Department of Health and Human Services

Centers for Medicare & Medicaid Services

Nevada Focused Program Integrity Review

Final Report

June 2022

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Executive Summary

In the Comprehensive Medicaid Integrity Plan for Federal Fiscal Years (FYs) 2019-2023, the Centers for Medicare & Medicaid Services (CMS) set forth its strategy to safeguard the integrity of the Medicaid program.[1] State Medicaid programs are required to have a fraud detection and investigation program and oversight strategy that meet minimal federal standards. To ensure states are meeting these requirements, CMS conducts focused program integrity reviews on high-risk areas, such as managed care, new statutory and regulatory provisions, nonemergency medical transportation, 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 identify areas of regulatory non-compliance and program vulnerabilities. The value of performing focused program integrity reviews include: (1) providing states with effective tools/strategies to improve program integrity operations and performance; (2) providing the opportunity for technical assistance related to program integrity trends; (3) assisting CMS in determining/identifying future guidance that would be beneficial to states; and (4) assisting with identifying and sharing promising practices related to program integrity.

This report summarizes information gathered during a focused review of the Nevada Medicaid managed care program. The primary objective of the review was to assess the state's program integrity oversight efforts for Medicaid managed care. A secondary objective was to provide the state with useful feedback, discussions, and technical assistance resources that may be used to enhance program integrity in the delivery of these services.

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 managed care organizations (MCOs) that receive a set per member per month (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.

In June 2021, CMS conducted a virtual review of Nevada's single state Medicaid agency, the Division of Health Care Financing and Policy (DHCFP), who is responsible for administering the Medicaid program. This focused review helped CMS to determine the extent of program integrity oversight of the managed care program at the state level and to assess the program integrity activities performed by selected MCOs under contract with the state Medicaid agency. CMS interviewed key staff and reviewed a sample of program integrity cases investigated by the MCOs Special Investigations Units (SIUs), as well as other primary data, to assess the state's and selected MCOs' program integrity practices. CMS also evaluated the status of Nevada's previous corrective action plan, which was developed by the state in response to a managed care focused review conducted by CMS in 2016.

During the review, CMS identified a total of four recommendations based upon the completed focused review modules, supporting documentation, and discussions and/or interviews with key staff. CMS also included technical assistance resources for the state to consider utilizing for its oversight of managed care. The review and recommendations encompass the following six areas:

1. State oversight of managed care program integrity activities Provider screening and

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

enrollment
2. MCO investigations of fraud, waste, and abuse
3. Encounter data
4. Payment suspensions based on credible allegations of fraud
5. Terminated providers and adverse action reporting

Overview of Nevada Medicaid

The Nevada Department of Health and Human Services is the single state agency charged with overseeing the medical assistance plans in Nevada. The DHCFP administers the Medicaid program and DHCFP's Program Integrity Unit has primary responsibility for the overall program integrity operations, although other units within the organization maintain roles in program integrity functions.

Nevada's Medicaid expenditures exceeded $3.9 billion, with approximately 896,300 beneficiaries enrolled in FY 2019. In addition, Nevada's managed care expenditures, excluding the Dental Benefits Administrator (DBA), were approximately $1.8 billion in FY 2019, as depicted in Table 2 below. This $3.5 billion represents approximately 46.6 percent of total Medicaid expenditures. The Federal Medical Assistance Percentage matching rate was 64.87 percent, while approximately 621,044, or just over 69 percent, of the Medicaid population was enrolled in four managed care plans.

Three out of the four operating MCOs were selected for interview during the virtual program integrity review, based on Nevada's previous 2016 program integrity on site review selections. The three MCOs interviewed were Health Plan of Nevada (HPN), Anthem BlueCross BlueShield, and Silver Summit of Nevada. Table 1 and Table 2 below provide enrollment/SIU and expenditure data for each MCO that CMS interviewed.

Table 1. Summary Data for Nevada MCOs[2]

	HPN	Anthem	Silver Summit
Total Beneficiary Enrollment	250,693	108,374	52,839
Total Provider Enrollment	7,079	9,482	5,808
Year Originally Contracted	1997	2009	2017
Size and Composition of SIU (FTEs)	10	3	2
National/Local Plan	Local, with a national affiliation	National	Local, with a national affiliation

Table 2. Medicaid Expenditure Data for Nevada MCOs[3]

[2] The beneficiary enrollment numbers for each plan reflect totals submitted by the MCOs as of 12/31/2020.

