Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Nevada Comprehensive Program Integrity Review

Final Report

March 2008

Reviewers:
Mark Rogers, Review Team Leader
Todd Chandler
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INTRODUCTION

CMS' Medicaid Integrity Group (MIG) conducted a comprehensive program integrity (PI) review of the Nevada Medicaid Program. The onsite portion of the review was conducted in April 2007 at the Nevada Department of Health and Human Services (DHHS) offices. The MIG review team also visited the State's Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Compliance/SURS unit which is primarily responsible for Medicaid program integrity. However, the DHHS Managed Care Unit's Business Lines unit also plays an important part in fighting fraud and abuse in Nevada's Medicaid program. The report addresses regulatory compliance issues and vulnerabilities. The review team identified four areas of non-compliance with Federal regulations during its review.

- 42 CFR § 455.18, requiring states to ensure that providers attest that information provided on claim forms is accurate.

- 42 CFR §§ 455.104(a)(1) and 455.104(a)(2), requiring that enrollment forms include the name and address of each person with an ownership or control interest of five percent or more in the disclosing entity, as well as the relationship of each owner to any other owner of the disclosing entity or its subcontractors.

- 42 CFR § 455.106(a), requiring the state to capture criminal conviction information.

- 42 CFR § 1002.3(b), requiring the Medicaid agency to notify the Department of Health and Human Services Office of the Inspector General (HHS-OIG) of action taken on a provider's application for participation in the program.

The State agreed to take actions to correct all areas of non-compliance and vulnerability. The State's response to the draft report is included as Attachment A to this final report.

THE REVIEW

Objectives of the Review

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

Overview of Nevada's Medicaid Program

The Nevada Medicaid program is administered by the DHHS. As of March 2007, the program serves approximately 166,437 recipients, with 53 percent receiving Medicaid services fee-for-service (FFS) and 47 percent enrolled in two Medicaid managed care plans. At the time of the

review, the State has enrolled 15,045 FFS providers. The two managed care organizations (MCO) enroll and contract with 4,834 providers.

Medicaid expenditures in Nevada for state fiscal year (SFY) ending June 30, 2006 totaled $1,177,644,544. The Federal government supplied 53.93 percent of the cost of medical services for Federal fiscal year (FY) 2007. Expenditures for managed care enrollees in SFY 2006 accounted for 18 percent of the total, despite the high proportion of managed care enrollees. DHHS processed an average of 10.8 million claims per year for the past three years for its FFS providers.

Division of Health Care Financing and Policy

In Nevada, the organizational component dedicated to anti-fraud and -abuse activities is located in the Division of Health Care Financing and Policy (DHCFP), located within DHHS. At the time of the review, DHCFP had approximately 13 full-time employees that investigated all suspected provider fraud and abuse. DHCFP considers all areas within the division responsible for program integrity, including: Surveillance and Utilization Review Subsystem (SURS); Payment Error Rate Measurement (PERM); financial and policy compliance audits; and provider support and third party liability (TPL) activities. While oversight of TPL is an important State program integrity function, the focus of this review is the prevention and detection of provider fraud in the Medicaid program. The table below shows the total number of audits and amounts collected in the past two SFYs as a result of program integrity activities.

Table 1

SFY	Number of Audits	Recoveries
2006	17	$1,652,544
2005	89	$ 181,082

Methodology of the Review

In advance of an onsite visit, the review team requested that Nevada complete a comprehensive review guide and supply documentation in support of its answers to the review guide. The review guide included such areas as provider enrollment, claims payment and post-payment review, managed care, SURS, and the MFCU. A four-person review team reviewed the answers and materials that the State provided in advance of the onsite visit.

During the week of April 16-20, 2007, the MIG review team visited the DHHS offices and the MFCU. While onsite, the team met with numerous DHHS officials, as well as with staff from First Health Services Corporation (FHSC), the State's provider enrollment agent and claims processing contractor, and with the MFCU director. To determine whether the managed care plan was complying with the contract provisions and other Federal regulations relating to program integrity, the CMS team reviewed the contract provisions. The team also conducted in-depth interviews with representatives of both MCOs under contract with the State and met separately with DHHS' Managed Care Unit and DHCFP staff to discuss the State's managed care oversight and monitoring efforts.

Scope and Limitations of the Review

This review focused on the activities of the DHCFP Compliance/SURS unit, which is primarily responsible for Medicaid program integrity. However, the Managed Care Unit's Business Lines unit also plays an important part in fighting fraud and abuse in Nevada's Medicaid program as it relates to managed care, transportation and dental services. Nevada's SCHIP program operates under Title XXI of the Social Security Act, and was, therefore, not included in this review. Unless otherwise noted, DHCFP provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or collections information that DHCFP provided.

RESULTS OF THE REVIEW

A. REGULATORY COMPLIANCE ISSUES

The State is not in compliance with Federal regulations related to provider attestation, disclosure of subcontractors and owner relationships, disclosure of criminal conviction information, and notification to HHS-OIG regarding exclusions.

