Department of Health and Human Services

Centers for Medicare and Medicaid Services

Center for Program Integrity

Nevada Focused Program Integrity Review

Final Report

March 2016

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Objective of the Review

The Centers for Medicare and Medicaid Services (CMS) conducted a focused review of Nevada 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 2010.

Background: State Medicaid Program Overview

Nevada's Medicaid program is administered by the Division of Health Care Financing and Policy (DHCFP), a component of Nevada's Department of Health and Human Services. The Surveillance and Utilization Review (SUR) Unit is housed under DHCFP and is responsible for all program integrity, audit, and fraud investigation activities. The DHCFP Business Lines Unit (BLU) has programmatic oversight of the MCO contracts, quality, and other monitoring activities. The BLU coordinates with the SUR Unit in reviewing MCO fraud and abuse and program integrity activities. All Medicaid providers enroll through DHCFP, including all managed care network providers. The state is contracted with two MCOs; Amerigroup (AGP), a subsidiary of Anthem Inc., and Health Plan of Nevada (HPN), a subsidiary of UnitedHealth Group (UHG). Both MCOs service two counties in the state. HPN has 57 percent of the enrolled managed care beneficiaries and AGP has 43 percent.

Axispoint Health is the state's care management vendor, operating under the 1115(a) Research and Demonstration Waiver approved by CMS. Axispoint Health operates under the Primary Care Case Management model and provides services on a fee-for-service (FFS) basis for beneficiaries with certain qualifying chronic conditions, such as heart disease, end stage renal disease, and traumatic brain injury. The MCOs are required to provide the same level of services that FFS beneficiaries receive, such as behavioral health and dental services. There are areas of dental care, such as orthodontia, that are carved out for adults and are handled through FFS.

Methodology of the Review

In advance of the onsite visit, CMS requested that Nevada complete a managed care review guide that provided the review team with detailed insight into the operational activities of the oversight of managed care by the state. Questionnaires were also completed by the MCOs selected to be interviewed. A four-person team reviewed these responses and materials in advance of the onsite visit.

During the week of August 17, 2015, the CMS review team conducted interviews with DHCFP staff involved in program integrity, provider enrollment, and managed care. The CMS review team also met with staff from the special investigations units (SIU) of the two MCOs and discussed their activities at length.

Results of the Review

Section 1: Managed Care Program Integrity

Overview of the State's Managed Care Program

In July 2015, the Nevada Medicaid program served 586,383 beneficiaries. Of that total, approximately 68 percent were enrolled in one of the two MCOs and the remaining beneficiaries were served on a FFS basis. Nevada's total Medicaid expenditures in state fiscal year (SFY) 2014 totaled approximately $2.31 billion with approximately $716 million of that in MCO expenditures. The Federal Medical Assistance Percentage for Nevada for federal fiscal year (FFY) 2014 was 63.1 percent. When beneficiaries become eligible for Medicaid services and live in urban Washoe County or Clark County, managed care enrollment is mandatory unless the beneficiary is under the special Medicaid category of aged, blind, or disabled. At the time the beneficiary applies for Medicaid, the beneficiary is asked to choose the MCO of preference. If the beneficiary does not choose an MCO, the beneficiary is automatically assigned to one.

Summary Information on the Plans Reviewed

The AGP is a national health plan that has Medicaid lines of business in 18 states. The MCO has been operational in Nevada since calendar year 2009. The corporation was purchased by Anthem in calendar year 2012, but is still operating as AGP in Nevada. AGP's program integrity operations are spread out across the country. It has an SIU that is dedicated to all of its Medicaid lines of business and is referred to as the Medicaid SIU (MSIU). The MSIU and other program integrity functions are not located in Nevada. AGP reported that its member enrollment had nearly doubled in the past year due to Medicaid expansion. In addition, it reported expenditures had more than doubled since the previous year. See Table 2 below for actual dollar amounts.

The HPN is a national plan that was acquired in calendar year 2008 by UHG. All operations under their contract with Nevada Medicaid are located within Nevada and may be different than other UHG plans throughout the country. The HPN's SIU is dedicated to all lines of business, which encompasses its commercial line of business as well as Medicare and Medicaid.

Enrollment information in each MCO as of July 2015 is summarized below:

Table 1. Summary data for Nevada MCOs1.