[3] Each of the MCOs submitted the expenditure data reported in Table 2. The state confirmed expenditure data during the review process. Discrepancies (if identified) were clarified prior to finalization of this report.

MCO	FY 2017	FY 2018	FY 2019
HPN	$950,038,077.71	$990,280,525.96	$1,072,483,611.32
Anthem	$653,620,422.70	$640,766,641.41	$737,862,205.54
Silver Summit	$6,094,153.53	$183,404,181.33	$6,879,597.71

Results of the Review

CMS evaluated the following six areas of Nevada's managed care program:

1. State oversight of managed care program integrity activities
2. Provider screening and enrollment
3. MCO investigations of fraud, waste, and abuse
4. Encounter data
5. Payment suspensions based on credible allegations of fraud
6. Terminated providers and adverse action reporting

CMS identified four areas of concern with Nevada's managed care program integrity oversight that may create risk to the Medicaid program. CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved as soon as possible through implementation of a corrective action plan. These areas of concern and CMS' recommendations for improvement are described in detail below.

1. State Oversight of Managed Care Program Integrity Activities

Nevada reported that the DHCFP Managed Care & Quality Assurance Unit is responsible for programmatic oversight of the MCO contracts along with other units within the Division. There are multiple units within the DHCFP that are responsible for monitoring compliance of the managed care contracts: Managed Care and Quality Assurance (MCQA); the Surveillance and Utilization Review Unit (SUR); the Supplemental Reimbursement Unit (SRU); Rate Analysis and Development (RAD); the Business Process Management Unit (BPMU); Provider Enrollment; and Fiscal Services. However, the overall program integrity operations for the state of Nevada are the responsibility of the Program Integrity Unit. The Program Integrity Unit fulfills these responsibilities in coordination with the SUR Unit and Provider Enrollment, who assist with the monitoring of the program integrity provisions of the managed care contracts. Nevada also has operational guidelines, policies and procedures, or interagency agreements that govern the interaction between Nevada's program integrity efforts and programmatic oversight for each managed care program.

In Nevada, investigations of managed care providers are the sole responsibility of the MCOs, and therefore the state did not conduct any investigations of managed care providers during the review period.
Nevada's MCOs are also required by their contract to randomly verify services across its Medicaid network, in accordance with federal regulations at § 438.608(a)(5). Anthem's method of verifying services has returned no credible allegations of fraud referrals during the review period, even though they have sent out more than 1500 verification letters in each year of the review period. HPN claims that less than five percent of their verification letter are even returned, with nothing credible resulting

from the initial analysis. A review of the letter format shows weaknesses in the structure and language within the verification letter that does not lend itself to any beneficiary response. In addition, the MCOs demonstrated inconsistency in the specifications around the contract, stating that beneficiary services are to be selected at random for verification versus instituting a strategy towards a targeted beneficiary verification process. Therefore, CMS observed inconsistent practices being performed in regards to Nevada's managed care program's beneficiary verification process and suggests the state review the VOS methods for consistency across the MCOs.

CMS did not identify any findings or recommendations for this review element.

2. Provider Screening and Enrollment

To comply with §§ 438.602(b)(1) and (b)(2), 438.608(b), 455.100-106, 455.400-470, and Section 5005(b)(2) of the 21st Century Cures Act, all providers furnishing services to Nevada Medicaid members, including providers participating in an MCO provider network, are required to be screened and enrolled with the SMA. Nevada requires all providers who seek participation in the Medicaid managed care program to enroll in Medicaid through an online provider portal. In addition, Nevada's MCO model contract states, "The contractor shall have written policies and procedures that include the contractor's initial process for credentialing as well as its re-credentialing process that must occur at a minimum every three (3) years." The three MCOs included in this review met this requirement during the review period.

Nevada performs all of the required provider screening and enrollment activities in accordance with the requirements of § 455, subparts B and E. Upon the Nevada's approval of the application, the providers may seek to secure contracts with participating MCOs. In accordance with § 455.432, Nevada ensures that pre-enrollment and post-enrollment site visits of providers who are designated as "moderate" or "high" categorical risks to the Medicaid program are occurring. The purpose of the site visit is to verify that the information submitted to the state is accurate and to determine compliance with federal and state enrollment requirements.

