Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Nebraska Focused Program Integrity Review:

April 2023

Final Report

TABLE OF CONTENTS

Executive Summary

Objectives

The Centers for Medicare & Medicaid Services' (CMS) conducted a focused program integrity desk review to assess Nebraska's program integrity oversight efforts of its Medicaid managed care program for the Fiscal Years (FYs) 2019 – 2021. This focused program integrity review specifically assessed the state's compliance with CMS regulatory requirements at § Part 438, Subpart H. A secondary objective of this review was to provide the state with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid managed care.

To meet the objectives of this focused review, CMS reviewed information and documents provided by the state in response to questions posed by CMS in a managed care review tool provided at the initiation of the review. CMS also conducted in-depth interviews with the state Medicaid agency and evaluated program integrity activities performed by selected managed care organizations (MCOs) under contract with the state Medicaid agency.

This report includes CMS' findings and resulting recommendations, as well as observations, that were identified during the focused review.

Findings and Recommendations

Findings represent areas of non-compliance with federal and/or state Medicaid statutory, regulatory, sub-regulatory, or contractual requirements. CMS identified six findings that create risk to the Nebraska Medicaid program related to managed care program integrity oversight. In response to the findings, CMS identified three recommendations that will enable the state to come into compliance with federal and/or state Medicaid requirements related to managed care program integrity oversight. These recommendations include the following:

State Oversight of Managed Care Program Integrity Activities

Recommendation #1: The state should upload all MCO contracts to their website with a publicly accessible hyperlink, in accordance with § 438.602(g)(1).

MCO Contract Compliance

Recommendation #2: The state should develop written policies for annual reporting of recoveries of overpayments, in accordance with § 438.608(d)(3).

Recommendation #3: Per § 438.608(d)(2), the state should develop written policies requiring MCOs to establish a mechanism for network providers to report and return identified overpayments to the MCO within 60 calendar days as well as to notify the MCO in

writing of the reason for the overpayment.

Observations

Observations represent operational or policy suggestions that may be useful to the state in the oversight of its Medicaid managed care program. CMS identified two observations related to Nebraska's managed care program integrity oversight. While observations do not represent areas of non-compliance with federal and/or state requirements, observations identify areas that may pose a vulnerability or could be improved by the implementation of leading practices. The observations identified during this review include the following:

MCO Contract Compliance

Observation #1: CMS encourages the state to clarify guidelines for overpayment identification, reporting requirements, and which entities are responsible for recovery.

Interagency and MCO Program Integrity Coordination

Observation #2: CMS encourages the Nebraska Medicaid Program Integrity unit and state plan management staff to reestablish regular collaboration and communication on program integrity issues pertaining to the Nebraska Medicaid Managed Care program.

I. BACKGROUND

Focused Program Integrity Reviews

In the Comprehensive Medicaid Integrity Plan for Fiscal Years (FYs) 2019-2023, CMS set forth its strategy to safeguard the integrity of the Medicaid program.[1] This plan encompasses efforts to ensure that states are adhering to key program integrity principles, including the requirement that state Medicaid programs have effective oversight and monitoring strategies that meet federal standards.

As a part of these efforts, CMS conducts Focused Program Integrity Reviews on high-risk areas in the Medicaid program, such as managed care, new statutory and regulatory provisions, non-emergency medical transportation, telehealth, and personal care services. These reviews include onsite or virtual state visits to assess the effectiveness of each state's program integrity oversight functions and to identify areas of regulatory non-compliance and program vulnerabilities. Through these reviews, CMS also provides states with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid.

Medicaid Managed Care

Medicaid managed care is a health care delivery system organized to manage cost, utilization, and quality. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care. This approach provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and MCOs that receive a set per member per month (i.e., capitation) payment for these services. By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services.

Overview of the Nebraska Managed Care Program and the Focused Program Integrity Review

Medicaid and Long-Term Care (MLTC) is the division of the Department of Health and Human Services (DHHS) that is responsible for the administration of the Nebraska Medicaid program, titled Heritage Health. Within MLTC, the Nebraska Medicaid Program Integrity (NMPI) unit is the organizational unit tasked with oversight of program integrity-related functions for the managed care program. During the review period, which covers FYs 2019 - 2021, Nebraska contracted with three MCOs to provide health services to the Medicaid population. As part of this review, the three MCOs were interviewed: Healthy Blue, Nebraska Total Care, and United Healthcare Community Plan. Appendix C provides enrollment and expenditure data for each of the selected MCOs.

