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Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Nevada Comprehensive Program Integrity Review

Final Report

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INTRODUCTION

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Nevada Medicaid Program. The MIG review team conducted the on-site portion of the review at the offices of Nevada's Division of Health Care Financing and Policy (DHCFP), a component of Nevada's Department of Health and Human Services. The review team also interviewed the director of Nevada's Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of DHCFP, which is responsible for Medicaid program integrity. This report describes four noteworthy practices, two effective practices, six regulatory compliance issues, and six vulnerabilities in the State's program integrity operations.

THE REVIEW

Objectives of the Review

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

Overview of Nevada's Medicaid Program

The Nevada Medicaid program is administered by DHCFP. In January 2010, the program served 238,893 beneficiaries. Of that total, 126,118 beneficiaries were enrolled in 2 managed care organizations (MCOs), and the remaining 112,775 beneficiaries were served on a fee-for-service (FFS) basis. The State had approximately 14,734 participating FFS providers and 4,934 MCO providers. Nevada's total Medicaid expenditures in the State fiscal year (SFY) 2009 totaled $1,357,918,917. This includes FFS expenditures of $1,151,388,747, and MCO expenditures of $206,530,170.

The Federal medical assistance percentage (FMAP) for Nevada for Federal fiscal year (FFY) 2009 was originally 50.00 percent. However, with adjustments attributable to the American Recovery and Reinvestment Act of 2009, the State's effective FMAP was 63.93 percent in all four quarters of FFY 2009.

Program Integrity Section

Since the MIG program integrity review in 2007, Nevada has increased its commitment to Medicaid program integrity by quadrupling its program integrity staff, strengthening its fraud identification and recovery efforts and initiating several effective practices. In February 2010, DHCFP reconfigured its decentralized program integrity function within the Medicaid agency by assigning program integrity coordination responsibility to a newly created position of Chief of

Audits. At the time of the review, DHCFP had 29 full-time equivalent (FTE) staff focusing on Medicaid program integrity. The table below presents the total number of investigations, identified overpayments, and amounts recouped in the past four SFYs as a result of program integrity activities.

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Amount of Overpayments Identified	Amount of Overpayments Collected
2006	67	34	$1,774,511	$1,647,978
2007	88	56	$86,182	$49,643
2008	506	290	$3,298,032	$3,053,982
2009	740	659	$2,972,172	$2,992,886

* Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation.
** Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved through a referral to the MFCU or administrative or legal disposition.

Methodology of the Review

In advance of the on-site visit, the review team requested that Nevada complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as program integrity, provider enrollment/disclosures, managed care, and the MFCU. A four-person team reviewed the responses and materials that the State provided in advance of the on-site visit.

During the week of March 22, 2010, the MIG review team visited the DHCFP offices and conducted interviews with numerous DHCFP officials, the State's provider enrollment contractor and transportation broker. The MFCU director was interviewed by phone prior to the on-site review. Finally, to determine whether the MCOs were complying with contract provisions and other Federal regulations relating to program integrity, the MIG team interviewed State staff from DHCFP with managed care oversight responsibilities. The team also reviewed the managed care contract provisions and gathered information through interviews with representatives of two MCOs. In addition, the team reviewed a sample of provider enrollment applications, FFS and MCO case files, selected claims, and other primary data to validate the State's program integrity practices.

Scope and Limitations of the Review

The review focused on the activities of DHCFP, but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment, managed care and non-emergency medical transportation.

Nevada operates a stand-alone Children's Health Insurance Program under Title XXI of the Social Security Act, which was, therefore, not included in this review. Unless otherwise noted,

Nevada 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 financial information that DHCFP provided.

RESULTS OF THE REVIEW

Noteworthy Practices

As part of its comprehensive review process, the CMS review team has identified four practices that merit consideration as noteworthy or "best" practices. The CMS recommends that other States consider emulating these activities.

Payment Error Rate Measurement (PERM)-type audits by DHCFP's Audit Unit

Nevada has adopted an audit process similar to audits conducted by CMS' PERM program. Since February 2007, Nevada has completed 52 PERM-type audits. These audits resulted in $114,000 in actual recoupment and unspecified additional savings after certain problematic claims processing edits were corrected. The State noted that its PERM-type audits revealed a number of edits that were not working the way in which staff originally intended. For example, dental claims were being paid with incorrect age parameters, claims for services by physician assistants were not being paid at the correct lower rate, and outpatient surgery and rehabilitation hospital claims were processed past the Medicaid claims filing deadlines. In all cases, the faulty edits were corrected, relevant claims were recycled through them, and appropriate recoupments were initiated. Additionally, through these audits, Nevada discovered issues with its fiscal agent including data entry errors and fiscal overrides that were not in accordance with policy. The State conducts these PERM-type audits on a regular basis unless other audit priorities arise causing these audits to be delayed.

