Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Nebraska Comprehensive Program Integrity Review
Final Report

January 2013

Reviewers:
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Introduction

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Nebraska Medicaid Program. The MIG review team conducted the onsite portion of the review at the Nebraska Department of Health & Human Services (DHHS) office. The MIG also conducted a telephone interview with the Medicaid Fraud and Patient Abuse Unit (MFPAU).

This review focused on the activities of the Program Integrity (PI) unit, which is responsible for Medicaid program integrity in Nebraska. This report describes one noteworthy practice, three effective practices, five regulatory compliance issues, and one vulnerability in the State's program integrity operations.

The CMS is concerned that the review identified two uncorrected partial repeat findings and one uncorrected repeat vulnerability from its 2009 review of Nebraska. The CMS plans on working closely with the State to ensure that all issues, particularly those that remain from the previous review, are resolved as soon as possible.

The Review

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help Nebraska improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Nebraska's Medicaid Program

The DHHS administers the Nebraska Medicaid program. As of January 1, 2012, the program served 238,365 beneficiaries, 43 percent of whom were enrolled in two managed care entities (MCEs). The State had 52,435 fee-for-service (FFS) enrolled providers, of which 12,407 are MCE providers. Medicaid net expenditures in Nebraska for the State fiscal year (SFY) 2011 totaled $1,634,003,621. This figure includes $204,585,253 in payments to MCEs.

Medicaid Program Integrity Division

In Nebraska, the PI unit is the organizational component dedicated to fraud and abuse activities. The PI unit is located in the Division of Medicaid & Long-Term Care (MLTC). At the time of the review, the PI unit had 6 full-time equivalent positions allocated to Medicaid program integrity functions. The table below presents the total number of investigations and overpayment amounts identified and collected in the last four SFYs because of program integrity activities.

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Amount of Overpayments Identified***	Amount of Overpayments Collected***
2009	130	99	$488,602	$505,715
2010	168	144	$1,124,447	$888,361
2011	120	92	$269,199	$745,229
2012	163	125	$ 259,878	$ 173,684

*Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation.
**Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved through administrative action, a referral to the Medicaid Fraud Control Unit (MFCU) or other legal disposition. The State conducts full investigations on all provider abuse cases and only refers suspected fraud cases to the MFCU.
***The State's identified and collected overpayment varies based upon administrative actions taken.

In SFY 2012, the PI unit has seen an increase in the number of providers appealing overpayment/refund requests. The vast majority of the appeals have either not been heard yet or had the hearing and the PI unit is still awaiting the finding and order from the Legal Hearing Office. The amounts identified and collected as indicated in the chart above should increase after the appeals are completed. The PI unit does not track the identified amount in the log until the appeal is completed because the entire amount may be dismissed or the hearing officer may remove amounts from what the PI unit is collecting if the provider or the hearing officer does not agree with the PI unit's actions on a claim by claim basis.

Methodology of the Review

In advance of the onsite visit, the review team requested that Nebraska complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as program integrity, provider enrollment/disclosures, managed care, and the MFCU. A three-person team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of June 26, 2012, the MIG review team visited the DHHS office. The team conducted interviews with program integrity and DHHS officials. To determine whether the MCEs were complying with the contract provisions and other Federal regulations relating to program integrity, the MIG team reviewed the State's managed care contracts. The team conducted in-depth interviews with representatives from both MCEs and met separately with DHHS staff to discuss managed care oversight and monitoring. In addition, the team conducted sampling of provider enrollment applications, program integrity cases, and other primary data to validate Nebraska's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of the PI unit but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment, contract management, and provider training. Nebraska's Children's Health Insurance Program (CHIP) operates under a Title XIX Medicaid expansion program. The CHIP

operates under the same billing and provider enrollment policies as the Nebraska Medicaid program. The same findings, vulnerabilities, and effective practices discussed in relation to the Medicaid program also apply to CHIP.

Unless otherwise noted, Nebraska provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information that the PI unit provided.

Results of the Review

Noteworthy Practice

As part of its comprehensive review process, the MIG review team identified one practice that merits consideration as a noteworthy or "best" practice. The CMS recommends that other States consider emulating this activity.

Enrollment of all FFS, MCEs, and managed care network and waiver providers in the State Medicaid program.

The State enrolls all FFS, MCEs, managed care network and waiver providers. By having one focal point of enrollment, the Medicaid agency ensures that all provider types are subject to the same enrollment processes in which required disclosures are made, license verifications conducted and exclusion searches performed. This standardization has eliminated essential discrepancies found in many other States, especially for providers participating in managed care networks who may be subject to different credentialing standards.