CMS did not identify any findings or recommendations for this review element.

3. MCO Investigations of Fraud, Waste, and Abuse

The regulation at § 438.608(a)(1) and §§ 455.13-17, requires the state to have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs. This review found that, while Nevada met these regulatory requirements, there were opportunities for improvement. As a result, CMS has made two recommendations for the state for this review element.

State Oversight of MCOs

Nevada's Medicaid contracts with its MCOs state that "The MCO must have in place policies and procedures for ensuring protections against actual or potential fraud, waste, and abuse." The contract further states, "The vendor shall have internal controls for Program Integrity including a Program Integrity Unit (PIU) designed to identify, review, recover and report improper payments, including fraud, waste and abuse (FWA) activities, on an ongoing basis." In addition, the contract specifies the Nevada Medicaid MCOs must develop a written integrity compliance plan that identifies the specific

resources dedicated to program integrity activities related to claims, members, providers, and subcontractors involved in delivering the services outlined in this contract.

Nevada's Medicaid contract requires one SIU FTE per 50,000 enrollees, but does not provide any specific guidance to MCOs outlining the minimum experience of key program integrity personnel and of the FTEs that are responsible for investigating and referring credible allegations of fraud. Nevada may wish to establish minimum experience requirements for SIU FTEs in its Medicaid contracts to ensure individuals will be effective in their role of investigating fraud, waste, and abuse.

MCO Oversight of Network Providers

HPN. HPN's SIU investigates reported potential fraud, waste, and abuse activities and, as appropriate, refers them to the state's Program Integrity Unit. Regardless of the channel by which a referral is received (e.g., service verification, hotline, email), an initial review is conducted. The SIU investigator takes all necessary initial actions to initiate a timely preliminary investigation, including gathering information necessary to further assess the allegation by utilizing industry-recognized databases; conducting internet searches; reviewing all appropriate internal systems; and running Geo Access reports for the area where the potential fraud, waste, and abuse may have occurred. The MCOs keep the state Program Integrity Unit apprised of ongoing case progress via a monthly report. HPN referred 17 credible allegations of fraud investigations to the state for the three FYs reviewed, which was the most cases referred during the review period across all three MCOs.

Anthem. Anthem's SIU monitors and examines providers suspected of fraud, waste or abuse through various prevention activities, such claim reviews. Referrals come to the SIU from both internal and external sources; however, mining of internal claims data is the primary way investigators detect and deter fraud, waste and abuse. Anthem (as well as the other MCOs) has also established a hotline to receive complaints and other referrals of potential fraud, waste and abuse. As part of CMS' procedure of calling each hotline, CMS discovered that Anthem's hotline was not answered by a live person and required that a voicemail message be left. Anthem explained this could possibly be due to the ongoing COVID-19 Public Health Emergency, but was unlikely an issue throughout the review period. Anthem's SIU conducts a preliminary investigation of any complaint received regarding Medicaid fraud and abuse from any source, including questionable provider practices identified through any internal methods. The preliminary investigation determines whether there is a credible allegation of fraud and, therefore, if the case warrants a full investigation. A full investigation continues until resolution is reached or until the case is otherwise closed. Anthem referred six credible allegations of fraud investigations to the state for the three FYs reviewed.