In April 2022, CMS conducted a virtual focused program integrity review of Nebraska's

[1] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf

managed care program. This focused review assessed the state's compliance with CMS regulatory requirements at § Part 438, Subpart H. As a part of this review, CMS also evaluated program integrity activities performed by the three selected MCOs. During this review, CMS identified three recommendations and two observations. CMS also included technical assistance and educational resources for the state, which can be found in Appendix B. The state's response to CMS' draft report can be found in Appendix D, and the final report reflects changes CMS made based on the state's response.

This review encompasses the following five areas:

A. **State Oversight of Managed Care Program Integrity Activities** - CMS established requirements at §§ 438.66 and 438.602 that require the SMA to have a monitoring system that includes mechanisms for the evaluation of MCO performance in several program integrity areas. These areas include, but are not limited to: data, information, and documentation that must be submitted under §§ 438.604 – 606, as well as compliance with contractual program integrity requirements under § 438.608.

B. **MCO Contract Compliance** - Regulations at § 438.608 require the state, through its contracts with the MCOs, to ensure that MCOs implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse, such as implementing compliance plans, payment suspensions based on credible allegations of fraud, and overpayment reporting.

C. **Interagency and MCO Program Integrity Coordination** - Within a Medicaid managed care delivery system, MCO SIUs, the SMA, and the state Medicaid Fraud Control Unit (MFCU) play important roles in facilitating efforts to prevent, detect, and reduce fraud and abuse to safeguard taxpayer dollars. Under § 455.21, the SMA is required to cooperate with the state MFCU by entering into a written agreement with the MFCU. The agreement must provide a process for the referral of suspected provider fraud to the MFCU and establish certain parameters for the relationship between the MFCU and the SMA.

D. **MCO Investigations of Fraud, Waste, and Abuse** - Regulations at § 438.608(a)(7) require states to ensure that MCOs promptly refer any potential fraud, waste, and abuse that the MCO identifies to the state Program Integrity Unit (PIU) or any potential fraud directly to the state's MFCU. Similarly, as required by § 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs.

E. **Encounter Data** - In accordance with § 438.242, the state must ensure, through its contracts, that each MCO maintains a health information system that collects, analyzes, integrates, and reports encounter data. In addition, in accordance with § 438.602(e), the state must periodically, but no less frequently than once every three years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, each MCO.

II. RESULTS OF THE REVIEW

A. State Oversight of Managed Care Program Integrity Activities

State oversight of managed care program integrity activities is critical to ensuring that MCOs are meeting all CMS requirements and state contractual requirements. CMS established state monitoring requirements at §§ 438.66 and 438.602 that require the SMA to have a monitoring system that includes mechanisms for the evaluation of MCO performance in several program integrity areas, including but not limited to, data, information, and documentation that must be submitted under § 438.604 – 606, as well as compliance with contractual program integrity requirements under § 438.608.

The state reported that oversight of the managed care system in Nebraska is a collaborative effort between MLTC's Plan Management team, NMPI, and the state's external quality review organization, Island Peer Review Organization (IPRO). NMPI consists of 34 full-time employees and covers program integrity, provider screening and enrollment, personal assistance, and waiver provider activities. The state confirmed that it does not have operational guidelines or interagency agreements that outline the specific program integrity responsibilities of each division in MLTC. Nebraska does not contract with other entities to conduct program integrity activities but coordinates with IPRO to compile annual technical reporting on each of the MCOs. This technical reporting includes information on quality measurement, performance improvement projects, and validation of performance measures.

The state has conducted annual onsite reviews at each of the three MCOs since 2017 to verify compliance with fraud and abuse contract requirements. The state began conducting virtual reviews in 2020, in which MCOs receive a toolkit and submit documentation to NMPI for review, due to the public health emergency. All reviews result in written reports with any findings. NMPI also conducts investigations of MCO providers based on referrals from agency staff, the public, and MCOs.

CMS regulations at § 438.602(g)(1) require that states post on its website all MCO contracts. The Nebraska Medicaid Program utilizes a contracting approach wherein the initial request for proposal (RFP) issued to MCOs during the solicitation process becomes the statement of work and requirements after the contract is awarded. As such, the RFP represents an essential supplemental document for determining the adequacy of MCO contract provisions relating to program integrity. CMS found this approach to be sufficient in ensuring that federal and state requirements are met and herein refers to the compilation of RFP and contracting documents as the "MCO general contract" for the purposes of this report. However, these contracting documents between the state and MCOs are hosted on the Nebraska Department of Administrative Services' website but cannot be accessed without a direct link. The state confirmed the contracts and accompanying documents are not accessible from the broader Nebraska Department of Health and Human Services website.