Nevada does not ensure that providers attest that information provided on claims is accurate
The Federal regulation at 42 CFR § 455.18 requires that providers attest to the accuracy of information on all claim forms. The Federal regulation at 42 CFR § 455.19 permits an alternative to attestations on claim forms: the State may print attestation language above the claimant's endorsement on checks or warrants payable to providers. FHSC processes all of Nevada's claims, with 38 percent processed via paper claims and 62 percent processed electronically. Nevada uses the CMS-1500 form for paper claims and the FH-35 form for electronic claims. While the CMS-1500 form has proper attestation language, the FH-35 does not. The FH-32 form that DHCFP uses to process claims payments electronically also contains no provider attestation.

DHCFP staff stated that Chapter 100 of the Medicaid Services Manual (MSM) has language that satisfies the regulation. The review team verified the MSM language, but the inclusion of language in the MSM does not satisfy § 455.18's requirement that information in claim forms be attested to by providers. The team requested, but was not provided, copies of a check or warrant; therefore, the team was unable to confirm whether the State's checks and warrants contained the alternative attestation language under § 455.19.

***Recommendation*:** Revise the FH-35 to be imprinted with boldface type with the required attestation statements given in 42 CFR § 455.18(1) and (2). As an alternative, DCHFP may revise its checks or warrants payable to providers to include appropriate language pursuant to 42 CFR § 455.19.

Nevada does not identify ownership or control interest of subcontractors
Federal regulations at 42 CFR §§ 455.104(a)(1) and 455.104(a)(2) require that enrollment forms capture the name and address of each person with an ownership or control interest of five percent or more in the disclosing entity or in a subcontractor the disclosing entity partially owns (with an ownership or control interest also of five percent or greater), as well as the relationship of each owner to any other owner of the disclosing entity or its subcontractors. Nevada's Medicaid provider enrollment forms do not solicit disclosure of this information.

***Recommendation*:** Modify enrollment packages to include required ownership and subcontractor information. DHCFP must also use this ownership information to search for possible OIG exclusions prior to enrolling providers and routinely thereafter.

Nevada does not require providers to disclose criminal conviction information
The Federal regulation at 42 CFR § 455.106(a), requires the disclosure of information regarding the identity of persons with ownership or control in the disclosing entity or agents or managing employees of the disclosing entity who have criminal convictions related to Federal health care programs. Nevada's provider enrollment forms do not ask for criminal conviction information concerning managing employees for individual providers.

***Recommendation*:** Develop and implement policies and procedures to solicit disclosure of managing employee criminal conviction information from owners, officers, and managing employees for all provider types.

Nevada does not notify HHS-OIG of actions taken on provider applications
The Federal regulation at 42 CFR § 1002.3 requires the reporting to HHS-OIG of any adverse actions taken by a State on provider applications for participation in the program. These adverse actions include the denial or termination of participation in the program, including when an owner or managing employee has been convicted of a criminal offense related to Medicare, Medicaid, or Title XX programs. DHCFP does not report to HHS-OIG such adverse actions.

***Recommendation*:** Submit appropriate reports to the HHS-OIG regarding adverse actions taken on a provider's application for participation.

B. AREAS OF VULNERABILITY

The review team identified three areas of vulnerability in Nevada's practices. They specifically include concerns about provider enrollment and MCO reporting of suspected fraud and abuse.

Inadequate information for effective exclusion searches
While the Nevada Provider Enrollment Application solicits provider applicant and owner information, including employer identification numbers or social security numbers, the application does not capture identity information on managing employees or subcontractor ownership information.

FHSC, the State's provider enrollment agent, performs an automated search for HHS-OIG exclusions at the time of enrollment and monthly thereafter. FHSC searches the entity's business name, facility name and the individual provider's name for exclusions. FHSC does not search for managing employees, and owners of subcontractors. Even if the information is disclosed in attachments to the provider enrollment forms, FHSC management told the review team that there would be no search for exclusions of such managing employees and subcontractors.

***Recommendation*:** Modify all enrollment forms to include managing employee and subcontractor ownership information for exclusion searches during, and routinely after, the enrollment process.

Not initiating provider exclusions
The Federal regulation at 42 CFR § 1002.210 requires that the State institute administrative procedures to exclude a provider for any reason for which the HHS-OIG could exclude a provider under 42 CFR Parts 1001 and 1003.

DHCFP indicated that it uses its exclusion authority only in instances where other authorities, such as the HHS-OIG or the State's medical licensing board, have already sanctioned providers or in instances where a provider has been convicted of a criminal offense. DHCFP does not initiate exclusions of providers on its own. Therefore, providers with a history of inappropriate behavior remain in the program as long as the HHS-OIG or the State's medical licensing board has not moved against them.

***Recommendation*:** Use the authority provided by 42 CFR § 1002.210 to exclude providers who, in the State's judgment, threaten the integrity of Nevada's Medicaid program.