Enhanced enrollment procedures for high risk provider types

Nevada has established several operational practices since 2003 which have enhanced enrollment procedures for high risk providers in the areas of personal care services (PCS), home health agencies (HHAs), durable medical equipment (DME), and outpatient behavioral health.

For increased oversight of enrollment and supervision of personal care attendants (PCAs), Nevada requires all PCAs to be employed through a PCS agency. The PCS agency must enroll with the State as a Medicaid provider, and must submit documentation related to areas such as licensure, corporate liability, worker insurances, and criminal background checking. These required items include:

- Documentation showing Taxpayer Identification Number,
- Proof of Worker's Compensation Insurance,
- Proof of Nevada Department of Public Safety account for Federal Bureau of Investigation criminal background checks,
- Bureau of Health Care Quality and Compliance (BHCQC) License (for PCS agencies),
- Proof of Commercial General Liability Insurance of not less than $2,000,000 general aggregate and $1,000,000 each occurrence, with the Nevada DHCFP named as an additional insured,
- Proof of Business Automobile Liability coverage of at least $750,000 combined single limit for bodily injury and property damage with coverage for any auto owned, leased, hired or borrowed for use in rendering services and with DHCFP named as an additional insured, and
- Proof of Commercial Crime Insurance for employee dishonesty with minimum of $25,000 per loss.

The State also conducts annual visits through its BHCQC, instead of the Federally required triennial visits, of HHAs to ensure that policies and procedures are in place and the provider understands what is needed for Medicaid compliance.

Since October 2008, the State has been conducting pre-enrollment on-site visits for all DME providers. This practice was adopted in response to Medicaid numbers having been issued to several non-existent DME providers. Although the State reported that no non-existent DME providers have been uncovered using this practice, it attributes sentinel effects to its use of DME pre-enrollment site visits. In 2008, 1 DME pre-enrollment visit was conducted and 11 were conducted in 2009.

In its behavioral health services programs, Nevada has established a system featuring tightened accountability for clinical services and supervision of non-licensed behavioral health practitioners within its Medicaid outpatient behavioral health programs. The DHCFP requires that the medical supervisor for any behavioral health outpatient treatment applicant Provider Type 14 (high school and/or Bachelor's-level educated mental health practitioners) attest in writing:

- that specific services are provided by the behavioral health entity,
- that certain policies and procedures related to clinical supervision and quality assurance are in place, and
- that the medical supervisor is licensed to practice in Nevada, enrolled as an individual provider, has at least two years of experience in a mental health setting, and is competent to oversee a comprehensive mental health program.

This Medical Supervisor Acknowledgement form is required as part of the enrollment package for the behavioral health outpatient provider and all information is subject to verification by the State prior to processing the enrollment.

Enhanced oversight of personal care services
Nevada has initiated several practices which strengthen its oversight of PCS, including unannounced reviews, using therapists to improve accuracy of initial service plans, and assigning registered nurses to support MFCU investigations.

Nevada PCS agencies have been reviewed on an annual basis since 2003. In 2009, these reviews were changed to unannounced reviews of randomly selected PCS agencies. Since 2006, an average of 72 agencies have been reviewed each year, and 40 reviews have been completed as of March 21, 2010.

The State has also revised its PCS procedures as of March 2010 to require occupational therapists (OTs) and physical therapists (PTs) to complete a functional assessment of the applicant for PCS and then complete initial service plans for the recipient. Prior to this initiative, DHCFP used a social work/nursing assessment interview to determine the amount of assistance and time allotted for activities of daily living (ADLs) and instrumental ADLs. Through quality assurance studies, the State discovered the existing assessment procedure did not produce an accurate assessment of actual recipient needs. The practice of using PTs and OTs increases service plan accuracy, since assessment of mobility and a functional level of ADLs is within the clinical scope of PTs and OTs.

In another effort to improve PCA oversight, in December 2008 Nevada initiated an inter-agency approach to PCA investigations by having DHCFP Surveillance and Utilization Review Subsystem (SURS) staff accompany MFCU personnel during 12 investigations of randomly selected recipients. Utilizing an investigator from the MFCU and a nurse from the SURS unit, on-site home care visits were conducted with the MFCU staff discussing Medicaid benefit issues with the beneficiary while the nurse observed the beneficiary's behaviors and abilities to determine if the approved service levels were accurate. This dual approach ensured a professional on-site assessment that the service was being delivered appropriately and the beneficiary actually needed the level of care ordered. Based on the joint activity, one beneficiary was terminated and four had service hours decreased. The program has been on hold in 2009 because of other MFCU priorities but is available to the MFCU upon request.