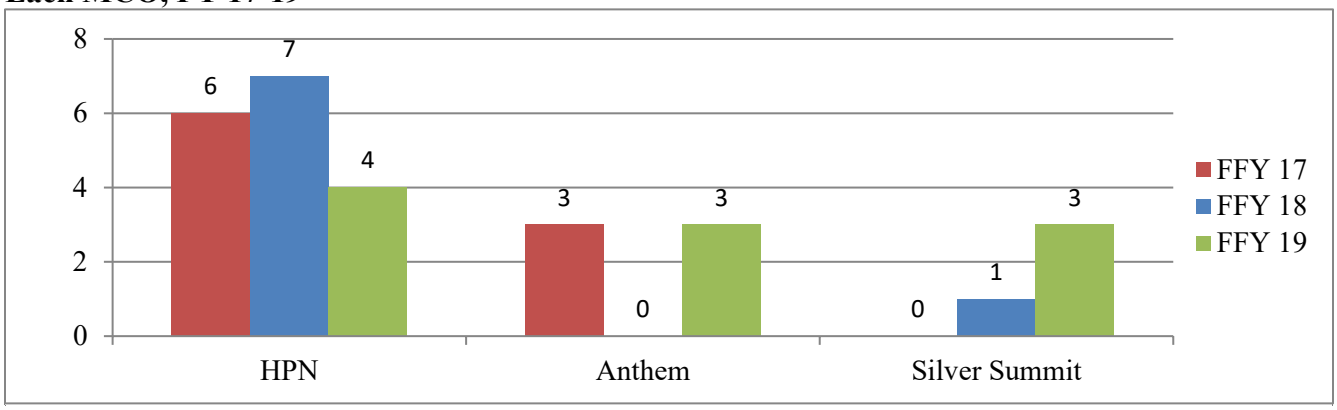
Silver Summit. Silver Summit's SIU is responsible for all fraud, waste, and abuse activities within its network. The SIU conducts a preliminary review when it receives information indicating potential fraud, waste or abuse. All preliminary reviews receive a case number and are tracked in the SIU tracking system. Once a preliminary review has been completed (generally within 30 working days), the SIU staff prepares a preliminary report that details its findings and provides recommendations for next steps. If the actions recommended by the SIU are approved by the SIU workgroup, the SIU conducts the additional approved investigative steps. A final report is completed within 15 working days of the completion of the clinical review, recapping the findings of the medical record review. After receiving the signed clinical findings summary, the SIU staff creates its final report, including a recoupment figure, important case steps, findings, and the recommended appropriate next action(s).

Silver Summit referred four credible allegations of fraud investigations to the state for the three FYs reviewed.

CMS Discussion. CMS expressed concern that inadequate staffing and resource allocation by both the MCOs and the state are leading to the low number of investigations of potential and suspected fraud, waste, and abuse in Nevada's Medicaid managed care program. The state appears to rely solely on the MCOs to investigate potential fraud within the managed care program due to its own staffing and resources constraints. However, although reported information indicates low productivity on part of DHCFP and the MCOs, the Nevada Medicaid Fraud Control Unit (MFCU) was not consulted during this review to ascertain their workload capabilities even if the state and the MCOs were to increase the amount of referrals annually. This lack of appropriate resource allocation at both the state and MCO levels has resulted in an overall low number of investigations and referrals of credible allegations of fraud from the MCOs, leaving the managed care program in Nevada potentially at substantial risk.

CMS also expressed concern over the quantity and quality of Nevada's MCO investigations of fraud, waste, and abuse based on the interviews conducted, as well as all the data and information collected for this review. Of the four Nevada contracted MCOs, these three MCOs accounted for approximately 99 percent of the total non-DBA managed care expenditures, totaling more than $1.8 billion in FY 2019. Overall, the number of Medicaid provider investigations and referrals by each of the MCOs is low compared to the size of the plans reviewed. Figure 3 lists the number of credible allegations of fraud referrals that the HPN, Anthem, and Silver Summit SIUs made to the state in the last three outlined FYs.

Figure 3. Number of Credible Allegations of Fraud Investigations Referred to the State by Each MCO, FY 17-19



As illustrated above, there is a low amount of credible allegations of fraud being referred to the state annually. HPN, Anthem and Silver Summit averaged approximately 6, 2, and 1 credible allegations of fraud referrals per fiscal year, respectively. While the level of investigative activity decreased for HPN in 2019, Anthem's and Silver Summit's credible allegation of fraud referrals varied across the CMS program integrity review periods. The quantity of referrals by Anthem and Silver Summit is of particular concern and was also an identified area of concern in the state's previous March 2016 program integrity review report.

Based upon the information gathered during this review, CMS has determined that the reviewed MCOs likely do not have adequate resources dedicated to program integrity activities. These

inadequate resources will adversely impact the quantity and quality of investigative referrals. As a result, the state should work more closely with the MCOs to improve the quality and increase the quantity of cases referred. Specifically, the state should incorporate a specific referral policy and procedure that provides a detailed description of the MCOs internal procedures for identifying and reporting possible acts of fraud, waste, and abuse by providers. The policy and procedure should clarify the way referrals are defined and tracked. In addition, the state should ensure that MCOs are provided program integrity policies and procedures related to suspected fraud referrals, and that MCO SIUs are adequately informed and/or trained in the prevention, detection, investigation and referral of suspected provider fraud. Although the state asserted that they are effectively communicating with all of their MCOs, CMS had concerns that the MCOs could not provide the disposition or status of submitted fraud referrals. CMS believes it would be beneficial to highlight this communication issue to provide all parties with an opportunity at improving communications around the disposition of referred cases to the MFCU, especially because this process ultimately impacts the MCOs' ability to conduct administrative actions, such as overpayment recoveries.

