Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Nebraska Focused Program Integrity Review

Final Report

June 2017

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Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review of Nebraska 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 managed care organizations (MCOs) under contract with the state Medicaid agency. The review also included a follow up on the state's progress in implementing corrective actions related to CMS's previous comprehensive program integrity review conducted in calendar year 2012.

Background: State Medicaid Program Overview

The state of Nebraska's Medicaid program is administered through the Department of Health and Human Services (DHHS), Division of Medicaid and Long-Term Care (MLTC). Nebraska does not participate in Medicaid expansion under provisions of the Affordable Care Act. Additionally, Nebraska's Medicaid program operates waivers with the following provisions and characteristics: pharmacy benefits are provided outside of managed care; physical health and behavioral health care are in separate waivers and contracts; and the populations in managed care are more limited and varied for each waiver.

Nebraska contracts with three for-profit plans to provide Nebraska's Medicaid managed care physical health care services. Those plans are Arbor Health, CoventryCares, and UnitedHealthcare Community Plan. A fourth for-profit plan, Magellan Behavioral Health, provides behavioral health and substance abuse services. When beneficiaries become eligible for Medicaid services, managed care enrollment is mandatory.

Nebraska's Medicaid program served 235,504 beneficiaries in April 2016. Of that total, approximately 22 percent, or 51,811 beneficiaries, were served on a fee-for-service (FFS) basis and the remaining 78 percent, or 183,693 beneficiaries, were enrolled in some form of managed care. Nebraska's total Medicaid expenditures in federal fiscal year (FFY) 2015 totaled approximately $1.9 billion with approximately $631.5 million in MCO expenditures. During FFY 2015, Nebraska's Federal Medical Assistance Percentage (FMAP) was 53.27 percent. Nebraska's FMAP was decreased to 51.16 percent in FFY 2016.

Methodology of the Review

In advance of the onsite visit, CMS requested that Nebraska and the MCOs selected for the focused review complete a review guide that provided the CMS review team with detailed insight into the operational activities of the areas that were subject to the focused review. A three-person team from CMS reviewed the responses and materials that the state provided in advance of the onsite visit.

During the week of May 16, 2016, the CMS review team met with staff from the DHHS and the MLTC's program integrity unit (PIU). It conducted interviews with numerous state staff involved in program integrity and managed care. The CMS review team also conducted interviews with three MCOs and their special investigations units (SIUs). In addition, the CMS

review team conducted sampling of program integrity cases and other primary data to validate the state and the selected MCOs' program integrity practices.

Results of the Review

The CMS review team identified areas of concern with the state's managed care program integrity oversight, thereby creating 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, particularly those that remain from the earlier review. These issues and CMS's recommendations for improvement are described in detail in this report.

Section 1: Managed Care Program Integrity

Overview of the State's Managed Care Program

As mentioned earlier, approximately 183,693 beneficiaries, or 78 percent of the state's Medicaid population, were enrolled in four MCOs during FFY 2015. The state spent approximately $631.5 million on managed care contracts in FFY 2015.

Summary Information on the Plans Reviewed

The CMS review team interviewed three MCOs as part of its review.

Arbor Health is a Medicaid managed care health plan serving 83 rural Nebraska counties and is part of the AmeriHealth Caritas Family of Companies. The MCO's SIU is a division of the payment integrity team, which is located in the corporate headquarters of AmeriHealth Caritas Family of Companies in Pennsylvania. The SIU team, supported by the corporate team of 33 full-time employees (FTEs), has one investigator assigned to the Arbor Health Plan in Nebraska, and conducts fraud and abuse activities for the plan 50 percent of the time.

CoventryCares (doing business as Aetna Better Health) is a national health plan that has Medicaid, Medicare, and commercial lines of business. Currently, Aetna Medicaid owns and/or administers Medicaid managed health care plans under the names of Aetna Better Health, CoventryCares, and other affiliate names. Together, these plans serve more than three million beneficiaries in 17 states. CoventryCares provides Medicaid coverage to more than 103,000 Nebraskans in all 93 counties. The Medicaid SIU is located in Connecticut and has 13 staff members dedicated to Medicaid investigational activities. Additionally, one investigator is located in Nebraska and conducts Medicaid fraud and abuse activities for the Nebraska plan 50 percent of the time.

Magellan Behavioral Health and its affiliates serve approximately three million Medicaid-eligible or otherwise publicly funded adults, children, and adolescents in Iowa, Louisiana, Nebraska, Pennsylvania, and Virginia. Magellan Behavioral Health also manages behavioral health services in New York. Magellan Behavioral Health-Prepaid Inpatient Health Plan is

contracted by the MLTC to provide an at-risk capitated rate Medicaid managed care program for behavioral health services in Nebraska. Magellan Behavioral Health is contracted to manage publicly funded mental health, substance abuse, and gambling addiction treatment for eligible children and adults across the state. Nationally, the SIU has 24 staff dedicated to fraud and abuse activities which include data mining, referral processing, audits, and investigations. Two staff members are located at the Nebraska site and conduct Medicaid fraud and abuse activities for the Nebraska plan 50 percent of the time.