Nevada MCO network providers must be enrolled in the Medicaid program
Nevada is able to maintain centralized control over the screening and credentialing process of all MCO network providers by requiring they enroll in Nevada's Medicaid program. This strategy helps to mitigate vulnerabilities found in other states where the State relies on contracted MCOs to provide network provider enrollment checks and controls. However, its value is diminished because the State does not require its MCOs to report adverse actions taken against network providers.

Effective Practices

As part of its comprehensive review process, the CMS also invites each State to self-report practices that it believes are effective and demonstrate its commitment to program integrity. The CMS does not conduct a detailed assessment of each State-reported effective practice. Nevada reported the State's commitment to program integrity and a State-developed SURS tracking database.

State's commitment to program integrity

Since Nevada's last program integrity review in 2007, the State has quadrupled its FTEs from approximately 7 in SFY 2007 to 15 in SFY 2008 and 29 in SFY 2009. The Medicaid director indicated that the previous MIG review was helpful in assisting the agency to quickly obtain additional positions from the legislature at a time when other State agencies were required to reduce staff. The Medicaid director also noted that this increase in staff has had an ongoing positive effect on overpayment collections, benefiting both the State and Federal government. Concurrently, Nevada reported increased SURS cases and recoveries. In SFY 2007, 56 cases generated approximately $49,643 in recoveries. In SFY 2008 and SFY 2009, 290 cases and 659 cases respectively generated approximately $3,000,000 in recoveries each of those years. This increase appears to have a direct correlation to increased program integrity staffing levels.

Nevada has also improved its efficiency in recoveries since the last Medicaid program integrity review when the program integrity activity cost the State $8 for every $1 recovered. In contrast, in SFY 2009, the recoveries were 31 percent greater than the cost of those activities. These figures do not reflect the added value of the deterrent effect which greater scrutiny adds through reduction of submission of problematic claims because providers are aware of the higher likelihood of review and the potential consequences of overbilling or defrauding the program.

Nevada has also provided enhanced training for program integrity staff through its ongoing commitment to sending State staff to Medicaid Integrity Institute (MII) courses during the past three years. As of March 2010, 11 agency staff, including auditors, analysts and coordinators, attended a total of 10 MII sessions, which the State indicated have been invaluable opportunities for program integrity education.

During the three years since the last program integrity review, the State Medicaid agency has also significantly improved its relationship with the MFCU. There now is clear and continuous communication and cooperation between the two agencies, reflecting many of the principles found in the Medicaid Integrity Group's *Best Practices for Medicaid Program Integrity Units' Interactions with Medicaid Fraud Control Unit* document.

State-developed SURS tracking database

In February 2008, the State developed a versatile and user-friendly stand-alone database to keep track of all SURS cases. The database allows the State to enter specific data in multiple fields, and allows easy report generation by SURS staff using various fields.

The State indicated this database has been extremely helpful in allowing tight tracking of the status of cases, which includes the location of the case, date of initial investigation, provider name, date of case referral to the MFCU, and date of disposition. The database was exhibited to the review team and appeared very useful. However, as noted later in this report, DHCFP still has an operational challenge related to the interface of this stand-alone program and the Medicaid Management Information System (MMIS).

Regulatory Compliance Issues

The State is not in compliance with Federal regulations related to disclosures of ownership and control, business transactions and criminal convictions, and notification activities.

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)

Under 42 CFR § 455.104(a)(1), a provider, or "disclosing entity," that is subject to periodic survey under § 455.104(b)(1) must disclose to the State surveying agency, which then must provide to the Medicaid agency, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. A disclosing entity that is not subject to periodic survey under § 455.104(b)(2) must disclose to the Medicaid agency, prior to enrolling, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. Additionally, under § 455.104(a)(2), a disclosing entity must disclose whether any of the named persons is related to another as spouse, parent, child, or sibling. Moreover, under § 455.104(a)(3), there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity has an ownership or controlling interest. In addition, under § 455.104(c), the State agency may not contract with a provider or fiscal agent that has not disclosed ownership or control information required under this section.

