing notes. Upon noticing that the notes appeared to be forged, Special Agent Costner interviewed Wills, and she admitted that she falsified the nursing notes. Wills admitted to creating and falsifying all of the nursing assessment forms beginning January 2014 after receiving the grand jury subpoena.

* * * * *

Attorney General DeWine announced on March 27 that Christine Bayes was sentenced to six months in jail, suspended, and placed on community control for two years. In addition, the court ordered Bayes to pay $2,505.60 in restitution.

On February 9, Bayes entered a guilty plea to one count of forgery, a felony of the fifth degree. The court ordered a presentence investigation and continued the matter.

Bayes served as a supervising registered nurse for a licensed practical nurse (LPN). Bayes backdated medical forms to cover periods of service that were not authorized and falsified medical documents for the LPN. According to Bayes, the LPN needed the medical documentation to support services performed and billings submitted to the Ohio Department of Medicaid. A fraud finding was calculated in the amount of $2,505.60.

* * * * *

Attorney General DeWine announced on April 13 that Lisa Jordan entered a plea of guilty to one count of theft by deception, a felony of the fifth degree. Jordan was sentenced to a three-year term of basic community control, with a ten month prison sentenced suspended. Jordan was ordered to pay restitution in the amount of $10,000 to ODM. No fine or costs were imposed and the defendant had no days of jail credit.

Portia Cooper is a licensed practical nurse who was the sole independent provider to Medicaid recipient Diamond Jackson. Cooper and Jackson's mother, Lisa Jordan, were engaged in a kickback scheme from November 14, 2010 through October 27, 2013. When interviewed, Cooper admitted that she and Jordan had an arrangement where Jordan worked some of Cooper's shifts in exchange for $100 to $200 per week. Ultimately, Jordan admitted to this kickback scheme. These admissions were corroborated by bank records, falsified billing records, falsified nursing notes, as well as physical and video surveillance. Cooper has previously plead guilty, and is awaiting sentencing.

For further information on these cases contact Keesha Mitchell, Director (614) 466-0722.

Nursing Assistants: Ohio

Attorney General DeWine announced on March 18 that Raven Capunay pleaded no contest and was found guilty on two counts of receiving stolen property. Capunay was ordered to pay $200 in fines, $75 in court costs, and restitution in the amount of $570 to victim #1 and $950 to victim #2. Capunay was also sentenced to 25 days in jail suspended on the condition that she pays the fines, court costs, and restitution on or before September 18.

While employed as a nursing assistant at Emeritus, Patty Thomas took 52 pieces of jewelry from 17 resident victims. The stolen jewelry items were pawned by Thomas and her family members. The total estimated loss to the victims based on appraisal value of these items is $26,398. Capunay is the niece of Patty Thomas. She also pawned jewelry items that were stolen by Thomas. On December 12, 2014, Capunay was indicted on two counts of receiving stolen property.

For further information contact Keesha Mitchell, Director (614) 466-0722.

Pharmacies: Vermont

Attorney General Sorrell announced on April 24 that the Office of the Attorney General is distributing over $118,000 in settlement funds to more than 1300 Vermonters who were Medicaid beneficiary customers of McGregor's Medicine-on-Time pharmacy, from 2004 through 2012. The average distribution is $85.

The distribution is the result of a settlement agreement between the state and McGregor's that resolved allegations of Medicaid fraud. The state set aside a portion of the settlement funds to distribute to McGregor's former Medicaid beneficiary customers who may have been improperly charged a monthly service fee or excessive copayments. The amount distributed to each beneficiary was determined based on the number of Medicaid pharmacy claims that McGregor's submitted in the beneficiary's name from 2004 through 2012.

1226 #2 3/6 Pg. 9

For further information contact Assistant Attorney General Steven Monde (802) 828-5518.

Rehabilitation Services: Massachusetts

Attorney General Healey announced on April 28 that a former nonprofit that provided day habilitation services to individuals with developmental disabilities has agreed to pay more than $94,000 to settle claims of billing the state's Medicaid program (MassHealth) for services not provided.

According to the settlement, Life Focus Center of Charlestown, Inc. allegedly violated the Massachusetts False Claims Act by billing more hours of service than were actually provided to a MassHealth member from 2008 through 2011, resulting in overpayments.