Enrollment information for each MCO as of April 2016 is summarized below:

Table 1.

	Arbor Health	**CoventryCares**	**Magellan Behavioral Health**
Beneficiary enrollment total	24,700	103,227	230,000
Provider enrollment total	8,479	10,796	1,317
Year originally contracted	2012	2010	2013
Size and composition of national SIU	33.0 FTEs	13.0 FTEs	24.0 FTEs
SIU Staff fully-dedicated to the state plan	0.5 FTEs	0.5 FTEs	1.0 FTE
National/local plan	National	National	National

Table 2.

MCOs	**FFY 2013**	**FFY 2014**	**FFY 2015**
Arbor Health	$56.5 million	$59.0 million	$74.0 million
CoventryCares	$250.3 million	$285.8 million	$293.6 million
Magellan Behavioral Health	$6.2 million	$95.2 million	$128.2 million

State Oversight of MCO Program Integrity Activities

The state reported that oversight of the managed care system in Nebraska is a collaborative group effort between the Home Community-Based Services, Plan Management, Health Services, and the MLTC's PIU. The PIU consists of 13 FTEs and is responsible for all program integrity, audit, and fraud investigation activities. The state confirmed that it does not have operational guidelines, policies and procedures, or interagency agreements which govern the interaction between the state's program integrity efforts and programmatic oversight for each managed care plan.

Fraud and abuse cases reported by MCOs to DHHS are reviewed by the PIU to determine if they should be referred to the Medicaid Fraud & Patient Abuse Unit (MFPAU) as credible allegations of fraud under 42 CFR 455.23.

Nebraska's provider screening and enrollment contractor, Maximus, reviews all applications, including initial enrollment, re-enrollment, or revalidation, based on a categorical risk level of

limited, moderate, or high for providers and provider categories posing an increased financial risk of fraud, waste, or abuse to the Medicaid program. Providers with a high categorical risk level are required to consent to criminal background checks. Nebraska submitted a plan to CMS on April 15, 2016, regarding the requirement of a fingerprint-based criminal background check for high risk providers.

The state does not conduct onsite reviews at the MCOs to verify compliance with its fraud and abuse contract requirements. However, the state's external quality review organization (EQRO), Island Peer Review Organization, Inc., does conduct annual reviews of the MCOs. While there are special projects which may qualify as program integrity projects, the model contract does not specifically include program integrity provisions allowing the EQRO to verify MCO compliance with required fraud and abuse-related activities.

All of the MCOs reviewed report their closed cases to the state on quarterly reports. The state confirmed that the number of cases opened then closed, and their disposition, is not tracked in a manner that allows for measurement. The state is only aware of cases that are reported, so it is possible that a case could be opened then closed without intervention or referral.

Nebraska's MCO contract states, "The MCO must have in place a method for verifying that beneficiary services were actually provided. The MCO must report the results of monitoring to the state quarterly." All three MCOs follow the requirement to verify that services billed by providers were received by beneficiaries and forward the verification results to the state in quarterly reports. Also, the state makes an effort to ensure that client services are verified in the managed care program. Verification is accomplished by mailing explanations of medical benefits (EOMBs) to 200 randomly selected eligible clients monthly. The EOMBs detail the paid claims for dates of service within the last 45 days.

MCO Investigations of Fraud, Waste, and Abuse

As required by 42 CFR 455.13, 455.14, 455.15, 455.16, and 455.17, the state does have an established process for the identification, investigation, referral and reporting of suspected fraud, waste, and abuse by providers and MCOs.

Nebraska's MCO contract states, "The MCO must report fraud and abuse information to the state, including the number of fraud and abuse complaints that warrant preliminary investigations. The MCO must report this information to the state immediately if the severity of the complaint impacts the care and treatment of the client, or quarterly upon investigation." The MCO must report fraud and abuse information to the state's PIU, including the number of fraud and abuse complaints that warrant preliminary investigation. The MCO must report this information to the state's PIU immediately, if the severity of the complaint influences the care and treatment of the client, or quarterly upon investigation. For each case which warrants investigation, the MCO must report the following information: name and ID number of the relevant party; source of the complaint; provider type; nature of the complaint; approximate monies involved; and the legal and administrative disposition of the case.

The MCOs interviewed submit monthly and/or quarterly reports of fraud, waste, and abuse activity to the state's PIU for review. The contract does not include language that requires the MCO to report suspected provider fraud, waste, or abuse to the Nebraska MFPAU. The state confirmed they do not have any written policies or procedures to oversee the MCO investigations related to fraud, waste, and abuse.