Nebraska's MCO general contract states, "[t]he MCO must have a [fraud, waste, and abuse] and erroneous payments unit within the organization comprised of experienced staff members… This

unit must include a State-based Program Integrity Officer and a minimum of one investigator for every 50,000 or fewer Members." All three MCOs followed these staffing ratio requirements during the review period. In addition, all of the MCOs reported subcontracting with vendors for some program integrity-related functions, or other Medicaid audits or reviews. CMS regulations at § 438.230 specify requirements for MCOs' sub-contractual relationships and delegations. CMS reviewed the subcontracting requirements in the finalized contracts between the state and MCOs and determined they are in compliance with § 438.230.

In accordance with § 438.66, the state's external quality review organization, IPRO, develops annual technical reports for each MCO. NMPI monitors program integrity performance through monthly and quarterly reporting from the MCOs. A review of the state's MCO contracts also showed compliance with §§ 438.48 and 438.602(h) regarding conflict-of-interest safeguards.

Recommendation #1: The state should upload all MCO contracts and amendments to their website with a publicly accessible link, in accordance with § 438.602(g)(1).

B. MCO Contract Compliance

Regulations at § 438.608 require the state, through its contracts with the MCOs, to ensure that MCOs implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. These requirements extend to any subcontractor that is delegated responsibility for coverage of services and payment of claims under the contract between the state and the MCO. As part of this review, the MCO general contract was evaluated for compliance with several of these requirements, which are described in greater detail below.

The MCO general contract for Nebraska is developed by the Plan Management division of MLTC. NMPI staff assists in developing contract language on fraud and abuse. Additionally, NMPI reviews and provides comments on the program integrity section. The state reported that NMPI staff are primarily responsible for developing language on program integrity requirements during RFP development. Plan Management is responsible for monitoring managed care contract compliance and collaborates with NMPI to oversee the program integrity provisions of the contract.

Compliance Plans

In accordance with §§ 438.608(a)(1)(i)-(vii), states must require MCOs to implement compliance programs that meet certain minimal standards, which include the following:

1. Written policies, procedures, and standards of conduct that articulate the MCO's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and state requirements
2. Designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Executive Officer and the board of directors

3. Establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the MCO's compliance program and its compliance with the requirements under the contract
4. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the Federal and State standards and requirements under the contract
5. Effective lines of communication between the compliance officer and employees
6. Enforcement of standards through well-publicized disciplinary guidelines
7. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract

Nebraska's MCO general contract explicitly addresses the requirement that all seven compliance plan elements listed above be addressed in Section O, Program Integrity, number 8b. As required by § 438.608, the state reviews the MCOs compliance plan annually, tracks the status of the review internally, and communicates approval/disapproval with the MCOs before implementation. Review of compliance plans is led by Plan Management. In the case of a corrective action plan (CAP) or deficiencies in the compliance plan, NMPI provides subject matter expertise, as needed, and Plan Management is responsible for monitoring the execution of the CAP. The state also requires MCOs to have a fraud, waste, and abuse plan, according to Section O, Program Integrity, number 8 of the MCO general contract. A review of the MCOs' compliance plans and programs also found that they are in compliance with the requirements at § 438.608.

CMS did not identify any findings or observations related to these requirements.

Beneficiary Verification of Services

In accordance with § 438.608(a)(5), the state, through its contract with the MCO, must require a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis.

In Nebraska, this requirement is met through MCO general contract Section O, Program Integrity, number 10, which stipulates that MCOs "…have a method and regularly verify that services have been actually provided. The MCO must report the results of this monitoring to NMPI quarterly." The SMA provides an explanation of medical benefits (EOMB) letter template and education sheet that MCOs send to beneficiaries. All of the MCOs follow the requirement to verify that services billed were received by beneficiaries and submit a quarterly report of all verifications to the state. The state performs additional beneficiary service verification activities across the Medicaid program in accordance with § 455.20, by mailing EOMBs to 200 random

beneficiaries each month, including both fee-for-service and managed care beneficiaries.

CMS did not identify any findings or observations related to these requirements.

False Claims Act Information

In accordance with § 438.608(a)(6), the state, through its contract with the MCO, must require that, in the case of MCOs that make or receive annual payments under the contract of at least $5,000,000, there are written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

A review of the MCO general contract and related policies revealed that the state requires false claims education and has written policies in place as described in § 438.608(a)(6). The state confirmed that NMPI includes the MCOs in the annual review of false claims act education by providers.