In the 2007 MIG review, DHCFP was cited for not capturing the ownership and control information required by § 455.104(a) and the State subsequently revised its FFS provider application to include this information. However, Nevada neglected to include in its revisions the disclosure of relationship information stipulated in § 455.104(a)(2). In addition, the State still does not require the fiscal agent to disclose ownership and control information required in § 455.104(c) prior to contracting.

The DHCFP also does not receive disclosure information from the State survey agency as required under § 455.104(b)(1), and does not have an interagency agreement requiring communication of that information. Furthermore, even if the State did receive the information from the survey agency, the licensure application only requires disclosure of each officer, director, and person having a direct or indirect ownership interest in the entity of 10 percent or more, which would still leave the State out of compliance. The § 455.104 regulation requires disclosure at ownership levels of 5 percent or more.

Nevada's MCOs are required to apply to and be approved by the Nevada Department of Insurance (DOI) prior to contract negotiations with DHCFP. The DHCFP does not receive disclosure information from the DOI.

Additionally, one of the two MCOs under contract with the Medicaid agency discloses and updates direct or indirect ownership interest in the entity at the 10 percent or more level. This practice does not comply with Federal disclosure requirements of 5 percent or more.

***Recommendations*:** Modify provider applications and contracts to request disclosures required by 42 CFR § 455.104. Develop and maintain a system to collect disclosures from the State survey agency and DOI.

The DHCFP does not require the disclosure of business transactions, upon request, from providers and MCOs.

The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or U.S. Department of Health and Human Services (HHS) information about certain business transactions with wholly owned suppliers or any subcontractors.

In Nevada, the provider contract contains an explicit reference that providers must adhere to the rules and responsibilities contained in the Medicaid Services Manual (MSM). Although Chapter 100 of the MSM requires that facilities which participate in Medicaid disclose business transactions upon request as required by 42 CFR § 455.105(b)(2), individual and group providers are not required to do so. Similarly, Nevada's contracts with Medicaid MCOs do not contain this requirement.

Recommendation: Modify provider agreements and MCO contracts to require disclosure, upon request, of the information identified in 42 CFR § 455.105.

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

The regulation at 42 CFR § 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify the HHS Office of Inspector General (HHS-OIG) whenever such disclosures are made.

The DHCFP revised its FFS applications in response to the 2007 program integrity review to collect required criminal conviction information for all provider types. The MCOs, however, are required to disclose criminal convictions through their application to Nevada's DOI prior to contract negotiations with DHCFP. The DHCFP, however, does not have a procedure for receiving disclosures of criminal convictions from DOI, and has not received notices from DOI of any criminal conviction disclosures by MCOs.

Recommendation: Develop and implement policies and procedures to collect criminal conviction disclosures from DOI and report such disclosures to HHS-OIG.

The DHCFP does not report to HHS-OIG adverse actions taken on provider applications for participation in the program. (Uncorrected Repeat Finding)

The regulation at 42 CFR §1002.3(b) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program.

The DHCFP staff interviewed acknowledged that they were not aware of the requirement to report to the HHS-OIG adverse actions taken on provider applications for program integrity-related reasons, and they did not have a point of contact within HHS-OIG for sending such information. This is a repeat finding.

Nevada noted that it planned to establish a written procedure to meet this requirement and would obtain the name and number of an HHS-OIG contact person.

Recommendation: Develop and implement policies and procedures to report to HHS-OIG all adverse actions taken against provider applicants to the Medicaid program.

The DHCFP does not notify all required parties when a provider has been excluded or terminated for cause.

Under 42 CFR § 1002.212, when the State agency initiates an exclusion, it must provide notice to the individual or entity, and must notify other State agencies, the State medical licensing board (where applicable), the public, beneficiaries and others.

The DHCFP terminated four providers during the past two years. Although the State is notifying the MFCU, relevant State agencies, and the beneficiaries who are directly affected (in order to transfer services) when it excludes a provider or terminates a provider for cause, the State has no mechanism in place to notify the general public, other beneficiaries (who may seek services with the provider), and other relevant parties.

Recommendation: Develop and implement policies and procedures to notify all required parties when a provider has been excluded or terminated for cause.

Nevada does not provide notification to all required parties when a provider is allowed back into the program after being terminated.
Under 42 CFR § 1002.215 (b), if the State approves a request for reinstatement, it must give written notice to the excluded party, and to all others who were informed of the exclusion, specifying the date on which Medicaid program participation may resume.

The DHCFP allows terminated providers to reenter the program if they meet all program requirements. Once approved, as with any newly admitted provider, the reinstated provider is considered an eligible provider. However, Nevada does not notify those parties who were originally contacted about the termination (or who should have been contacted) of the reinstatement as required by this regulation. The State, instead, has left the responsibility for this notification with the reinstated provider.