Notwithstanding the State's efforts to enroll all FFS, MCEs, managed care network and waiver providers, the review team found certain problems in the collection of provider disclosures using State forms. These are discussed in the Regulatory Compliance Issues section of the report.

Effective Practices

As part of its comprehensive review process, CMS also invites each State to self-report practices that it believes are effective and demonstrate its commitment to program integrity. The CMS does not conduct a detailed assessment of each State-reported effective practice. Nebraska reported an ability to report cost avoidance based on the implementation of the National Correct Coding Initiative (NCCI), the PI unit's participation in the healthcare fraud task force, and the PI unit's partnership with the MFPAU.

The State's ability to report cost avoidance based on the implementation of the NCCI.

Section 6507 of the Patient Protection and Affordable Care Act requires that States implement the NCCI for claims filed on or after October 1, 2010. Nebraska Medicaid contracted with a vendor to apply the edits to claims. While Nebraska Medicaid did not request deactivation of any edits, the edits were not applied on a pre-payment basis until November 2, 2011. Claims subject to the NCCI are sent for processing before final adjudication and as part of certain adjustment scenarios. Nebraska Medicaid has

developed unique reduced reasons so that the cost avoidance can be measured. Since implementation of the pre-pay editing, Nebraska Medicaid has realized the cost avoidance of $461,249 from November 2011 through March 2012.

Since implementation of the NCCI edits, Nebraska has developed a very good working relationship with its vendor. Due to this good working relationship, Nebraska is in the process of working with the vendor to review additional edits to implement in its claims processing system. These additional edits are beyond what are required under Section 6507 of the Patient Protection and Affordable Care Act.

The PI unit's active participation in the healthcare fraud task force.
Nebraska has a comprehensive healthcare fraud task force chaired by the Nebraska United States (U.S.) Attorney's Office. Members include the MFPAU, CMS, U.S. Drug Enforcement Agency, U.S. Food and Drug Administration, U.S. Internal Revenue Service, Federal Bureau of Investigation, Nebraska Office of Inspector General, U.S. Postal Inspector, U.S. Department of Labor, U.S. Veterans Administration, Nebraska Public Health, Nebraska State Patrol, Nebraska Department of Insurance, and private insurance company investigators. The meetings are held quarterly with information sharing occurring between meetings on an as needed basis between the PI unit and other participating agencies. The membership encourages cooperation, sharing of information, and a coordinated approach to targeting fraud, waste, and abuse.

In December 2011, the PI unit participated in a Federal case that resulted in a criminal conviction, for which the provider was ordered to pay $1.4 million in restitution. Approximately $279,000 was identified by the Medicaid agency but has not yet been received. Furthermore, the conviction resulted in the provider's office manager being sentenced to three years in Federal prison and supervised release.

In addition to working cases, the PI unit has developed positive relationships with members of the task force that have enabled them to utilize each other for sources of data related to programs, rules, regulations, and general information that the PI unit may not otherwise have access to.

The PI unit's partnership with the MFPAU.
The Nebraska PI unit and the MFPAU continue to have a well-functioning and committed partnership between the two entities. Activities include regularly scheduled meetings as evidenced by the entities' participation in the fraud task force. Both the MFPAU and the PI unit meet with the U.S. Attorney's healthcare task force on a quarterly basis. This is in addition to the MFPAU's monthly case review and quarterly trend analysis meetings with the PI unit.

The PI unit and MFPAU have established a clear understanding of the standards for appropriate referrals. Over the years, the PI unit has come to know what the MFPAU director expects in making an appropriate referral. In addition, the PI unit knows to contact the MFPAU director or the appropriate member of his staff if they think they may have a case which the MFPAU would be interested in reviewing. This has resulted in the MFPAU accepting almost all of the referrals from the PI unit. Prior to sending a case to

the MFPAU, the PI unit staff conducts a review of raw data that aids in the facilitation of the MFPAU's evaluation of a case. Even after a referral is made, the PI unit staff is ready and able to assist the MFPAU with the MFPAU's evaluation of the case and any subsequent investigation that might occur.

While an investigation is being conducted by the MFPAU, the PI unit staff assists the MFPAU by providing subject matter expertise. When requested, the PI unit has been available to directly assist the MFPAU in further investigating cases, assisting in search warrants and being available to provide information and assistance in the development and settlement of criminal and civil cases pursued by the MFPAU. After the case is fully developed, the PI unit and MFPAU continue communication regarding the status of the case until its conclusion.