CMS did not identify any findings or observations related to these requirements.

Payment Suspensions Based on Credible Allegations of Fraud

Pursuant to § 438.608(a)(8), states must ensure that MCOs suspend payments to a network provider for which the state determines there is a credible allegation of fraud in accordance with § 455.23.

Nebraska Medicaid MCOs are contractually required to suspend payments to providers at the state's request, according to Section O, Program Integrity, number 8b of the state's general contract. After the Medicaid Fraud and Patient Abuse Unit (MFPAU) ends their request for a law enforcement exception, NMPI makes the determination on payment suspension. If suspension is the most appropriate action, a credible allegation of fraud letter is sent to the provider and copied to all MCOs. In addition to requiring that MCOs suspend payments at the state's request, the MCO general contract Section O, Program Integrity, number 16a states that MCOs must "…ensure no Nebraska Medicaid dollars are paid to a provider whose payments have been suspended." The state reported that NMPI periodically reviews encounter data to ensure no payments have been made to suspended providers.

Nebraska Total Care, United Healthcare, and Healthy Blue verified that they suspend provider payments upon written notice from NMPI. The state requested that the MCOs suspend payments to one provider due to a credible allegation of fraud in FY 2021, four providers in FY 2022 and four providers in FY 2019.

CMS did not identify any findings or observations related to these requirements.

Overpayments

Regulations at §§ 438.608(a)(2) and (d) require states to maintain oversight of MCOs' overpayment recoveries. Specifically, § 438.608(a)(2) requires states to ensure that MCOs promptly report all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the state. In addition, § 438.608(d) requires states to specify in MCOs' contracts how the MCOs should treat overpayment recoveries. This must include retention policies for recoveries of all overpayments, including overpayments due to fraud, waste, and abuse; the process, timeframes, and documentation requirements for reporting the recovery of all overpayments; and the process, timeframes, and documentation requirements for payment of recoveries to the state in situations where the MCO is not permitted to retain some or all of the recoveries. States must also ensure that MCOs have a process for network providers to report to the MCO when it has received an overpayment (including the reason for the overpayment), and to return the overpayment to the MCO within 60 calendar days. Each MCO must report annually to the state on their recoveries of overpayments, and the state must use the results of the information in setting actuarially sound capitation rates, consistent with the requirements in § 438.4.

Section O, Program Integrity, number 13a of Nebraska's MCO general contract requires MCOs to submit a monthly cumulative report of "…all overpayments identified and collected [and] all new referrals of potential fraud, waste, and abuse and erroneous payments received by the MCO," in accordance with § 438.608(a)(2) and (c)(3). Nebraska also specifies retention policies for the treatment of recoveries of all managed care plan overpayments as required by § 438.608(d)(1). Section O, Program Integrity, number 1f of the MCO general contract specifies that the MCO will retain overpayment recoveries unless the overpayment is discovered by the SMA or involves the MFCU. The SMA also analyzes MCO quarterly financial reports, including overpayment amounts, against claims extracts to assist in rate-setting, consistent with § 438.608(d)(4).

However, CMS found that the state did not adequately address the requirements as § 438.608(d)(2)-(3). Section 438.608(d)(2) requires each MCO to have a mechanism for network providers to self-report and return overpayments to the MCO within 60 calendar days, and (d)(3) requires annual reporting of MCO overpayment recoveries to the state. The current contracts do not include language requiring MCOs to have a process for network providers to report and return excess capitation or overpayments to the MCO within 60 calendar days, as required in § 438.608(d)(2). In addition, at the time of the review, the executed contracts between the MCOs and the state did not include provisions for MCOs to report recoveries of overpayments annually as required by § 438.608(d)(3). The SMA confirmed they do not currently have a process for annual reporting of overpayment recoveries.

During the three FYs reviewed, there were no identified or returned overpayments from the MCOs to the state. However, Healthy Blue and Nebraska Total Care stated that excess capitation and other contract overpayments are reported to the state within 60 days. CMS' review of the MCO general contract revealed that the MCO, "…must pursue all recovery of payments identified as fraud, waste, and/or abuse or erroneous. In the event that the MCO does not pursue all recoveries, MLTC will pursue them and recoup the money." The MCO general contract also specifies that the MFPAU has the right to recover inappropriately expended Medicaid funds in

prosecuted cases or settlements. In this case, the MCO is not entitled to the recovered money. Although MCOs are not required to return all their overpayments from their network providers to the state, CMS observed that the MCO general contract had several areas of ambiguity that caused misaligned understanding of responsibilities and reporting requirements between MCOs and the SMA. While these observed areas do not constitute regulatory non-compliance, it is advised that the state clarify terms and requirements to avoid miscommunications and inefficiencies in reporting and pursuing overpayments. The state reported to CMS team that they are refining the overpayment reporting and recoupment processes for future contracts.