Recommendation #1: CMS encourages the state to ensure that the MCOs have sufficient resources and staffing commensurate with the size of their Medicaid managed care programs, as well as adequately addresses the experience required by the SIU staff within the state's general MCO contract. The MCOs must maintain sufficient staffing levels to conduct a full range of program integrity functions including, but not limited to reviews, investigations, and audits of providers and services that represent the highest risk of fraud, waste and abuse to the Medicaid program.

Recommendation #2: CMS encourages the state to work with the MCOs to develop more case referrals and routinely provide specific program integrity training related to enhancing the quality of case referrals from the MCOs. CMS also encourages the state to provide more frequent feedback to the plans regarding the quality and quantity of MCO cases referrals forwarded to the state and ensure the appropriate MCO staff is receiving adequate training in identifying investigating and referring potential fraudulent billing practices by provider.

Overpayments and Recoveries

The regulation at §438.608(d)(1) requires MCO contracts to specify the retention policies for treatment of recoveries of all overpayments to providers by plans, while § 438.608(a)(2) requires MCOs to promptly report to the state all overpayments identified or recovered, including specific identification of the overpayments due to potentially fraudulent activities.

Nevada's MCO model contract does not require MCOs to return overpayments recovered from the providers as a result of fraud and abuse investigations. As such, MCOs are entitled to retain overpayments identified. However, Nevada's MCO model contract does state at §3.16.22.2 that the vendor must report certain information to the DHCFP on a per occurrence basis. This includes, but is not limited to, "…every allegation, complaint, or referral pertaining to overpayments whether caused by fraud, waste, abuse or billing errors." In addition, the contract requires the MCOs to promptly report to the state all overpayments identified or recovered, including specific identification of the overpayments due to potentially fraudulent activities. The potentially fraudulent overpayments are captured in the investigative report when the MCOs recommend referrals for a "reasonable belief of fraud."

The state reported that overall overpayment recoveries are reported through the encounter data received from the MCOs and in an MCO reported/attested financial template submitted annually to the state actuary. However, the state appears to lack any processes to verify overpayments being identified by the MCOs. CMS received no evidence that the state was performing any audits of the investigative cases to substantiate the figures being reported as identified overpayments. In addition, there was a large disparity between the overpayments identified versus the overpayments collected within the managed care program. The state should enhance its oversight and tracking of MCO overpayments identified and recovered, including by examining all potential barriers that may be contributing to the discrepancies in overpayments identified versus overpayments collected by the MCOs and take steps to remedy any issues. This will likely prove to be beneficial as other state and federal audit entities request similar data from the state in the future.

CMS also found during this review that the overpayments identified and recovered by the MCOs during this time period were very low. All three MCOs reported that no overpayments were identified and recovered from providers as a result of fraud and abuse investigations in FY17 and FY18. In addition, although all three MCOs reportedly identified overpayments in FY19, the percentage of those overpayments recovered was extremely small relative to the identified total. Anthem collected approximately two percent of their identified overpayments, Silver Summit collected less than one percent, and HPN collected approximately six percent. DHCFP did not provide CMS with any reported overpayment figures.

Table 4-A. HPN's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2017	33	33	$0	$0
2018	33	33	$0	$0
2019	76	76*	$1,853,596.07	$104,914.59

***Of the 76 Investigations in FY 2019, four were actual credible allegations of fraud (CAF) of which 1 was accepted by the MFCU with 3 declined. HPN had 7 CAFs in FFY 2018 (2 accepted, 5 declined) and 6 CAFs in FFY 2017 (4 accepted, 2 declined).

Table 4-B. Anthem's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2017	39	39	$0	$0
2018	61	61	$0	$0
2019	105	105**	$1,013,529.26	$20,190.36

***Of the 105 Investigations in FY 2019, three were actual credible allegations of fraud (CAF) of which 2 were accepted, and 1 declined. Anthem had no CAF referrals in 2018 and 3 CAFs in FY2017 (2 accepted, 1 declined).