Inconsistent reporting of suspected fraud and abuse cases to the State by MCOs
The MCO contract requires MCOs to report instances of suspected fraud and abuse to DHCFP immediately. Health Plan of Nevada, Inc. (HPN) does not adhere to reporting requirements in section 2.13.7 of the MCO contract which indicate that all suspected recipient and provider fraud and abuse should be immediately reported to DHCFP. The MCO stated that the staff investigate complaints, visit providers, review medical records, take action, and refer the providers to the MFCU. The investigation by HPN can take up to 60 days or more. The MCO only notifies DHCFP when the review is completed, and only if there are negative findings.

The review team also met with Anthem Blue Cross Blue Shield Partnership Plan (Anthem). Anthem had only begun performing its contract with the State in November 2006. Anthem's Director for Statewide Programs, David Blackman, stated that there had been no complaints of fraud and abuse since November 2006 and Anthem had not yet run any reports to determine whether it had complaints to report to the State.

***Recommendation*:** Closely monitor the MCOs for compliance with contractual requirements regarding reporting suspected fraud and abuse complaints.

CONCLUSION

The CMS review team identified four areas of non-compliance with Federal regulations. Each area of non-compliance should be addressed immediately. It is imperative that DHCFP come into compliance with Federal program integrity regulations as soon as possible.

CMS also encourages DHCFP to closely examine each identified area of vulnerability. DHCFP is not obligated to follow CMS' recommendations on these vulnerabilities; however, its overall efforts will be considerably strengthened if it does so.

The Medicaid Integrity Group looks forward to working with the State of Nevada on correcting its areas of non-compliance and eliminating its areas of vulnerability.

ATTACHMENT A

JIM GIBBONS
Governor

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
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1100 E. William Street, Suite 101
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MICHAEL J. WILLDEN
Director

CHARLES DUARTE
Administrator

March 4, 2008

Robb Miller, Director
Division of Field Operations
Medicaid Integrity Group
233 North Michigan Avenue, Suite 600
Chicago IL 60601

Dear Mr. Miller:

On behalf of the Compliance Unit staff, our fiscal agent, First Health Services Corporation, and myself, I would like to thank you for your assistance in identifying these areas of non-compliance and bringing them to our attention. I have directed staff and our fiscal agent to resolve these issues immediately. In addition, I have also directed staff and our fiscal agent to treat the areas of vulnerability as areas of non-compliance and have directed them to correct those areas as well.

Regulatory Compliance Issues

Nevada does not ensure that providers attest that information provided on claims is accurate.

RESPONSE: DHCFP will revise the FH-35 to be imprinted with boldface type with the required attestation statements given in 42 CFR 455.18(1) and (2).

All claim forms are standardized and contain the information at 455.18(b). DHCFP is also in compliance with 42 CFR 455.19 as the statement is on all warrants. DHCFP also has a statement on all provider applications which states; I understand I am responsible for the presentation of true, accurate and complete information on all invoices/claims submitted to First Health Services. In addition, there is policy in Chapter 100, Section 102.4A, which indicates the statement as required in 455.19 does appear on the warrant. It was also updated to include policy regarding electronic payments. (see attached for a copy of the warrant…I believe your report said your staff was unable to receive one of these).

Nevada does not identify ownership or control interest of subcontractors.

RESPONSE: DHCFP will modify the enrollment packages to include required ownership and subcontractor information. DHCFP will use this information to search for possible OIG exclusions prior to enrolling providers and routinely thereafter.

Nevada does not require providers to disclose criminal conviction information.

RESPONSE: DHCFP will develop and implement policies and procedures to solicit disclosure of managing employee criminal conviction information from owners, officers, and managing employees for all provider types.

Nevada does not notify HHS-OIG of actions taken on provider applications.

RESPONSE: DHCFP will submit report to HHS_OIG on all adverse actions taken on a provider's application for participation.

Areas of Vulnerability

Inadequate information for effective exclusion searches.

RESPOSNE: DHCFP will modify all enrollment forms to capture managing employee and subcontractor ownership information for use in exclusions searches during, and after, the enrollment process.

Not initiating provider exclusions.

RESPONSE: DHCFP understands that it can use the authority found in 42 CFR 1002.210 to excluded providers who, in its judgment, threaten the integrity of Nevada's Medicaid program.

Inconsistent reporting of suspected fraud and abuse cases to the State by MCOs.

RESPONSE: DHCFP will closely monitor the MCOs for compliance with contractual requirements regarding reporting suspected fraud and abuse complaints.

Once again, thank you for sharing this information with us, if you have any additional questions, please direct them to John Liveratti, Chief, Compliance at 775-684-3606 or liveratt@dhcfp.nv.gov.

Sincerely,

Charles Duarte,
Administrator

Attachment

Cc: Michael J. Willden, Director, DHHS
Candis Lee Englant, Medicaid Director, FHSC