	AGP	HPN
Beneficiary enrollment total	171,856	224,427
Provider enrollment total	6,009	5,680
Year originally contracted	2009	2006
Size and composition of SIU	45 FTEs	5 FTEs
National/local plan	National	National

[1] Figures based on data reported by the plans as of August 2015.

Table 2. Medicaid expenditure data for Nevada MCOs2.

MCOs	FFY 2012	FFY 2013	FFY 2014
AGP	$141,717,233	$145,083,238	$330,957,023
HPN	$154,211,000	$162,066,000	$385,291,893

State Oversight MCO Program Integrity Activities

The state reported that oversight of the managed care system in Nevada is a collaborative effort between the BLU and the SUR Unit. The BLU has programmatic and contractual oversight for the MCOs; in addition, contract oversight is a coordinated effort with the DHCFP and its contracted external quality review organization, Health Services Advisory Group. The SUR Unit is housed under the Nevada DHCFP and is responsible for all program integrity, audit, and fraud investigation activities. However, the state does not have written policies and procedures or an interagency agreement detailing how the two units will conduct oversight activities of the MCOs and which unit within the state Medicaid agency will be responsible for each specific activity.

The MCOs do not verify receipt of services as required by the FFS program. Furthermore, the state does not contractually require its MCOs to have a method for verifying with beneficiaries whether services billed by providers were received.

MCO Investigations of Fraud, Waste, and Abuse

Nevada's MCO contract states that "Vendors must comply with all applicable program integrity requirements, including those specified in 42 CFR 455." However, during the interview the state was not clear or aware of all of the obligations that are required under the regulations at 42 CFR part 455.

The state's MCO contract requires that "When a Vendor (MCO) investigation reveals that an incident of suspected fraud and/or abuse by a member or provider may have occurred, the Vendor (MCO) is required to report the instances of suspected fraud and/or abuse to the SUR Unit at the DHCFP no later than 10 business days after the completion of an investigation." The MCOs submit monthly reports of fraud, waste, and abuse activity to the BLU which is then sent to the SUR Unit for review. The contract also includes language that requires the MCO to report suspected provider fraud, waste, or abuse to the Nevada MFCU.

AGP's MSIU maintains a case tracking system for all complaints received that includes the status of the case and any referrals made. Further, the MSIU has developed a fraud plan. As part of the preliminary investigation stage, the fraud plan directs the investigator to obtain permission from the state in developing the investigative strategy. However, AGP indicated that in Nevada,

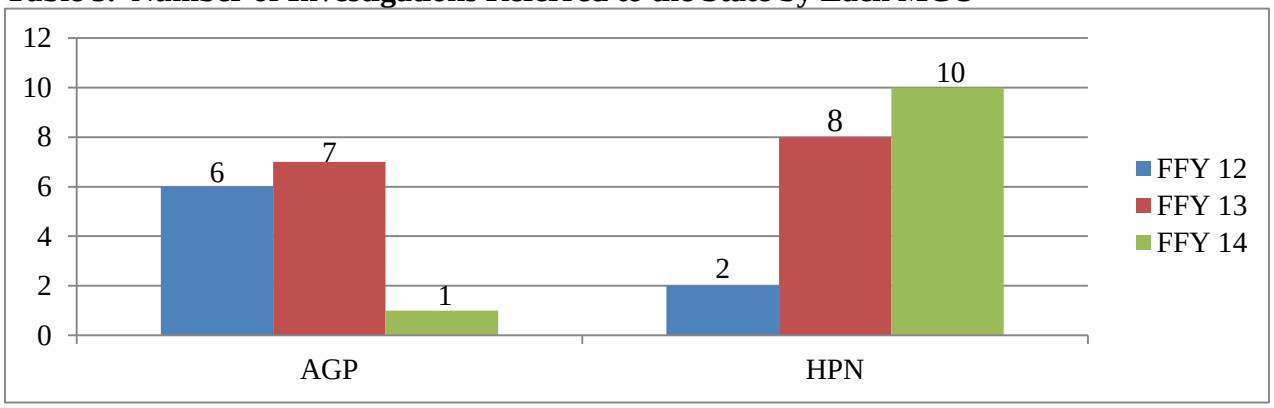
[2] Figures based on data reported by the plans as of August 2015.

the state does not require that it be notified when continuing with an investigation. Therefore, the MCO normally notifies the state after completing a full investigation in accordance with contract requirements for reporting. AGP reported that it identified 16 cases of suspected fraud or abuse in the four quarters preceding the review.