Notwithstanding the close cooperation between the State agency and the MFPAU, the team found problems with the coordination of payment suspensions. This issue is discussed in the Regulatory Compliance Issues section of the report.

Regulatory Compliance Issues

The State does not comply with Federal regulations relating to the suspension of Medicaid payments in credible allegation cases and provider disclosures. Issues also include not conducting complete exclusion searches, and not reporting all adverse actions within the required timeframe.

The State does not suspend payments in cases of credible allegations of fraud.

The Federal regulation at 42 CFR 455.23(a) requires that upon the State Medicaid agency determining that an allegation of fraud is credible, the State Medicaid agency must suspend all Medicaid payments to a provider, unless the agency has good cause to not suspend payments or to suspend payment only in part. Under 42 CFR 455.23(d) the State Medicaid agency must make a fraud referral to either a MFCU or to an appropriate law enforcement agency in States with no certified MFCU. The referral to the MFCU must be made in writing and conform to the fraud referral performance standards issued by the Secretary.

The PI unit is not suspending payments or invoking a good cause exception not to suspend payments immediately upon referral to the MFPAU. The PI unit referred 12 cases to the MFPAU from March 25, 2011 through June 29, 2012. Based on the PI unit's current procedure, the MFPAU responds to the PI unit within five days of the referral to not suspend payment. A total of $5,983 was paid to these providers after the referral to the MFPAU. These cases should have been suspended immediately upon referral to the MFPAU, unless the MFPAU requested a good cause exception in writing or the PI unit exercised one of the other good cause exceptions not to suspend payments in whole or in part immediately upon the referral to the MFPAU.

***Recommendation*:** In the 2009 review report the recommendation was to modify withholding letters to include language that references 42 CFR § 455.23(b) as required by the regulation. The MIG now recommends that the State develop and implement policies and procedures to meet the fraud referral standards for MFCU referrals and the requirements of 42 CFR 455.23 concerning

the suspension of payments to providers upon MFCU referral.

The State does not capture all required ownership and control disclosures from disclosing entities.

Under 42 CFR 455.104(b)(1), a provider (or "disclosing entity"), fiscal agent, or MCE, must disclose to the State Medicaid agency the name, address, date of birth, and Social Security Number (SSN) of each person or entity with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. Additionally, under 455.104(b)(2), a disclosing entity, fiscal agent, or MCE must disclose whether any of the named persons is related to another disclosing entity, fiscal agent, or MCE as spouse, parent, child, or sibling. Moreover, under 455.104(b)(3), there must be disclosure of the name of any other disclosing entity, fiscal agent, or MCE in which a person with an ownership or controlling interest in the disclosing entity, fiscal agent, or MCE has an ownership or controlling interest. In addition, under 455.104(b)(4), the disclosing entity must provide the name, address, date of birth, and SSN of any managing employee of the disclosing entity, fiscal agent, or MCE. As set forth under 455.104(c), the State agency must collect the disclosures from disclosing entities, fiscal agents, and MCEs prior to entering into the provider agreement or contract with such disclosing entity, fiscal agent, or MCE.

The State began using the most current Nebraska Ownership/Controlling Interest and Conviction Disclosure form (MLTC-62) in March 2011 to collect required disclosures from their providers. However, it is not capturing all of the required disclosures. The form does not require non-profit organizations to provide the name, address, date of birth, and SSN of each person or entity with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. It also does not require non-profit organizations to disclose whether any of the named persons is related to another disclosing entity, fiscal agent, or MCE as spouse, parent, child, or sibling.

Furthermore, the MLTC-62 does not solicit enhanced address information for corporate business entities as well as not soliciting address information for managing employees. The MCEs used the 2009 version of the MLTC-62 to provide their disclosures. That disclosure form does not capture managing employee information. The MCEs update their disclosure information every contract period, which is every two years. The team was notified that the MCEs would be updating their disclosure information in September 2012.

The non-emergency medical transportation (NEMT) contractor used the calendar year 2010 version of the MLTC-62 to provide its disclosures. That disclosure form does not capture each person or entity with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. It also does not solicit enhanced address information nor does it capture the managing employee's SSN, date of birth, and address information. In addition, the form does not have space to capture multiple names if needed nor does it give instructions to use another sheet if more space is needed. The review team identified an instance where the State enrolled a

provider who failed to provide the required disclosures.