Life Focus Center provided day habilitation services to individuals with mental retardation and other developmental disabilities with the goal of helping each member reach his or her optimal level of physical, cognitive, psychosocial, and occupational capabilities. Under MassHealth regulations, day habilitation providers will not be paid for any cancelled sessions or sessions missed by a member, and will not pay for any portion of a day during which the member is absent from the site, unless the provider documents that the member received services from the program staff in a community setting.

Day habilitation services are provided by a team consisting of a licensed registered nurse, a licensed occupational and physical therapist, a speech and language therapist, a psychologist, and a rehabilitation counselor. Sessions are billable in 15-minute units. Under MassHealth regulations, providers must report the actual time spent by each member in the program.

According to the settlement, from December 2008 to February 2011, Life Focus Center allegedly engaged in a scheme where it billed MassHealth for day habilitation services not rendered to a developmentally disabled MassHealth member who either did not attend at all or rarely attended the day habilitation program. MassHealth relied upon Life Focus' alleged false claims submitted for the member's day habilitation services and reimbursed Life Focus Center as if it had provided full days of service.

This investigation against Life Focus Center was initially referred to the MFCU by MassHealth following a review of its billing. In June 2012, Life Focus Center ceased its operations and Bay Cove Human Services assumed operation of the program. Under the terms of the settlement, Life Focus Center has also agreed to no longer participate as a MassHealth provider.

For further information contact Assistant Attorneys General Angela Neal or Gregory Matthews (617) 727-2200.

Resident Trust Funds: Ohio

Attorney General DeWine announced on February 4 that Marissa Whitledge was sentenced after pleading guilty to one count of theft. Whitledge admitted to stealing $20 in cash from a resident while she was employed at the Heartland of Woodridge nursing facility in Fairfield, Ohio. Whitledge was sentenced to 180 days of jail time, suspended upon completion of two years of community control and payment of $20 in restitution to the victim, $500 in fines (with $250 to be waived if Whitledge meets all obligations), and $25 in fees.

For further information contact Keesha Mitchell, Director (614) 466-0722.

Treatment Centers: Massachusetts

Attorney General Healey announced on April 22 that the Center for Psychiatric Medicine (CPM), a treatment center has been sued for unlawfully profiting off of patients seeking treatment for opiate addiction, charging hundreds of dollars per visit and allowing them to avoid counseling services.

The civil complaint filed against CPM, alleges that since October 2010, the business increased its profit by charging hundreds of its patients cash fees to receive Suboxone treatment, a medication covered by MassHealth that is used to treat narcotic opiate addiction under a physician's supervision. Patients were also allegedly told by CPM that they could avoid required weekly therapy sessions and monthly physician visits by paying cash instead.

CPM charged patients fees as high as $325 in cash for an initial visit and between $150 and $200 in cash for each subsequent visit, when they should not have been charged at all. MassHealth would have reimbursed anywhere from $15-$75 for these claims. Providers are required by law to only accept payments from MassHealth for services to the plan's members.

According to investigators, CPM staff had allegedly told new patients that the center did not accept MassHealth for Suboxone treatment and that their program was cash only. The MFCU estimates that CPM unlawfully obtained hundreds of thousands of dollars in payments from patients.

Documents obtained in the investigation also revealed that patients were allegedly required to sign a waiver form, stating that they agreed to pay in cash for their Suboxone treatment. Prior to the waiver, CPM discussed the cash policy verbally with patients. The civil complaint against CPM seeks restitution for the victims, civil penalties, attorneys' fees, costs and injunctive relief as a result of violations of MassHealth regulations.

The MFCU is seeking to obtain a court order that would prohibit CPM from charging patients cash, and prohibit the center from removing any current MassHealth patients from its Suboxone program that is required to include comprehensive counseling services.

According to the complaint, CPM is a MassHealth provider that currently employs nine physicians who are legally authorized to prescribe Suboxone. In addition to substance abuse treatment, CPM also provides services involving psychiatric evaluations, psychiatric medication management, psychological testing and individual therapy.

This matter is being handled by Assistant Attorney General Jennifer Goldstein and Investigator Christopher Cecchini of the Medicaid Fraud Division.

For further information contact Assistant Attorney General Jennifer Goldstein (617) 727-2200.