HPN's SIU reported that it spends approximately 20 percent of its time dedicated to Medicaid program integrity efforts. The MCO is not currently verifying receipt of services with Medicaid beneficiaries, nor is it a contract requirement; however, explanations of member benefits are available online for viewing by beneficiaries. HPN reported that it identified six cases of suspected fraud or abuse in the four quarters preceding the review.

Table 3 lists the number of referrals that AGP's MSIU and the HPN's SIU made to the state in the last three FFYs. Overall the number of Medicaid provider investigations and referrals by each of the MCOs is very low. This is magnified by the fact that expenditures for both plans more than doubled in 2014 due to Medicaid expansion.

Table 3. Number of Investigations Referred to the State by Each MCO



MCO Compliance Plans

The state requires its MCOs to have a compliance plan to guard against fraud and abuse. In 2011, the state contracted with a contractor to conduct a performance audit review and report if the MCOs were compliant with federal regulations. The contractor evaluated MCO compliance with 42 CFR 438.600 – 438.610, and determined if the MCOs' SIUs have methods in place for referring fraud to the state/MFCU and verified whether such referrals had been made. The review revealed minimal issues; however, the state has not reviewed the MCOs compliance plans since calendar year 2011. The state is also unsure when the next review of the MCOs compliance plan will occur.

Meetings and Training

The SUR manager, MCO SIUs, and the MFCU meet quarterly to discuss open cases on network providers and share information about specific scenarios which have been identified. These meetings are also used to educate the MCOs on how to develop and create quality referrals.

However, the state reported that most case referrals received from the MCOs are lacking in quality and quantity.

The BLU last conducted a formal basic training with the MCOs in July 2013 educating the plans about federal and state contractual requirements. This training used to occur annually; however, due to a change in the BLU staffing, it has not been conducted since July 2013. The state staff has attended courses offered at the Medicaid Integrity Institute and the SUR Unit also conducts in-house training for all state staff on the specific duties it performs.

AGP's MSIU meets both internally and externally to promote its program integrity activities. As the MSIU oversees all Medicaid lines of business, it coordinates its efforts locally with the Nevada plan through monthly activity reports to department heads, face-to-face meetings with key personnel, and ongoing meetings with relevant staff as needed during specific investigations. In addition, AGP participates in quarterly meetings with the state's SUR Unit and the MFCU where problem providers and cases are discussed. AGP also participates in quarterly meetings hosted by the United States Attorney's Task Force and requires that all of its employees receive annual corporate compliance training on fraud and abuse. Continued employment for all employees is contingent upon successfully completing training and passing the review test with at least a score of 90 percent.

HPN's SIU participates in quarterly MCO/Medicaid conference calls as well as monthly America's Health Insurance Plan Fraud and Abuse Work Group conference calls. All HPN staff complete annual fraud and abuse training courses as well as privacy and security training via a corporate webinar system. The state has presented annual fraud waste and abuse training during joint MCO meetings. UHG has a compliance, ethics, and integrity program which includes education and training on identifying, reporting, and addressing potential misconduct, noncompliant activities, and instances of fraud, waste and abuse. Upon hire and annually thereafter, all HPN employees are required to complete training that includes ethics and integrity, key compliance policies, standards of conduct, privacy, personal information security, conflicts of interest and specific training on recognizing fraud, waste, and abuse.

Encounter Data

The state has recently received access to MCO encounter data; however, the warehouse data is not in a format that is usable for the SUR Unit at this time. The state is working on making this raw encounter data usable to identify aberrant billing patterns in the managed care sector.

Overpayment Recoveries, Audit Activity, and Return on Investment

The state does not require MCOs to return to the state or report on overpayments recovered from providers as a result of MCO fraud and abuse investigations or audits.

The AGP reported cost savings from its MSIU through pre-payment reviews, recovered dollars, and other program integrity activities which would impact savings. The table below shows the respective amounts reported by AGP for the past three FFYs.

Table 4. AGP's Savings and Recoveries from Program Integrity Activities

FFY	Total Prevented	Total Recovered	Total Cost Avoidance
2012	$6,913	$103,832	$585,625
2013	$12,556	$192,594	$818,613
2014	$41,303	$75,716	$851,889

The CMS review team observed that recoveries dropped dramatically in 2014, while expenditures for that year more than doubled due to Medicaid expansion. This drop was also noted in the number of referrals to the state in Table 3.