Arbor Health's SIU investigates reported potential fraud and abuse activities and, as appropriate, refers suspected or confirmed fraud or abuse to the appropriate oversight agencies, as required by the state. When a referral warrants investigation, the case is assigned to an investigator. The investigator prepares an initial investigative plan for SIU management review within three business days after assignment. The target for case completion is between four to six months from assignment to conclusion. According to state guidelines and upon evidence supporting a credible suspicion of fraud, the investigator refers the case to the state's PIU.

CoventryCares' SIU is responsible for initiating a preliminary investigation and reporting it to the state within 24 hours of its determination, upon the receipt of an allegation of fraud. The SIU investigator utilizes a proprietary case tracker to document each step of the investigation. Referrals are made to the state's PIU and any appropriate federal agency.

Magellan Behavioral Health's cases are processed, analyzed, and preliminarily reviewed by their Nebraska SIU analyst. If an allegation requires additional research or investigative actions, a three-day report form is completed and sent to the state program integrity manager via the Nebraska compliance officer. The SIU public sector manager then reviews the *Provider Preliminary Review Report* and, if warranted, assigns a case to the SIU investigator for full investigative activities. Investigative findings are reported to the state program integrity manager via the Nebraska compliance officer. When warranted by the findings, investigations

are placed in an inactive status to await direction from either the state or the MFPAU as to whether to proceed with the investigation.

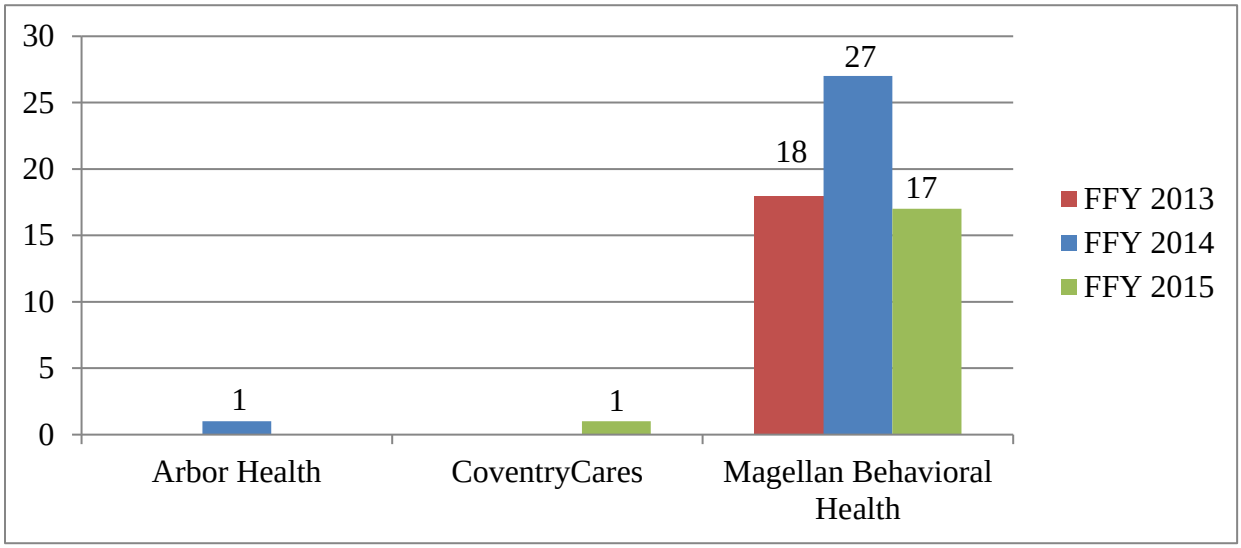
The state considers the cases referred by the MCOs to be of adequate quality. Additionally, the state considers the quantity of cases referred by the behavioral health MCO to be adequate and consistent with the number of cases historically investigated by the state. However, as previously mentioned, the state is only aware of cases that are reported, so it is possible that a case could be opened then closed without intervention or referral. The state told the CMS review team that it frequently questions the quantity of the cases referred by the physical health MCOs. The state reported to the CMS review team that there are numerous factors which impact the quantity of cases reviewed by the physical health MCOs. Those factors are:

- The volume of fraud, waste, abuse, and erroneous payments in the provider types covered by the MCOs is less than provider types that remain covered by the FFS program.
- The MCOs each have a smaller segment of the provider population, making anomalies less noticeable.
- The MCOs have more cost avoidance measures methods available, such as prior authorization, prepayment review, and limited networks to limit their exposure to fraud, waste, abuse, and erroneous payments.

The MFPAU frequently reminds all MCOs of the need to uncover fraudulent behavior and refer it to them for investigation.