Recommendation #2: The state should develop written policies for annual reporting of recoveries of overpayments, in accordance with § 438.608(d)(3).

Recommendation #3: Per § 438.608(d)(2), the state should develop written policies requiring MCOs to establish a mechanism for network providers to report and return identified overpayments to the MCO within 60 calendar days as well as to notify the MCO in writing of the reason for the overpayment.

Observation #1: CMS encourages the state to clarify guidelines for overpayment identification, reporting requirements, and which entities are responsible for recovery.

C. Interagency and MCO Program Integrity Coordination

Within a Medicaid managed care delivery system, MCO SIUs, the SMA, and the state MFCU play important roles in facilitating efforts to prevent, detect, and reduce fraud and abuse to safeguard taxpayer dollars and beneficiaries. Each of these entities performs unique functions that are critical to providing effective oversight of the Medicaid program. The ability to reduce fraud in Medicaid managed care will be greatly enhanced as these entities develop methods and strategies to coordinate efforts. Ineffective collaboration can adversely affect oversight efforts, putting taxpayer dollars and beneficiaries at risk. Under § 455.21, the SMA is required to cooperate with the state MFCU by entering into a written agreement with the MFCU. The agreement must provide a process for the referral of suspected provider fraud to the MFCU and establish certain parameters for the relationship between the MFCU and the SMA.

The state has a Memorandum of Understanding (MOU) in place with the MFCU that meets the regulatory criteria. Specifically, section III, part E of the MOU contains procedures by which the MFCU will receive referrals of potential fraud from MCOs, as required by § 455.21(c)(3)(iv). Additionally, the SMA meets with the MFCU director monthly to discuss case referrals.

The SMA contractually requires MCOs to immediately report allegations of fraud to the SMA directly. After the case is referred, NMPI is responsible for conducting a preliminary review and determining the appropriate course of action. In cases where credible allegation of fraud is found,

NMPI refers the case to the MFCU for investigation. The state reported that the MFCU typically accepts all cases referred by NMPI for an initial review and case workup, then notifies the SMA of formal acceptance or denial of a referred case within five business days. Denied cases are returned to the SMA for administrative action. The MFCU provides written request for good cause exception within one business day of a written credible allegation of fraud notice.

While there is no requirement for SMAs to meet on a regular basis with its MCOs for collaborative sessions to discuss pertinent program integrity issues regarding fraud, waste, and abuse and relevant contractual concerns, such collaborative sessions are an effective and important process to ensure open communication and strong partnerships. The state reported that each MCO has a quarterly meeting with NMPI, MCO program integrity staff, state plan management staff, and the MFCU. During these quarterly meetings, monthly fraud, waste, and abuse reports and biweekly tips reports provided by the MCO are reviewed. NMPI also shares information on current cases and high-risk providers at these meetings. The MCOs confirmed meeting with NMPI, MFCU, and Plan Management quarterly; Nebraska Total Care reported that their SIU also meets with NMPI monthly. The state and MFCU have not provided program integrity training to the MCOs. However, the MCOs are contractually responsible for providing program integrity training to their staff, according to Section O, Program Integrity, number 9 of the MCO general contract.

The SMA does not hold regular collaborative sessions to discuss program integrity issues, such as case referrals, leads, and administrative actions. The NMPI met with Plan Management staff previously but received minimal information and feedback; therefore, NMPI ceased to conduct these meetings. However, each NMPI investigator assigned to an MCO has an informal weekly meeting with contract management and plan administrators at the state.

Observation #2: CMS encourages the NMPI unit and state plan management staff to reestablish regular collaboration and communication on program integrity issues pertaining to the Nebraska Medicaid Managed Care program.

D. MCO Investigations of Fraud, Waste, and Abuse

State Oversight of MCOs

Regulations at § 438.608(a)(7) require states to ensure that MCOs promptly refer any potential fraud, waste, and abuse that the MCO identifies to the state Medicaid PIU or any potential fraud directly to the state's MFCU. Similarly, as required by §§ 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs.