The MSIU calculates cost avoidance by identifying the change in cost per visit after MSIU had some type of intervention with the provider. After three months of a downward trend in cost per visit, the savings are forecast out for 12 months. If a provider is terminated, the MSIU factors in the identified overpayments, since the current provider billing is no longer available. In its most recent calculation, the APG found that for calendar year 2015, the MSIU had saved $709,730 in cost avoidance and recoveries and is projecting to finish the year at $1,371,574.

The HPN SIU recoveries are tracked by the Recovery Unit and they report the recovery dollars to the state. However, the recovery dollars provided to the state do not detail the reasons for each recovered item. Therefore, the SIU related recoveries are not differentiated from other types of overpayment recoveries. Table 5 details the overpayments by year.

Table 5. HPN Overpayments Identified and Recovered

FFY	Total Overpayments Identified	Total Overpayments Recovered
2012	$3,912	$3,896
2013	$81,164	$8,738
2014	Not provided	Not provided

Overall, the amount of overpayments identified and recovered by the MCOs appears to be exceedingly low for a managed care program with over $700 million in expenditures and over 11,000 participating providers. Further, although MCOs may not be required to return overpayments from their network providers to the state, it is important that Nevada obtain a clear accounting of any recoupments, so that these dollars can be factored into establishing annual rates. Without these adjustments, MCOs could be receiving inflated rates per member per month.

Payment Suspensions

In Nevada, 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 state lacks sufficient program integrity policies and procedures for payment suspensions within its managed care program. The state indicated that their Deputy Attorney General was hesitant to implement payment suspensions as providers complain about the financial impact it has on them. The lack of a policy that covers the regulation leaves the state at risk.

AGP reported that it had not issued any payment suspensions in the past four FFYs. When the MSIU refers a case to the state for a credible allegation of fraud, AGP does not suspend payments. Instead, the MCO reported that it will normally have the provider on pre-payment review at that point and will wait until the state suspends payments and/or will take direction from the state to suspend payments. To date, the state had not asked AGP to suspend payments to any provider.

HPN has not issued any payment suspensions in the past four FFYs. HPN has the authority to temporarily suspend payments without the direction of the state until additional information is submitted by the provider. Once HPN validates the claim, payment is turned back on, or in the event the additional information did not validate the claim, referral to the state could be made at that time. If fraud is suspected, a referral to the state is made. HPN reported that they have not received feedback from the state on referrals they have submitted.

Terminated Providers and Adverse Action Reporting

The state MCO contract states "If the Vendor (MCO) decredentials, terminates, or disenrolls a provider, the Vendor (MCO) must inform the state within 15 calendar days. If the decredentialing, termination or disenrollment of a provider is due to suspected criminal actions, or disciplinary actions related to fraud or abuse, the state will notify HHS-OIG". The state also requires the MCO to give written notice of termination of a contracted provider within 15 days of receipt or issuance of the termination notice to each beneficiary that receives primary care from, or was seen on a regular basis by the terminated provider.

AGP indicated that it reports to the state any provider removed from its network within one business day of doing so. In addition, if the removal of a provider will impact beneficiaries' access to care, AGP will notify the state 14 days before doing so. AGP lists the providers who are removed as being "dismissed" whether for-cause as defined by CMS or not for-cause. AGP provided a list of providers who have been dismissed from their network for the past four FFYs, along with reasons for the removal[3]. In addition, AGP reported that the state will notify it of provider terminations that occur in FFS. When they receive these notices, if the provider is also in the MCO's network, they will terminate them. APG had a list of eight providers that the state had notified them were being terminated from the Nevada Medicaid program. The MCO found

[3] See Table 6 for highlights of the data from the plan for the past three FFYs.

that six of them were not active in their network at the time of the notification. The other two providers were subsequently terminated from the network.

HPN provides a monthly network file to the state which reflects all changes in the network. HPN notifies the state via email when a provider is terminated, decredentialed, or disenrolled for cause. HPN does not notify the other MCO of these actions. HPN receives notice that the state has terminated a provider for-cause via an email to the Medicaid compliance officer. The Medicaid compliance officer forwards the notice to HPN's credentialing lead, who in turn reviews the internal systems to determine whether or not the provider is participating in HPN's network. If a provider is found to be participating, the information is conveyed to the internal Medicaid compliance contact and network contracting advising that the provider has been terminated.