Recommendations: Develop and implement policies and procedures for the appropriate collection of disclosures from disclosing entities, MCEs and NEMT regarding persons with an ownership or control interest, or who are managing employees of the disclosing entities or MCEs. Modify disclosure forms as necessary to capture all disclosures required under the regulation.

The State does not adequately address business transaction disclosure requirements in its provider agreements. (Uncorrected Partial Repeat Finding)

The regulation at 42 CFR 455.105(b) requires that, upon request, providers furnish to the State or U.S. Department of Health & Human Services (HHS) information about certain business transactions with wholly owned suppliers or any subcontractors.

Also, the regulation requires that, upon request, providers furnish to the State or HHS information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request as stated in 42 CFR 455.105(b)(1).

The State's Service Provider Agreement does not reference the complete 42 CFR 455.105(b) regulation. It only references to 42 CFR 455.105(b)(2). The agreement does not mention anything about 42 CFR 455.105(b)(1).

In the 2009 MIG review, the team found that Nebraska's provider agreements did not include a reference to 42 CFR 455.105(b)(2), but this was subsequently corrected in Nebraska's corrective action plan.

Recommendation: In the 2009 review report the recommendation was to modify the provider enrollment agreements to meet the requirement in 42 CFR 455.105(b) and revise the language in Title-471 to be consistent with the regulation. The MIG continues to recommend revising the provider agreement to require disclosure upon request of the information identified in 42 CFR 455.105(b).

The State does not conduct complete searches for individuals and entities excluded from participating in Medicaid.

The Federal regulation at 42 CFR 455.436 requires that the State Medicaid agency must check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider on HHS-OIG's List of Excluded Individuals/Entities (LEIE) and the General Services Administration's Excluded Parties List System (EPLS)[1] no less frequently than monthly.

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[1] On July 30, 2012, the EPLS was migrated into the new System for Award Management (SAM). State Medicaid agencies should begin using the SAM database. See the guidance at http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-08-01-12.pdf for assistance in accessing the database at its new location.

Although the State is conducting searches for individuals and entities excluded from participating in Medicaid at enrollment and re-enrollment for all individuals listed on the enrollment forms by checking the LEIE and the EPLS, it is not able to check all the required individuals because the disclosure form is not capturing all of the required individuals (i.e. Board of Directors and any person or entity with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more for non-profit organizations).

While the State is conducting searches for individuals and entities excluded from participating in Medicaid at enrollment, on a monthly basis they are not checking anyone that is not captured in their Medicaid Management Information System (MMIS) because they do not have these names in a searchable database to be able to conduct the monthly checks. The State is not able to capture anyone who is not a provider in their MMIS.

Furthermore, for the monthly check the State is only looking at providers that have been added to the LEIE and EPLS that month. The State is only checking the providers from Nebraska and neighboring States.

In the 2009 MIG review the State was cited with vulnerability under 42 CFR 455.104 through 455.106 because the Division of Developmental Disabilities (DDD) was not searching providers for exclusions, which was subsequently corrected in their corrective action plan.

Recommendations: Develop and implement policies and procedures for appropriate collection and maintenance of disclosure information about the provider, any person with an ownership or control interest, or who is an agent or managing employee of the provider. Search the LEIE (or the Medicare Exclusion Database) and the EPLS upon enrollment, reenrollment, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded persons or entities.

The State does not report all adverse actions taken on provider participation to the HHS-OIG within the required timeframe. (Uncorrected Partial Repeat Finding)

The regulation at 42 CFR 1002.3 requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program.

The State is notifying HHS-OIG of adverse actions it takes on provider applications for participation in the program, however, the notification is not occurring within 20 working days from the date it receives the information. Although, Nebraska now reports adverse actions since the 2009 MIG review, the reporting period is not within 20 working days as required by the regulation.

Recommendation: In the 2009 review report the recommendation was to require DDD to notify the State when taking adverse action against a provider's participation in the program, including when it denies credentials for fraud-related concerns and develop and implement procedures to report to HHS-OIG all adverse actions taken against and limits placed on providers applying to participate in the program. The MIG continues to recommend that the State develop and

implement procedures for reporting to HHS-OIG program integrity-related adverse actions on a provider's participation in the Medicaid program.

Vulnerabilities

The review team identified one area of vulnerability in the State's practices. It is related to the State's inability to place edits in the Nebraska Family On-line Client User System (N-FOCUS) for personal care services (PCS).