CMS verified that Nebraska has a process in place for the reporting and investigation of identified potential fraud, waste, and abuse, in accordance with §§ 455.13-17 and 438.608(a)(7). Nebraska's MCO general contract, Section O, Program Integrity, number 1e states, "[t]he MCO must immediately report to NMPI any suspicion or knowledge of fraud." MCOs are also

contractually required to provide results of any preliminary investigation of potential fraud to NMPI in an official referral. MCOs are provided with a standardized referral form to report suspected fraud to NMPI. NMPI then performs a preliminary review of the case, which may include vetting the case with the other MCOs to assess exposure to other areas of the Nebraska Medicaid program. If NMPI determines that a full investigation is appropriate, NMPI directs the MCO to continue their investigation, collaborate with other entities, or stand down. NMPI may also refer cases identified by the state to the MCOs for further investigation. The MCOs interviewed submit monthly and/or quarterly reports of fraud, waste, and abuse activity, as well as biweekly tips reports, to NMPI for review. NMPI also requests cases found through data mining from the MCOs on an ad-hoc basis.

MCOs are also contractually required to submit a monthly fraud, waste, and abuse report to NMPI. All monthly fraud, waste, and abuse reports are reviewed by the NMPI investigator assigned to the MCO. The NMPI investigator meets with the MCO quarterly to review and may identify cases that should be referred as suspected fraud and can direct the MCE to make an official referral. The state reported that NMPI investigators have a collaborative relationship with MCO investigators in regard to identifying cases for investigation. Overpayment recovery efforts by the three MCOs are only initiated with NMPI approval. Each of the three MCOs confirmed the use of this process.

CMS did not identify any findings or observations related to these requirements.

MCO Oversight of Network Providers

CMS verified whether the Nebraska MCOs had an established process for conducting investigations and making referrals to the state, consistent with CMS requirements and the state's contract requirements.

Healthy Blue: Healthy Blue's cases are triaged and reviewed by their SIU, which includes two investigators fully dedicated to Nebraska. If a case is opened, a full investigation begins, and the provider is put on prepayment review. When the SIU identifies suspected fraud and abuse, a referral is submitted to NMPI using the provided fraud reporting form. Providers must reach a 70 percent approval rate for three months and attend ongoing education to be removed from prepayment review, unless NMPI directs otherwise. The SIU reported that NMPI typically responds to fraud referrals within two weeks. The SIU submits monthly reports of fraud, waste, and abuse activities, as well as identified and collected overpayments. Healthy Blue also compiles an annual overpayments report to be submitted to the state. The MCO was unable to report on the investigations and overpayments identification and recovery activities for FY19 or FY20, as Healthy Blue acquired WellCare Nebraska, the previously-contracted MCO, effective January 1, 2021. The SIU also clarified that the reported overpayments recovered exceeded the amount identified in FY21 due to outstanding recoveries from WellCare.

Nebraska Total Care: Nebraska Total Care's SIU is responsible for initiating and conducting a preliminary investigation based on a referral or through data mining. The preliminary investigation utilizes a one-to-three-year lookback period of provider claims. Outcomes for all

investigations are sent to NMPI. Once accepted, the state provides any additional information about credible allegations of fraud, payment suspensions, or MFCU responses. The SIU seeks approval from NMPI for any action taken related to providers, such as education or network termination. All overpayments identified and recovered are approved or denied by NMPI in writing. Nebraska Total Care stated that the variances in identified and recovered overpayments are due to being denied extrapolation on cases that were appealed. The MCO's identified and collected overpayments, new preliminary investigations, and tracking of active investigations and previously reported referrals, are reported to the state monthly.

United Healthcare Community Plan: At United Healthcare, investigators are assigned cases within three business days of receipt and use claims data and other sources to assess the allegation. If there is suspicion of fraud, the investigator prepares an investigative plan within two days of initial assessment and refers the case to NMPI. Cases and investigations are tracked using an internal tool and reported monthly with other fraud, waste, and abuse activities to NMPI. Once the SMA has sent formal approval on overpayment recovery, collection is coordinated by Optum Payment Integrity, a UnitedHealth Group subsidiary. The SIU stated that fluctuations in identified and recovered overpayments are due to large national settlements in certain years and fewer claims submitted during the public health emergency, despite increased enrollment.

Overall, CMS found the reported MCO processes for the investigation of suspected fraud, waste, and abuse to adequately meet CMS requirements and state contract requirements. CMS did not identify any findings or observations related to these requirements.

Figure 1 describes the number of investigations referred to Nebraska by each MCO. As illustrated, Healthy Blue does not have information for investigations conducted by WellCare Nebraska for FYs 2019 and 2020 prior to being acquired.