Table 6: Provider Terminations in Managed Care

MCOs	Total # of Providers Disenrolled or Terminated in Last 3 Completed FFYs		# of Providers Terminated For Cause in Last 3 Completed FFYs	
AGP	2014 2013 2012	148 221 189	2014 2013 2012	2 2 4
HPN	2014 2013 2012	29 16 17	2014 2013 2012	0 2 0

Overall, the number of providers terminated for cause by both of the plans appears to be low 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. Rather, it appears that the plans both rely on the state to notify them of actions taken at the state level against providers before taking any action.

Recommendations for Improvement

- Given the limited number of provider investigations and referrals by the MCOs along with the low number of overpayments and terminations that the MCOs reported, it is imperative that Nevada ensures that both the DHCFP and its MCOs are allocating sufficient resources to the prevention, detection, investigation and referral of suspected provider fraud.
- Develop written policies and procedures or an interagency agreement that outlines which state unit will be responsible for various program integrity related oversight functions.
- Work with the MCOs to develop specific program integrity training to develop and enhance case referrals from the MCOs. Provide more frequent feedback to the plans on the cases they refer to the state. Ensure that all SIU staff are receiving appropriate training in identifying and investigating potential fraudulent billing practices by providers.

- Continue efforts to improve the state's ability to analyze encounter data reported by MCOs and perform state-initiated data mining activities in order to identify fraud, waste, and abuse issues with MCO network providers.
- 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.
- Develop a plan to review the MCOs compliance plans on a regular basis.
- Contractually require MCOs to suspend payment to providers against whom an MCO or the state can document a credible allegation of fraud. The payment suspension requirements in the federal regulation at 42 CFR 455.23 should be consulted in designing this provision. The state should provide training to its contracted 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.

Section 2: Status of Corrective Action Plan

Nevada's last CMS program integrity review was in March 2010, and the report for this review was issued in December 2010. The report contained six findings and six vulnerabilities. During the on-site review in August 2015, the CMS review team conducted a thorough review of the corrective actions taken by Nevada to address all issues reported in calendar year 2010. The findings of this review are described below.

Findings

1. The DHCFP does not collect required disclosures of ownership and control from providers, MCOs, the fiscal agent, and the state survey agency. (Uncorrected Repeat Finding) (42 CFR 455.104)

Status at time of the review:

1. The state has revised its disclosure forms in the application.
2. Language is now in the contract requiring the MCOs to comply with all of 42 CFR 455.
3. These are now in the contract with the fiscal agent.
4. The previous regulation at 42 CFR 455.104 required disclosing entities that are subject to periodic surveys by a state surveying agency to disclose its ownership and control information to the state surveying agency, which in turn must report to the state Medicaid agency. This is no longer applicable under the revised regulation.

2. The DHCFP does not require the disclosure of business transactions, upon request, from providers and MCOs. (42 CFR 455.105)

Status at time of the review: The state has revised its provider agreement several times since the last review; the last time being in April 2013. The revised contract requires the MCO and its subcontractors to comply with 42 CFR 455.105. Also, the state has included comprehensive

language in its MCO contracts requiring MCOs to be compliant with all of 42 CFR 455, as previously discussed in this document.

3. The DHCFP does not collect required disclosures of health-care related criminal convictions from MCOs. (Uncorrected Repeat Finding) (455.106).

Status at time of the review: The state should be collecting disclosures on the MCO itself. The state was not able to provide the disclosures that were collected from the MCOs, therefore this issue remains open.

4. The DHCFP does not report to the U. S. Department of Health and Human Services Office of the Inspector General (HHS-OIG) adverse actions taken on provider applications for participation in the program. (Uncorrected Repeat Finding) (42 CFR 1002.3(b))

Status at time of the review: The state was able to identify their point of contact in the regional Office of Inspector General, and reported that they refer everything to point of contact.

5. The DHCFP does not notify all required parties when a provider has been excluded or terminated for cause. (42 CFR 1002.212)

Status at time of the review: In the 2010 program integrity review, the state did not have a mechanism in place to notify the general public, other beneficiaries, and other relevant parties when it excluded or terminated a provider for-cause. The state provided the CMS review team proof that public notification is now available on the state website. The website contains exclusion and reinstatement information of providers. In addition, letters go out to other agencies. Instead of copying other parties on the letter to the provider, they will scan the letter and e-mail to everyone. This includes sending it to bordering states and MCOs.