Inability to place edits in N-FOCUS for PCS. (Uncorrected Repeat Vulnerability)

The Chore program (under the aged and disabled waiver) provides Nebraska personal care services. The State enrolls both personal care agencies and personal care attendants in the Medicaid program. Social service workers in more than 100 local offices statewide oversee the provision of PCS and are responsible for authorizing PCS to Medicaid-eligible individuals. The PCS claims are paid through a system outside the MMIS referred to as N-FOCUS. The timesheets are sent to the local office where they are reviewed, verified, and then submitted to N-FOCUS staff for processing. There are no specific edits within N-FOCUS that limit PCS claims, for example, an edit to limit PCS claims during inpatient stays. Manual post payment reviews are conducted to check overlapping of services including hospital stays.

In the 2009 MIG review, Nebraska was cited for the same vulnerability. The State responded with a corrective action plan signifying that they developed a Chore/Personal Assistance Services provider agreement addendum to be used when enrolling PCS providers. The addendum requires the provider to initial three separate sections indicating they understand billing for days they or their client spends in a hospital, nursing facility, rehabilitation, or correctional facility. In addition, documentation must include actual in and out times on actual dates, and the services that were provided, and they are only authorized to bill in the specific time increments identified. The Chore/Personal Assistance Services provider agreement addendum is on-line and must be filled out and signed before the provider is enrolled. Even though the vulnerability was addressed in the corrective action plan, it remains uncorrected. The claims are continuing to be paid outside the MMIS with no specific edits in place.

Recommendations: In 2009, the MIG review team recommended that the State investigate the provider claim forms and determine if additional information is available regarding the dates to rule out duplicate billing. Consider obtaining greater specificity on the dates being billed, and adopting procedures to ensure there is no duplicate billing. In addition, the MIG recommends developing and implementing procedures to ensure edits are in place to avoid making duplicate payments. Ensure that Federal financial participation on any duplicate payments previously made and not properly adjusted is promptly reported and returned to CMS.

Conclusion

The State of Nebraska applies a noteworthy and some effective practices that demonstrate program strengths and the State's commitment to program integrity. The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity.

However, the identification of five areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, one area of vulnerability was identified. The CMS is particularly concerned over the two uncorrected partial repeat findings and one uncorrected repeat vulnerability. The CMS expects the State to correct them as soon as possible.

To that end, we will require Nebraska to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerability identified in this report.

The corrective action plan should address how the State of Nebraska will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the regulatory compliance issues or vulnerability will take more than 90 calendar days from the date of the letter. If Nebraska has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the State of Nebraska on correcting its areas of non-compliance, eliminating its area of vulnerability, and building on its effective practices.

Official Response from Nebraska
March 2013

DHHS
Nebraska Department of Health and Human Services
Division of Medicaid and Long-Term Care
State of Nebraska
Dave Heineman, Governor

March 6, 2013

Pete Leonis
Acting Direct of the Division on Field Operations

Dear Mr. Leonis:

Nebraska Medicaid has reviewed the Final Report of the Comprehensive Program Integrity Review. Thank you for identifying the noteworthy and effective practices. The feedback concerning compliance with Federal regulations and areas of vulnerability is also appreciated.

The review process began in September 2011 when Nebraska received the extensive documentation to be submitted for review prior to the onsite visits. Nebraska was contacted in February of 2012 with the plan for the audit. The required documentation was submitted timely and the on-site audit was held during the last week of June 2012. The draft report was received in early November. After the review of comments and discussion, the final report was received on January 22, 2013. Nebraska was granted an extension for submitting the response and corrective action plan.

Nebraska Medicaid agrees with five of the six findings and has prepared a corrective action plan to address the deficiencies. The deficiencies related to provider screening and enrollment activities will take more than 90 days to correct. Nebraska Medicaid does not have the staff and information systems resources to implement the requirements at this time. The State is working on a project to implement the provider screening and enrollment requirements by October of 2014.

Nebraska Medicaid disagrees with one finding. More specific information about the issue is included in the corrective action plan.

The attached corrective action plan address how Nebraska Medicaid will ensure that the deficiencies be addresses. Nebraska Medicaid will monitor compliance with the corrective action plan regularly to ensure ongoing compliance. The Program Integrity staff will contact Mr. Brasky with questions.

Thank you for the opportunity to respond to these findings.

Sincerely,

Vivianne M. Chaumont, Director
Division of Medicaid & Long-Term Care

CC: Anne Harvey, Program Integrity Director
Mark Collins, MFCU Director
Jackie Garner, CMCHO Consortium Administrator
James Scott, DMCHO Associate Regional Administrator