1226 #2 3/6 Pg. 11

CASE UPDATES

Physicians: Massachusetts

Attorney General Healey announced on April 7 that Dr. Punyamurtula Kishore pleaded guilty, was sentenced to jail, and was ordered to pay $9.3 million in restitution for running an intricate Medicaid fraud scheme involving millions of dollars in taxpayer funds.

Preventive Medicine Associates, Inc. (PMA),Dr. Kishore's company pleaded guilty to charges of Medicaid kickbacks (eight counts), Medicaid false claims (19 counts) and larceny over $250 (11 counts). Dr. Kishore pleaded guilty to one count of larceny over $250.

A Superior Court judge sentenced Dr. Kishore to 360 days in the House of Correction, with 11 months to serve and the balance suspended for ten years. As a condition to his sentence, Dr. Kishore has also agreed to surrender his medical license.

Dr. Kishore previously owned and managed PMA, a network of 29 medical branches throughout Massachusetts, including physician office laboratories and one independent clinical laboratory. Based on the MFCU's investigation, Dr. Kishore used bribes, or kickbacks, to induce sober house owners to send their residents' urine drug screening business to his laboratories for testing. Residents were typically screened three times per week.

A urine drug screen may be billed to MassHealth by a physician if the screen is medically necessary. Drug screens generally are billed to the MassHealth program for approximately $100 to $200. Dr. Kishore manipulated his business relationships with sober house owners to illegally obtain tens of thousands of drug screens paid for by MassHealth for sober house residents who were never treated by PMA providers.

In September 2011, Dr. Kishore and PMA were indicted, and individually charged with Medicaid kickbacks (eight counts), and Medicaid false claims (eight counts). In November 2013, Dr. Kishore and PMA were indicted on additional charges of Medicaid false claims (11 counts) and larceny over $250 (11 counts) for billing MassHealth for millions of dollars in drug screens using the names of PMA physicians and nurse practitioners who were not actually treating the patients or determining the drug screens to be medically necessary. (See: *Medicaid Fraud Report,* September/October 2011 p. 16). State regulations require that the services must be medically necessary and the provider must be physically present and actively involved in the treatment of the member.

Two other individuals previously pleaded guilty to one count of Medicaid kickbacks in connection with their involvement in Dr. Kishore's scheme to defraud MassHealth. In June 2012, Damion Smith, President of Fresh Start Recovery Coalition, was sentenced to two years in the House of Correction suspended for two years with probation. Carl Smith, manager of New Horizon House, pleaded guilty in January and was sentenced to two years in the House of Correction suspended for two years with probation.

The case against Thomas Leonard, the part owner and manager of the Marshall House, a sober house, is ongoing. John Coughlin of Carver, President of Gianna's House Inc., which operates several sober houses, began his trial in Suffolk Superior Court.

This case was prosecuted by Assistant Attorneys General Angela Neal, David Scheffler, and Lee Hettering of the Medicaid Fraud Division and was investigated by Investigators Erica Schlain and Denise Long. Massachusetts State Police assigned to the Attorney General's Office, Examiners from the Attorney General's Computer Forensics Lab, Special Agents from the Boston Office of the United States Department of Health and Human Services, Office of the Inspector General, and investigators from the Massachusetts Insurance Fraud Bureau also assisted with this case.

For further information contact Assistant Attorney General Angela Neal (617) 727-2200.

1226 #2 3/6 Pg. 13

Inquires on editorial content should be addressed to:

Barbara L. Zelner
Executive Director
National Association of Medicaid Fraud Control Units
2030 M Street NW, 8th Floor
Washington, DC 20036
bzelner@naag.org

1226
#2
3/6
Pg. 14

INDEX OF CASES

COUNSELORS 2

DENTISTS 2

HOME HEALTH CARE
Mohammed Abdi 5
Theresa Ambrose 6
Julia Andrews 4
Landon Michael Armani 6
Misty Barney 5
Sharon Guei 6
Jene Love 5
Brenda Mencer 3
Angela Nelson 3
Amy Neubacher 5
Tanisha Paige 4
Makita Pope 4
Dawn Shannon 3
Erika White 3

HOSPITALS 1

NURSES
Christine Bayes 7
Lisa Jordan 8
Sophia Mulle 7
Timnah Wills 7

NURSING ASSISTANTS 8

PHARMACIES 8

PHYSICIANS 11

REHABILITATION SERVICES 9

RESIDENT TRUST FUNDS 9

TREATMENT CENTERS 10