Table 3 lists the number of referrals that Arbor Health, CoventryCares, and Magellan Behavioral Health made to the state in the last three FFYs. Overall the number of Medicaid provider investigations and referrals by each of the MCOs is low, compared to the size of the plan. The level of investigative activity has not changed over time.

Table 3.



The CMS review team selected samples of five MCO network provider investigations conducted by the state conducted during the past four FFYs. Upon review of the case files, two providers resulted in unfounded allegations of fraud, two providers received educational letters, and one provider case was settled.

Meetings and Trainings

State program integrity staff meets every other month with state managed care staff to discuss program integrity activities. The state program integrity staff and the state managed care staff also meet regularly with the state data analytics team to review reports on managed care payments. During these regularly scheduled meetings, additional program integrity training is conducted on an as needed basis, or when there is a specific question or topic. Program integrity staff provide training covering topics that include recent trends in fraud, waste, and abuse; information from other states' PIUs or Medicaid Fraud Control Unit groups; the functioning of the Medicaid Management Information Systems (MMIS); and other general program issues. The most recent managed care oversight training was held during April 2016.

In addition, the state Medicaid agency and the MFPAU jointly provide program integrity training to the MCOs every six months. The most recent training held in October 2015, discussed date of death audits and hospice service vulnerabilities. However, the MCOs are also responsible for providing program integrity training to their SIU personnel.

MCO Compliance Plans

The state does require its MCOs to have a compliance plan to guard against fraud and abuse in accordance with the requirements at 42 CFR 438.608.

The state does not have a process to review the compliance plans and programs. In addition, the state does not have written policies or procedures for the state's compliance plan review process of the managed care program. Also, the effectiveness of the compliance program is not measured.

As required by 42 CFR 438.608, the state does review the MCOs compliance plan and communicates approval/disapproval with the MCOs. Each plan is reviewed by the state's assigned contract manager and the state's assigned program integrity staff. It was noted during the review that the compliance plan for one MCO was reviewed in September 2013 and the compliance plans for three MCOs were reviewed in July 2012. The next review of the compliance plans is scheduled for the end of 2016. The results of the review of the compliance plans revealed minimal issues such as grammatical errors, lack of reporting, and troublesome execution.

All of the MCOs provided the CMS review team with a copy of their compliance plans that have been submitted to the state. A review of these plans revealed they were in compliance with 42 CFR 438.608.

Encounter Data

The MCO model contract with the state requires the submission of an electronic record for every encounter between a network provider and an enrollee. The state does receive encounter data from the MCOs and reported that it does receive all the certified data the state requires to perform data mining activities. However, the state does not have policies and procedures to oversee the collection and validation of encounter data reported by the MCOs.

Overpayment Recoveries, Audit Activity, and Return on Investment

The state does not have any regulations or policies for identifying, collecting, or reporting and returning to the state overpayments recovered from providers as a result of MCO fraud and abuse investigations or audits. In general, the state identifies erroneous payments and directs the MCO to collect and report the payments using the void/replace process utilizing encounter data. However, overpayment recovery information is neither verified nor monitored by the state. As previously mentioned, the state allows the MCOs to collect and retain overpayments that are not potentially fraud and abuse-related, therefore, overpayments due to waste are not returned to the state.

The table below shows the respective amounts reported by Arbor Health for the past three FFYs.

Table 4-A.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified*	Total Overpayments Recovered**
2013	6	6	$31,782	$3,632
2014	14	14	$164,869	$1.4 million
2015	7	7	$0	$1.3 million

*The amount of overpayments identified does not include monies attributed to waste.
**The amount of overpayments recovered includes monies attributed to fraud, waste, and abuse.

Arbor Health draws no distinction between preliminary and full investigations. Arbor Health also stated that the variances in identified and recovered overpayment is due to investigations spanning multiple years and recovered amounts do not always correlate to the year in which they were identified. Also, the MCO cited some large internal audit projects generated for the first time in FFY 2014, which lowered recoveries during FFYs 2014 through 2015. Arbor Health's recovered overpayments are tracked by their PIU's Program Integrity Reporting and Recoupment Team, and reported to the state on a quarterly basis. Also, Arbor Health includes their editing of duplicate claims, non-covered services, and diagnosis-related group validation, and cost avoidance activities in their reports.

The table below shows the respective amounts reported by CoventryCares for the past three FFYs.

Table 4-B.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2013	64	36	$12,180	$23,330
2014	65	20	$8,907	$19,117
2015	28	24	$4,149	$17,877

*The table contains the results of program integrity activities related to fraud, waste, and abuse.