Figure 1. Number of Investigations Referred to Nebraska by each MCO

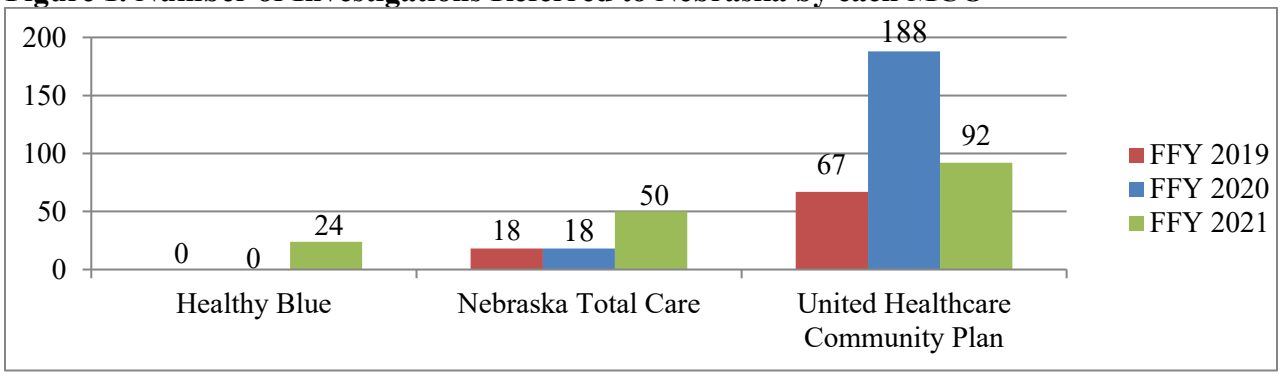

Table 1, below, describe each MCO's recoveries from program integrity activities. The state must obtain a clear accounting of any recoupments for these dollars to be accounted for in the annual rate-setting process (§ 438.608(d)(4)). Without these adjustments, MCOs could be receiving inflated rates per member per month. The state reported that rate setting is based on net amounts that account for overpayments. NMPI investigators verify claims in encounter data to

ensure the appropriate claims were adjusted.

Table -Healthy Blue Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2019	--	--	--	--
2020	--	--	--	--
2021	35	33	$36,944.25	$57,743.52

Table -Nebraska Total Care Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2019	18	18	$293,061.78	$47,478.09
2020	29	18	$514,026.83	$2,895.52
2021	72	50	$231,308.86	$43,723.01

Table - United Healthcare Community Plan Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2019	134	92	$112,697.97	$6,168.73
2020	235	52	$5,633.16	$8,944.86
2021	95	41	$55,098.55	$21,112.05

E. Encounter Data

In accordance with § 438.242, the state must ensure, through its contracts, that each MCO maintains a health information system that collects, analyzes, integrates, and reports encounter data. Additionally, § 438.242 further states that state MCO contracts must specify the frequency and level of detail of beneficiary encounter data, including allowed amount and paid amount, that the state is required to report to CMS under § 438.818. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility. Through a review of the Nebraska MCO general contract and interviews with each of the MCOs, CMS determined that Nebraska is in compliance with § 438.242. Specifically, the contract language in Section S, Claims Management, number 10 - Encounter Data includes all the necessary provisions in accordance with § 438.242. MCOs are contractually required to submit encounter data to the line level on a monthly basis. CMS determined during the review that all MCOs were in compliance with this requirement. The

MCOs reported that Plan Management provides an acceptance and error report and summary based on data submitted by the MCO. NMPI also stated that they run quarterly exception reporting, fraud abuse detection reports, and ad-hoc data mining.

In addition, in accordance with § 438.602(e), the state must periodically, but no less frequently than once every three years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, each MCO. CMS found that Nebraska was in compliance with § 438.602(e) during the review period. Specifically, Section M, Quality Management, number 13 - External Quality Review, states, "[t]he MCO is subject to annual, external independent reviews of the quality outcomes, timeliness of, and access to services covered under the contract. The external quality review will include, but is not limited to, annual operational reviews, performance improvement plan assessments, encounter data validation, focused studies, and other tasks requested by MLTC." The review is conducted by the MLTC's contracted external quality review organization, or another designee.

While it is not a requirement, regularly analyzing the encounter data submitted by MCOs will allow the state to conduct additional program integrity activities, such as identifying outlier billing patterns, payments for non-covered services, and fraudulent billing. CMS found that Nebraska does not have a process to regularly analyze MCO encounter data for program integrity purposes. Specifically, the state reported there is no standard process to reconcile encounter data for investigations but did advise that investigators often compare overpayment recoveries against encounter data to validate the recovery.
CMS did not identify any findings or observations related to these requirements.