6. Nevada does not provide notification to all required parties when a provider is allowed back into the program after being terminated. (42 CFR 1002.215(b))

Status at time of the review: As mentioned above, the state has an exclusion list on their website. When a provider is reinstated, they will be added to the "Reinstatement List" on the website.

Vulnerabilities

1. Backlog of program integrity cases

Status at time of the review: The state reported that it currently has approximately 500 open cases. These include routine audits of personal care agencies which are reviewed annually. The state reports that their current full time equivalent numbers are higher now than at the time of the review in 2010. The SUR Unit was recently tasked with reviewing all pending cases. However, a sample of state cases revealed that at least one current case had originally been received in 2012.

2. Not notifying HHS-OIG of local convictions

Status at time of the review: The state indicated that their point of contact at the HHS-OIG's local office receives a letter from the state Attorney General regarding convictions, and the information is also posted on the state's website under "Press Releases."

3. Not using permissive exclusion authority. (Uncorrected Repeat Vulnerability)

Status at time of the review: The state has established sanction periods as part of the Nevada Medicaid Service Manual.

4. Not conducting monthly searches for individuals and entities excluded from participating in Medicaid. (Uncorrected Repeat Vulnerability)

Status at time of the review: This is an ongoing issue. The state reported that its fiscal agent is capturing the information in a spreadsheet for future reference when their system is updated. At this time, the state does run monthly checks against the HHS-OIG's List of Excluded Individuals and Entities for providers, but because of limitations with their MMIS, it is not able to run checks of the other required parties. The fiscal agent is conducting searches of the Excluded Parties List System (EPLS) on the System for Award Management (SAM), the Social Security Administration's Death Master File, and the National Plan and the Provider Enumeration System (NPPES) at enrollment and revalidation, but is not searching the EPLS/SAM monthly. The state is in the process of implementing an online enrollment system which will encapsulate all federal database checks that are required to be conducted. The monthly EPLS checks are scheduled to be part of the development process of their new system. The new online enrollment system is slated to be implemented at the latest by June 2019.

5. Not maintaining a centralized program integrity function.

Status at time of the review: The state indicated that in the past, some program integrity functions regarding personal care agencies were occurring in district offices and the reports generated from these reviews were not being sent to the SUR Unit. Now, the SUR Unit gets those reports and will open cases as needed. The SUR Unit is looking at such things as inpatient stays with home service overlap.

6. Not reporting adverse actions taken on managed care provider applications to HHS-OIG.

Status at time of the review: The state reports that if MCOs terminate network providers for cause, then the state would take similar action in FFS, when applicable, and notify their point of contact at the local HHS-OIG contact.

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:

- 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 Nevada 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
- Access the Toolkits to Address Frequent Findings: 42 CFR 455.436 Federal Database Checks website at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/fftoolkit-federal-database-checks.pdf.

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 Nevada to build an effective and strengthened program integrity function.

Official Response from Nevada
April 2016

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Governor

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April 18, 2016

Mark Majestic
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Dear Mr. Majestic:

This is in response to your letter dated March 22, 2016 requesting the Nevada Division of Health Care Financing and Policy (DHCFP) provide a corrective action plan for recommendations identified for the recent focused program integrity oversight of managed care organizations (MCOs) review. The DHCFP has included a response to the 2010 uncorrected findings and vulnerabilities that were also identified during this review. The DHCFP has already taken steps to correct some issues and our specific plan of correction is as follows:

Recommendations for Improvement

1. Recommendation: Given the limited number of provider investigations and referrals by the Managed Care Organizations (MCO) along with the low number of overpayments and terminations that the MCOs reported, it is imperative that Nevada ensure that both the DHCFP and its MCOs are allocating sufficient resources to the prevention, detection, investigation, and referral of suspected provider fraud.
   Corrective Action:

   Responsible Party: The Surveillance and Utilization Review (SUR) Unit will be the responsible part for ensuring the DHCFP and each MCO allocate sufficient staff and other applicable resources toward the prevention, detection, investigation and referral of suspected provider fraud, waste and abuse.

   Action Plan: The DHCFP will ensure all MCO compliance reviews specifically address the identification review recovery and/or prevention, and reporting of improper payments including fraud, waste and abuse. The criteria will include reporting every tip, complaint, referral, and credible allegation of fraud promptly on an individual basis. The current status of active reviews, and all completed reviews including the amount of any identified overpayment, is to be submitted to the DHCFP SUR Unit on a monthly basis.