CoventryCares' recovered overpayments from providers as a result of its fraud and abuse investigations are tracked by their SIU and reported to the state on a quarterly basis. The recovery amounts reported by the MCO are greater than the monies identified, due to cost avoidances (claims sums which are determined to be inappropriate prior to actual payment to the provider) which add to the overpayments recovered versus pure overpayments (which are claims paid and then recovered after payment to a provider). Both the number of investigations and the amounts recovered by CoventryCares demonstrate a declining trend over the time period reviewed, and are low in comparison to the size of the plan.

The table below shows the respective amounts reported by Magellan Behavioral Health for the past three FFYs.

Table 4-C.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2013**	5	0	$0	$0
2014	63	9	$23,535	$19,854
2015	27	14	$7,821	$7,624

*The table contains the results of program integrity activities related to fraud, waste, and abuse.
**The MCO's at-risk contract did not begin until September 1, 2013.

Magellan Behavioral Health's recovered overpayments from providers as a result of its fraud and abuse investigations are tracked and reported monthly to the state by the SIU and the cost containment unit. The MCO's preliminary investigations increased during FFY 2014, due to a high utilization project. Both the number of investigations and the amounts recovered by Magellan Behavioral Health demonstrate an overall declining trend over the time period reviewed, and are low in comparison to the size of the plan.

Overall, the amount of overpayments identified and recovered by the MCOs appears to be low for a managed care program of Nebraska's size. Although MCOs are not required to return all overpayments from their network providers to the state, it is important that the state obtain a clear accounting of any recoupments, since that these dollars may be factored into establishing annual rates. Without these adjustments, the rates paid to the MCOs may be inflated per member per month.

Additionally, the CMS review team discussed cost avoidance measures with the MCOs reviewed. Arbor Health utilizes prepayment review to ensure proper billing by providers. Arbor Health placed one provider on prepay review in FFY 2015; that provider still remained on prepay during the time of this review. CoventryCares placed seven providers on prepay review in FFY 2015; these providers remained on prepay review for a period of three months. Magellan Behavioral Health does not utilize prepay review; the MCO monitors medical necessity and appropriateness of services through prior authorization of services and post-payment review.

Waste Recoveries Retained by the MCOs

As previously mentioned, the state does not have any contract language for identifying, collecting, reporting, or returning overpayments identified or recovered from providers as a result of MCO fraud and abuse investigations or audits; the state only provides verbal direction to the MCOs. In addition, the state allows the MCOs to collect and retain an overpayment that is not potentially related to fraud and abuse. As a result, the CMS review team further evaluated the amount of waste recoveries retained by the MCOs and not returned to the state.

Both CoventryCares and Magellan Behavioral Health reported overall low recovery amounts resulting from fraud, waste, and abuse cases cumulatively. However, Arbor Health's recoveries directly resulting from waste activities demonstrated that more than 99.9 percent of the total overpayments recovered were attributed solely to waste.

During the three FFYs reviewed, Arbor Health was required to return fraud and abuse recoveries totaling $884 to the state. This amount is extremely low, in comparison to the total waste recoveries of approximately $2.7 million which the MCO retained. When questioned about these low fraud and abuse recovery amounts, Arbor Health reported that the cases worked by the SIU did not rise to a level that warrants recoupment of the amounts overpaid.

The table below shows the specific recovery amounts attributed to waste and reported by Arbor Health for the past three FFYs.

Table 5.

FFY	Overpayments Recovered (Fraud and Abuse)	Overpayments Recovered (Waste)	Total Overpayments Recovered (Fraud/Waste/Abuse)
2013	$0	$3,632	$3,632
2014	$0	$1,400,487	$1,400,487
2015	$884	$1,276,844	$1,277,728

Overall, the amount of Arbor Health's recoveries categorized as waste is significant and the implications of identifying a case as waste potentially exempts suspect providers from being reported to the state or MFPAU, payment suspensions, termination actions, and the other processes that are part of the program integrity activities. As previously mentioned, the state does not have established policies and procedures; this includes guidance for defining and recovering overpayments attributed to waste.

Payment Suspensions

In Nebraska, Medicaid MCOs are not contractually required to suspend payments to providers at the state's request. The state confirmed that there is not any contract language mirroring the payment suspension regulation at 42 CFR 455.23.

The MCOs have been directed to suspend payments in compliance with 42 CFR 455.23; however, the state confirmed there is no process to ensure that the MCOs suspend payments.

Arbor Health, CoventryCares, and Magellan Behavioral Health suspend provider payments upon receipt of written notice from Nebraska's Medicaid PIU. The state has requested that the MCOs suspend payments to five providers due to credible allegations of fraud in the past fiscal year. However, the three MCOs interviewed by the CMS review team reported they do not suspend payments to providers.