Table 4-C. Silver Summit's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2017	1	1	$0	$0
2018	14	14	$0	$0
2019	77	77***	$785,410.08	$182.59

***Of the 77 Investigations in FY 2019, three were actual credible allegations of fraud and none were accepted by the MFCU. Silver Summit had one accepted credible allegation of fraud in FY 2018.

Recommendation #3: Consistent with § 438.608(d), the state should verify that identified and collected overpayments are correctly reported by the MCOs, such as through reviews, audits or other appropriate oversight activity.

Provider Corrective Action Plans

In accordance with Nevada's MCO model contract, each MCO must have an established process for monitoring its providers for non-compliance with contractual agreements and medical management standards. This process should include steps for disciplining providers and correcting activities that are found to be out of compliance. Nevada's MCO model contract states, "The vendor must submit these policies and procedures to the DHCFP within 5 business days upon change of policies and procedures or upon request."

HPN. HPN has written policies and procedures for monitoring and disciplining providers who are found to be out of compliance with HPN's medical management standards or contractual requirements. However, HPN has not placed any provider on a corrective action plan since the implementation of this policy in 2017. Similarly, as with its providers, HPN mentioned they routinely monitor their subcontractors (also referred to as delegates) performance. If deficiencies are identified, HPN works with the delegated organization to set priorities and develop a corrective action plan. The organization is sent an analysis report that explains the deficiencies identified. HPN may request the organization outline the cause of the issue and implement strategies to correct the issue. The organization has an opportunity to provide feedback on root causes and possible barriers along with actions they will take to correct. Although HPN discussed this policy and procedure, they did not provide any figures on how many delegates had received a corrective action plan.

Anthem. Anthem utilizes a "settlement agreement" in lieu of a formal corrective action plan for recoveries and to confirm the providers' understanding of the education provided. In addition, Anthem stated they put providers on corrective action plans in tandem with a settlement agreement in the future, but there has been no guidance from the state on when a corrective action plan should be utilized with Medicaid providers. Anthem reevaluates corrective actions after a 12-month monitoring period to ensure the provider did not revert back to the behavior requiring correction. Anthem uses a prepayment review process to monitor the provider as part of the settlement agreement.

Silver Summit. Silver Summit conducted only one corrective action plan during the review period. Silver Summit's Network Integrity Department notifies any provider who falls below an acceptable standard of the non-compliance via written communication and informs the provider that a second audit will be conducted approximately 90 days after the receipt of the letter. The provider relations

representatives contact the non-compliant providers to explain the audit results and to reinforce the need for compliance. Any provider found non-compliant after the second audit is sent written notification requesting a corrective action plan be submitted within 30 days of receipt of the letter. Providers who are not compliant after the second audit, fail to respond, or do not provide an acceptable corrective action plan are referred to the Nevada Medical Director and the Provider Relations Director for further action/outreach. Providers who provide an acceptable corrective action plan or written notification will be sent a communication confirming that sufficient documentation has been provided and their status will be changed from non-compliant to compliant.

CMS Discussion. CMS observed that Nevada's MCO model contract does not specifically include program integrity provisions addressing guidelines for corrective action plans for MCO network providers. CMS encourages the state to ensure that MCOs have sufficient corrective action plan procedures in place and utilize them appropriately to address noncompliant Medicaid providers. Additionally, CMS encourages the state to ensure the full requirements of the corrective action plan are completely satisfied by MCO providers.

CMS did not identify any findings or recommendations for this review element.

4. Encounter Data

In accordance with § 438.602(e), the state must periodically (but no less frequently than once every three years) conduct, or contract for, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each MCO, PIHP or PAHP.

The DHCFP collects encounter data from each of the MCOs electronically, on a bi-weekly basis, through an automatic deposit by the MCOs into a data warehouse. However, CMS could not find any indication the encounter data was being independently audited during the review period. HPN was not aware of the state auditing encounter data; Silver Summit stated there was not a formal audit conducted during the review period to their knowledge, but the state does on occasion question some dollar amounts. CMS also observed that the encounter data submitted by MCOs was not utilized by the DHCFP during the reporting period to proactively identify improper claims that may have been paid inappropriately to managed care providers or for conducting any internal audits of the encounter data to identify possible credible allegations of fraud.