III. CONCLUSION

CMS supports Nebraska's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused review identified three recommendations and two observations that require the state's attention.

We require the state to provide a corrective action plan for each of the recommendations within 30 calendar days from the date of issuance of the final report. The corrective action plan should explain how the state will ensure that the recommendations have been addressed and will not reoccur. The corrective action plan should include the timeframes for each corrective action along with the specific steps the state expects will take place, and identify which area of the SMA is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the corrective action plan, such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of issuance of the final report. If the state has already acted to correct compliance deficiencies or vulnerabilities, the corrective action plan should identify those corrections as well.

The state is not required to develop a corrective action plan for any observations included in

this report. However, CMS encourages the state to take the observations into account when evaluating its program integrity operations going forward.

CMS looks forward to working with Nebraska to build an effective and strengthened program integrity function.

IV. APPENDICES

Appendix A:

Nebraska's last CMS program integrity review was in May 2016, and the report for that review was issued in June 2017. The report contained 13 recommendations for improvement. During the virtual review in April 2022, CMS conducted a thorough review of the corrective actions taken by Nebraska to address all recommendations reported in calendar year 2017. While most recommendations have been implemented, some were only partially implemented.

Appendix B:

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance and educational resources for the SMA.

- Access COVID-19 Program Integrity educational materials at the following links:
  - Risk Assessment Tool Webinar (PDF) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-tool-webinar.pdf
  - Risk Assessment Template (DOCX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.docx
  - Risk Assessment Template (XLSX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.xlsx
- Access the Resources for State Medicaid Agencies website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Resources-for-SMAs to address techniques for collaborating with MFCUs.
- Access the Medicaid Payment Suspension Toolkit at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf, to address overpayment and recoveries.
- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the RISS for information provided by other states including best practices and managed care contracts. http://www.riss.net/
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute. More information can be found at https://www.cms.gov/medicaid-integrity-institute
- Regularly attend the Fraud, Waste, and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Participate in Healthcare Fraud Prevention Partnership studies and information-sharing activities. More information can be found at https://www.cms.gov/hfpp.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of managed care staff in program integrity issues. Use the Medicaid PI Promising Practices information posted in the RISS as a tool to identify effective program integrity practices.

Appendix C:

Table C-1 and Table C-2 below provide enrollment and expenditure data for FYs 2019 through 2021 for each of the selected MCOs.

Table C-1. Summary Data for Nebraska MCOs

Nebraska MCO Data	Healthy Blue	Nebraska Total Care	United Healthcare Community Plan
Beneficiary enrollment total	91,515	116,251	98,688
Provider enrollment total	27,509	34,668	110,506
Year originally contracted	2016[2]	2017	2017
Size and composition of SIU	2.775 FTEs (2 dedicated SIU investigators)	3.0 FTEs (dedicated SIU investigators)	3.0 FTEs (dedicated SIU investigators)
National/local plan	Local	National	National

Table C-2. Medicaid Expenditure Data for Nebraska MCOs

MCOs	FY 2019	FY 2020	FY 2021
Healthy Blue	$389,599,838.02[3]	$402,464,503.29[3]	$425,779,078.01
Nebraska Total Care	$478,998,497.00	$497,930,422.28	$705,207,424.49
United Healthcare Community Plan	$469,440,467.05	$496,788,157.90	$694,630,225.34
Total MCO Expenditures	$1,338,038,802.07	$1,397,183,083.47	$1,825,616,727.84

[2] WellCare Nebraska is the original contracted entity. Healthy Blue went live on January 1, 2021.
[3] Expenditures from WellCare Nebraska.

Appendix D:

State PI Review Response Form

INSTRUCTIONS:

For each draft recommendation listed below, please indicate your agreement or disagreement by placing an "X" in the appropriate column. For any disagreements, please provide a detailed explanation and supporting documentation.

Classification	Issue Description	Agree	Disagree
Recommendation #1	The state should upload all MCO contracts to their website with a publicly accessible hyperlink, in accordance with § 438.602(g)(1).		
Recommendation #2	The state should develop written policies for annual reporting of recoveries of overpayments, in accordance with § 438.608(d)(3).		
Recommendation #3	Per § 438.608(d)(2), the state should develop written policies to establish a mechanism for network providers to report and return identified overpayments to the MCO within 60 calendar days.		

Acknowledged by:

_____
[Name], [Title]

_____
Date (MM/DD/YYYY)