Terminated Providers and Adverse Action Reporting

The state MCO contract states, "The MCO will report to DHHS monthly those providers that have terminated from the network." The state also requires the MCO to make a good faith effort to give written notice of termination of a contracted provider within 15 days after receipt or issuance of the termination notice to each enrollee who received his or her primary care from, or was seen on a regular basis by the terminated provider.

During the onsite interview, the state confirmed that no process is in place which to ensure that the MCOs are terminating providers for cause.

The three MCOs interviewed confirmed that they report all terminated providers to DHHS on a monthly basis. Additionally, Arbor Health, CoventryCares, and Magellan Behavioral Health notify the state via email when a provider is decredentialed or disenrolled for cause.

Arbor Health submits a termination report, which includes the reason for the termination, to the state within 30 days. The state's Medicaid PIU notifies the MCO when a provider is terminated for cause. Notification is forwarded to provider network management which determines whether the provider is participating or not participating in the MCO's plan. If the provider is participating in the plan, the provider is terminated from the network.

CoventryCares provides the state of Nebraska with a provider termination report monthly. This report captures all terminations, including those for cause. The MCO's compliance officer receives notifications from the state regarding providers which have been terminated for cause. Upon receipt of these state notifications, the MCO's compliance officer informs the provider network and the provider relations team of the termination, and requests immediate flagging in the system that the provider has been terminated by the state.

Magellan Behavioral Health submits to the state a monthly termination report, which includes the reason for the termination. The state's Medicaid PIU notifies the MCO's compliance officer

by email, when a provider is terminated for cause. This notice is forwarded to the provider network department which determines if the provider is participating in their network. If the provider is participating in the plan, the provider will be terminated from the network.

The three MCOs interviewed by CMS reported they do not notify other MCOs of their terminations. However, the state does notify MCOs of any terminated providers from other plans, so that MCOs may ensure that terminated providers are not operating in another plan.

Table 6.

MCOs	Total # of Providers Disenrolled or Terminated in Last 3 Completed FFYs		Total # of Providers Terminated For Cause in Last 3 Completed FFYs	
Arbor Health	2013 2014 2015	717 1,793 1,027	2013 2014 2015	0 1 19
CoventryCares	2013 2014 2015	193 263 118*	2013 2014 2015	1 1 5*
Magellan Behavioral Health	2013 2014 2015	381 256 383	2013 2014 2015	0 3 9

*CoventryCares reported for the time period of January through September 2015.

Overall, the number of providers terminated for cause by the three plans appears to be low, when compared to the number of providers in each of the MCO's networks and compared to the number of providers disenrolled or terminated for any reason. Prior to taking any actions, the MCOs appear to rely on the state to notify them of actions taken at the state level against providers, before taking any action.

Federal Database Checks

The regulation at 42 CFR 455.436 requires that the state Medicaid agency must check the exclusion status of the provider or persons with an ownership or control interest in the provider, and agents and managing employees of the provider on the U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE); the Excluded Parties List System (EPLS) on the System for Award Management (SAM); the Social Security Administration's Death Master File (SSA-DMF); the National Plan and Provider Enumeration System upon enrollment and reenrollment, and check the LEIE and EPLS no less frequently than monthly.

As previously mentioned, Maximus is responsible for provider screening and enrollment in the state. The onsite CMS review team confirmed that Maximus is performing all required federal database checks for the managed care providers as well as collecting and storing all required

disclosure information. However, the state confirmed they do not have any written policies and procedures for overseeing the screening and enrollment process.

Recommendations for Improvement

- The DHHS should ensure that the it is allocating sufficient resources to program integrity oversight and that its MCOs build PIUs with sufficient resources and staffing commensurate with the size of their managed care programs to conduct the full range of program integrity functions including the review, investigation, referral, and auditing of provider types where Medicaid dollars are most at risk.
- The state should consider the inclusion of contract language requiring annual onsite visits to the MCOs. Regular onsite visits would provide increased oversight by the state Medicaid agency, in addition to the reporting methods currently in place.
- The state should develop written policies and procedures for oversight of the MCO investigations of fraud, waste, and abuse.
- The state should develop written policies and procedures to track the number of cases closed without a referral.
- The state should work with the MCOs to develop and routinely provide specific program integrity training related to developing and enhancing the quantity of case referrals from the MCOs. The state should provide more frequent feedback to the plans regarding the quality and quantity of MCO case referrals forwarded to the state. The state should also ensure that MCO staff is receiving adequate training in identifying, investigating, and referring potential fraudulent billing practices by providers.
- The state should develop written policies and procedures regarding the review process of their compliance plan for the managed care program. The state should develop and implement procedures measuring the effectiveness of the compliance program and the MCOs' compliance plans should be reviewed annually.
- The state should develop written policies and procedures to oversee the collection and validation of encounter data reported by the MCOs.
- The state should consider amending the current MCO model contract to include language regarding identifying, collecting, and reporting overpayments by the MCOs, and returning to the state overpayments recovered from providers resulting from MCO fraud and abuse investigations and/or audits. Also, the state should verify that identified and collected overpayments are fully reported by the MCOs and that they are incorporated into the rate-setting process along with the overpayments determined by state initiated reviews. The state should develop written policies and procedures of the overpayments recoveries oversight process.
- The state and the MCOs should work together to strengthen parameters regarding prepayment rules, policies, and requirements. The length of time that providers remain on prepayment should be evaluated with regard to the effectiveness and resources allocated to monitoring providers over an extended duration. The MCOs utilizing post-payment recovery measures, should be encouraged by the state to consider instituting cost avoidance measures which lessen the need for recovery of monies overpaid.
- The state should have policies and procedures which establish guidelines for the identification of waste cases. Parameters would prevent cases not meeting the criteria for waste from being improperly classified and, therefore, exempted from fraud and abuse program integrity activities, such as suspect providers being reported to the state or MFPAU, payment suspensions, and termination actions. The state should include