Based on this reported information, CMS concluded that the accuracy and validity of the encounter data used by the state to perform its full managed care oversight responsibilities may not be reliable; however, the state reported being optimistic about its current process. CMS encourages the state to continue efforts to proactively improve its ability to analyze encounter data reported by MCOs and perform state-initiated data mining activities to identify fraud, waste, and abuse issues with MCO network providers.

CMS did not identify any findings or recommendations for this review element.

5. Payment Suspensions Based on a Credible Allegation of Fraud

Federal regulations at § 455.23(a) require that, upon a determination 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 not to suspend payments or to suspend payment only in part. Under § 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.

Consistent with fraud, waste and abuse contractual requirements under § 438.608(a)(8), the Nevada general MCO contract states, "The contractor shall have written procedures for the termination or suspension of providers; and written procedures for, and implementation of, reporting to the appropriate authorities serious quality deficiencies resulting in suspension or termination of a provider." The MCO contract requires plans to suspend payments to a network provider on notice by the state that it has determined a credible allegation of fraud in accordance with § 455.23. Payment suspensions must be implemented immediately and apply to all Medicaid claims (fee-for-service and encounter/managed care based) submitted by the provider.

The MCOs expressed that they may only suspend providers at the state's request; however, the state has not requested the MCO suspend payments for any of the MCO referrals during the review period, nor have the MCOs received guidance regarding the appropriate payment suspension process from the state. CMS was informed by the state that it streamlined the process to have the MCOs report credible allegations of fraud directly to the MFCU. Although this process may be more efficient, it removes the state from the credible allegation of fraud determination process and places responsibility for determination solely with the MCOs. CMS was informed that the state will set up a corresponding fee-for-service investigation and corresponding action will be determined once the MFCU has indicated whether they are accepting or declining a referral. Succinct written policies and procedures, or an interagency agreement, that outlines which state unit or entity is responsible for the various aspects of the payment suspension process as outlined in § 455.423 are needed.

No payment suspensions were initiated by any of the Nevada MCOs during the review period, nor were the MCOs aware of the good cause exception. The MCOs had written policies and procedure in place; however, neither had performed a payment suspension in accordance with § 455.23 during the review period. In addition, the state seems to lack the appropriate program integrity policies and procedures for payment suspensions within its managed care program to address MCO initiated payment suspensions. Therefore, CMS identified a recommendation regarding Nevada's payment suspension policies and processes.

Recommendation #4: The state should modify the MCO contract to ensure compliance with § 438.608(a)(8). This includes assessing if the memorandum of understanding with the MFCU should be revised to incorporate enhancements to case referral and payment suspension procedures for program integrity-related case referral functions and post-referral responsibilities, such as payment suspensions, in accordance with § 455.23. Lastly, the state should provide training to its contracted MCOs on the circumstances in which payment suspensions are appropriate pursuant to § 455.23.

6. Terminated Providers and Adverse Action Reporting

Nevada's MCO model contract contains termination guidance for its MCOs that complies with the regulation at § 438.608(a)(8) and, therefore, § 455.23. Specifically, Nevada's contract states, "On a

monthly basis, no later than the tenth (10) calendar day of the month, the vendor will submit to the DHCFP a list of all providers who have been enrolled and a list of all providers who have disenrolled, deactivated, terminated, de-credentialed or been removed from the active provider enrollment. If the provider has been terminated, de-credentialed or disenrolled, the cause and all required documentation of the termination will be supplied to the DHCFP within five (5) business days of the decision to terminate." In addition, Nevada's MCO model contract states, "The contractor shall have written procedures for the termination or suspension of providers; and written procedures for, and implementation of, reporting to the appropriate authorities serious quality deficiencies resulting in suspension or termination of a provider." Nevada MCOs are therefore contractually required to comply with all requirements for provider disenrollment and termination as required by § 455.416. The state confirmed there is a monthly process in place to ensure that the MCOs are terminating providers for cause. In addition, Nevada's Program Integrity Unit does notify MCOs of any terminated providers from other plans, so that the MCOs may ensure that terminated providers are not operating in another plan. The three MCOs interviewed confirmed that they report all terminated providers to Nevada's Program Integrity Unit within five business days of any provider termination via email, as well as by a monthly termination report.