language in its model contract related to the retention of recovery monies by the MCOs. Also, the state should implement requirements to report all recoveries, including those attributed to waste.

- The state should consider amending the managed care model contract to require MCOs to suspend payments to providers against whom an MCO or the state can document a credible allegation of fraud. The payment suspension requirements at 42 CFR 455.23 should be consulted, when drafting this provision. The state should provide training to its MCOs on the circumstances in which payment suspensions are appropriate pursuant to 42 CFR 455.23 and should further require the reporting of plan-initiated payment suspensions based on credible allegations of fraud. The state should develop written policies and procedures to monitor payment suspensions within its managed care program.
- The state should develop written policies and procedures to monitor reported terminated providers received from the MCOs.
- To ensure that all required federal database checks continue to be performed at the appropriate intervals per 42 CFR 455.436, the state should develop written policies and procedures to oversee the provider screening and enrollment process performed by its delegate.

Section 2: Status of Corrective Action Plan

Nebraska's last CMS program integrity review was in June 2012, and the report for this review was issued in January 2013. The report contained five regulatory compliance issues and one vulnerability. During the on-site review in May 2016, the CMS review team conducted a thorough review of the corrective actions taken by Nebraska to address all issues reported in calendar year 2012. The findings of this review are described below.

Findings -

1. ***The state does not suspend payments in cases of credible allegations of fraud. (Uncorrected Repeat Regulatory Compliance Issue)***

   Status at time of the review: Not corrected

   The state has developed and implemented policies and procedures to meet the fraud referral standards for MFPAU referrals and the requirements of 42 CFR 455.23, concerning the suspension of payments to providers upon MFPAU referral. However, the state is not documenting detailed information on the "basis for the existence of the good cause not to suspend payments" as required by 42 CFR 455.23(g)(2)(ii).

   The state utilized the good cause exception in 42 CFR 455.23 (e)(6) which states, "… State determines that payment suspension is not in the best interests of the Medicaid program," in all cases reviewed from 2013 to the date of the onsite review, which were referred to the MFPAU, except one, but failed to maintain "detailed information on the basis for the existence of the good cause not to suspend payments" as required in 42 CFR 455.23(g)(2)(ii).

   Although the state maintains that these exceptions are considered on a case-by-case review, these determinations are made without any defined parameters in the policy and procedures even though the same exception is used in almost all cases. As such, we believe rigorous documentation requirements that go beyond what may be reviewed during on-site program integrity reviews actually serve to protect everyone's interests. Moreover, we believe it is particularly important the states carefully document those processes that require special judgment calls, such as with respect to exercising the various good cause exceptions, so that, upon CMS review, FFP is not inappropriately withheld. The state needs to create clear guidelines for making the determination that a good cause exists not to impose a payment suspension in order to comply with the "detailed information" requirement when the state fails to impose a payment suspension as required by 42 CFR 455.23(a) when a credible allegation of fraud exists.

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

Status at time of the review: Corrected

The state has modified the disclosure forms to capture all disclosures required in 42 CFR 455.104.

3. The state does not adequately address business transaction disclosure requirements in its provider agreements.

Status at time of the review: Corrected

The state has modified the provider agreement to meet the requirement in 42 CFR 455.105(b) requiring that providers furnish information about certain business transactions with wholly owned suppliers or any subcontractors to the state or U.S. Department of Health & Human Services (HHS), upon request.

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

Status at time of the review: Corrected

The Division of Developmental Disabilities (DDD) uses the MLTC-62 enrollment form from the provider enrollment process and searches for excluded individuals and entities found in the List of Excluded Individuals and Entities (LEIE) and the Excluded Parties List System (EPLS) upon enrollment, reenrollment, and at least monthly thereafter in accordance with the requirements at 42 CFR 455.436.