All MCOs verified submitting their termination report to Nevada's Program Integrity Unit on a monthly basis as required by the MCO contract. The report includes the reason for termination. In addition, the MCOs each stated that they send the state a weekly report, on the state's template, as part of their weekly provider reporting. Therefore, their appeals to be sufficient reporting taking place around the topic of de-credentialed, terminated or disenrolled providers. Each of the MCOs stated that for cause information is also shared with the state and other MCOs in their quarterly SIU meetings held by the state, but providers termed without cause are not shared with the other MCOs. The information shared at this meeting is not required by contract. Once the provider termination process is complete, termination letters are then sent to the providers.

The state uploads the for-cause terminated providers to the CMS-Data Exchange (DEX) managed file transfer server. However, as seen in Table 5 below, the amount of for-cause terminations depicted are low in comparison to the terminations depicted, which are classified as not for-cause. For example, HPN reported 456 not for-cause terminations taken against providers in federal fiscal year 2019, yet none of those actions were for-cause provider terminations meaning zero for-cause terminations were reported for the entire federal fiscal year of 2019.

Table 5: Provider Terminations in Managed Care

MCOs	Total # of Providers Disenrolled or Terminated in Last 3 Completed FYs		Total # of Providers Terminated For Cause in Last 3 Completed FYs	
HPN	2017	749	2017	8
	2018	825	2018	3
	2019	456	2019	0
Anthem	2017	2365	2017	6
	2018	2360	2018	2
	2019	5174	2019	23
Silver Summit	2017	34	2017	2
	2018	153	2018	1
	2019	343	2019	8

Overall, the number of providers terminated for cause by the plans appears to be low compared to the number of providers in each of the MCOs networks and compared to the number of providers disenrolled or terminated for any reason. This would indicate that the plans are not apt to terminate the providers operating in the program for-cause, likely because of the simplicity of terminating providers not for-cause. The MCOs mentioned they preferred to cancel the providers' contract for general business reasons rather than going through the administrative burden of the appeals process.

The MCO interviews indicate the MCOs desire more education and training around the appropriate way to handle adverse actions and for cause terminations. The low amount of terminations and the lack of understanding by the MCOs around for cause terminations is creating vulnerabilities in Nevada's Medicaid program.

CMS observed that in the absence of specific contract language that outlines a specific process in regard to how MCOs are to terminate providers from the Medicaid program, the MCOs typically revert to their own internal practices, which are contrary to the federal regulations involving adverse actions, such as terminating providers from the Medicaid program for cause. Therefore, CMS encourages the state to develop a comprehensive managed care provider termination process aimed at improving state oversight and initiating more frequent information sharing within its contracted MCOs regarding all adverse actions taken to limit a provider's participation in the Medicaid managed care program to include, but not limited to terminations, de-credentialed, or disenrolled network providers.

Nevada should consider adopting for-cause provider termination criteria consistent with the guidance listed in the Medicaid Provider Enrollment Compendium[4] including, but not limited to the implementation of terminations and Medicaid termination reporting, as well as timely action and amend its MCO contracts to include such provisions. Further, the state should implement policies and/or contract language to address clear reporting of for-cause terminations and require prompt reporting requirements that should be adopted by all MCOs. Also, the state should provide additional education in order to ensure provider for-cause terminations are identified, reported, and handled accurately and appropriately.

CMS did not identify any findings or recommendations for this review element.

[4] https://www.medicaid.gov/sites/default/files/2021-05/mpec-3222021.pdf

Status of Nevada's 2016 Corrective Action Plan

Nevada's previous focused program integrity review was in August 2015, and the final report was issued in March 2016. The report contained seven recommendations. CMS completed a desk review of the corrective action plan in April 2016, which indicated that the findings from the 2016 review were satisfied by the state. However, the 2021 managed care program integrity review has several similar recommendations that were issued in the 2016 report.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for Nevada to consider utilizing:

- 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 Provider Requirements website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Provider-Requirements to address site visit requirements.
- 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.

Conclusion

CMS supports Nevada's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused review identified four areas of concern and instances of non-compliance with federal regulations that should be addressed immediately.

We require the state to provide a corrective action plan for each of the four recommendations within 30 calendar days from the date of issuance of the final report. The corrective action plan should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies 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 state Medicaid agency 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.

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