5. ***The state does not report all adverse actions taken on provider participation to the HHS-Office of the Inspector General (OIG) within the required timeframe.***

Status at time of the review: Corrected

The state issued an educational memo to the DDD in February 2011. The DDD has been notifying the MLTC regarding adverse actions taken against providers participating in the program. The MLTC reports all DDD adverse actions to the HHS-OIG within 20 working days and utilizes the same procedures for reporting adverse actions to the MLTC.

Vulnerability

1. Inability to place edits in N-FOCUS for Personal Care Services. (Uncorrected Repeat Vulnerability)

Status at time of the review: Not Corrected

During both the 2009 and 2012 Medicaid Integrity Group reviews, Nebraska was cited for this vulnerability. Nebraska remains unable to place edits in N-FOCUS system. The state reported it evaluated the possibility of procuring a new MMIS; however, they decided to utilize their current system. Claims continue to be paid outside of the MMIS with no specific edits in place. The state reported that they are currently working on a solution.

Technical Assistance Resources

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

- Use the program integrity review guides posted in the Regional Information Sharing Systems as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the Regional Information Sharing Systems for information provided by other states including best practices and managed care contracts.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute which can help address the risk areas identified in this report. Courses that may be helpful to Nebraska based on its identified risks include those related to managed care. More information can be found at http://www.justice.gov/usao/training/mii/.
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- 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. The CMS annual report of program integrity reviews includes highlights of states that have been cited for noteworthy and effective practices in managed care. These reports can be found at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html
- Consult the Encounter Data Toolkit developed for CMS by a private contractor in November 2013. This is available on the CMS website at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/downloads/medicaid-encounter-data-toolkit.pdf
- Consult CMS's Medicaid Payment Suspension Toolkit at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/MedicaidGuidance.html to develop a payment suspension process for MCOs that is consistent with federal regulations and guidance.

Conclusion

The CMS focused review identified areas of concern and instances of non-compliance with federal regulations which should be addressed immediately.

We require the state to provide a CAP for each of the recommendations within 30 calendar days from the date of the final report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction 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 CAP 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 the letter. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the CAP should identify those corrections as well.

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

Official Response from Nebraska
July 2017

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 18, 2017

Centers for Medicare & Medicaid Services
Laurie Battaglia, Director of the Division of State Program Integrity 7500
Security Boulevard, Mail Stop AR-21-55
Baltimore, MD 21244-1850

Sent via email to: Laurie.Battaglia@cms.hhs.gov

RE: Nebraska Medicaid Program Integrity
May 16 -19, 2016

Dear Ms. Battaglia,

The final report for the focused review of Nebraska Medicaid's Program Integrity procedures and processes related to the oversight of managed care programs has been reviewed. The onsite review was conducted in May of 2016 by a team from the CMS Investigations and Audit Group. The final report was received on June 6, 2017. Thank you for the opportunity to review and respond to the report and for the assistance provided in strengthening Nebraska's Program Integrity Efforts.

The Nebraska Medicaid Program Integrity Team has drafted the attached Corrective Action Plan in response to the final report. The Corrective Action Plan addresses each of the final report's recommendations and responds to the repeat finding of a vulnerability. Nebraska Medicaid continues to dispute that payments are not suspended when there is a credible allegation of fraud.

Since the onsite review last year, Nebraska Medicaid's managed care program (Heritage Health) has implemented new model contracts and three new contractors started 1/1/2017. Heritage Health include physical and behavioral health care and pharmacy services. Starting on 10/1/2017, dental services will be covered through a separate managed care organization that was procured and will have a similar model contract. Waiver services are carved out of the managed care contracts.

The recommendations are based on the model contract and managed care organizations that were in place as of the onsite review. The Corrective Action Plan will address the recommendations based on the current model contract and the Heritage Health program.

While many of these plans can be initiated within 90 days, the prioritization of other work and staff availability will require that additional time be taken on others.

Official Response from Nebraska
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Nebraska Medicaid Program Integrity will supply quarterly reports detailing the number of provider investigations conducted by each of the managed care organizations beginning in October of 2017. Nebraska Medicaid will also submit report information of the investigations from 1/1/2017 as soon as it is gathered. Nebraska Medicaid Program Integrity shares referrals of all providers of services covered by the managed care organizations, not just those that are credible allegations of fraud. The number of referrals originating with the state will be included on the report.

If you have questions about the Corrective Action Plan, please contact Anne Harvey at (402)471-1718 or by email at anne.harvey@nebraska.gov

Sincerely,

Thomas "Rocky" Thompson
Division of Medicaid and Long-Term Care
Nebraska Department of Health & Human Services

Enclosure

cc: Anne Harvey, Nebraska Medicaid Program Integrity
Mark Collins, MFPAU Director