Recommendation: Develop and implement policies and procedures to notify all parties required by this regulation when a provider has been reinstated in Nevada's Medicaid program.

Vulnerabilities

The review team identified six areas of vulnerability in Nevada's Medicaid practices. These include a backlog of program integrity cases; not notifying HHS-OIG of local convictions and adverse actions taken on provider applications; not using permissive exclusion authority; not conducting monthly searches for excluded individuals; and not maintaining a centralized program integrity function.

Backlog of program integrity cases.
Although the program integrity unit has had a significant increase in staff over the past few years, it continues to be challenged with a large backlog of 368 cases, including cases initiated several years ago which are still pending action. The Medicaid agency noted that it does not have adequate resources to resolve all these cases, and the issue is exacerbated by the potential expiration of some cases due to Nevada's six year Statute of Limitations and records retention requirements. The State noted, however, it does act on priority cases.

Nevada has shown a great commitment to program integrity by increasing program integrity staffing levels when other State operations have lost staff due to budgetary limitations, but the State might consider further increasing staffing levels in program integrity to address its backlogged cases. With the program integrity unit's proven return on investment of at least $1.30 for every $1 spent on staffing, action on these cases may result in recovery of funds greater than what is expended in investigation.

Recommendation: Develop a system to reduce the backlog of program integrity cases with attention to regulatory factors causing cases to close without DHCFP resolution.

Not notifying HHS-OIG of local convictions.
Under the regulation at 42 CFR § 1002.230, the State Medicaid agency must provide notice to HHS-OIG within specified timeframes, unless the MFCU has already provided such notice, when an individual has been convicted of a criminal offense related to the delivery of health care items or services under the Medicaid program. If the State agency was involved in the investigation or prosecution, the State agency must provide notice to HHS-OIG within 15 days after conviction, and if the State agency was not involved in the investigation or prosecution, the State agency must provide notice to HHS-OIG within 15 days after learning about the conviction.

The DHCFP does not have a policy to inform HHS-OIG of local convictions related to crimes in the Medicaid program, and relies on the MFCU to do this. The State-MFCU memorandum of understanding (MOU) does not address the MFCU's responsibility to inform HHS-OIG of such convictions. As indicated during an interview with State program integrity staff, DHCFP does not always know if the MFCU has notified HHS-OIG.

Recommendation: Develop policies and procedures to notify HHS-OIG of local convictions or modify the DHCFP-MFCU MOU to indicate that the MFCU has that responsibility.

Not using permissive exclusion authority. (Uncorrected Repeat Vulnerability)
Despite having the authority to initiate exclusions, Nevada has not applied this program integrity compliance and enforcement tool. The DHCFP has policies in place which allow the State to terminate a provider permanently or indefinitely, and to suspend or exclude a provider for a period of not less than one year in accordance with the permissive exclusion authority conveyed by the Federal regulation at 42 CFR § 1002.210; however, the State is not using this exclusionary authority. The State cited that it faced limitations in creating an in-state exclusion list which were exacerbated by the MMIS' inability to capture information indicating that a provider has been excluded or terminated.

The DHCFP only exercises its exclusion authority when other authorities, such as the HHS-OIG or the State's medical licensing board, have already sanctioned providers and when the providers appear on other exclusion lists. Only when such an exclusion update is received from an outside authority, and the provider is found in Nevada's MMIS, does DHCFP issue a letter terminating the provider from Medicaid. The failure to use permissive exclusions is a repeat vulnerability.

Recommendation: Implement existing policies and procedures to use State-initiated exclusions.

Not conducting monthly searches for individuals and entities excluded from participating in Medicaid. (Uncorrected Repeat Vulnerability)
The regulations at 42 CFR § 455.104 through § 455.106 require States to solicit disclosure information from disclosing entities, including providers, and require that provider agreements contain language by which the provider agrees to supply disclosures upon request.

In response to the 2007 MIG review, DHCFP developed and maintained a system to gather information on all required parties and check those parties for exclusions upon enrollment. It also checks providers for exclusions on a monthly basis.

However, DHCFP is not retaining complete information on owners, officers and managing employees in the MMIS or in another database, and this prevents DHCFP from conducting adequate searches of these individuals against the List of Excluded Individuals/Entities (LEIE) or the Medicare Exclusion Database (MED) on a monthly basis. Similarly, both of Nevada's MCOs do not check the owners and managing employees of network providers on a monthly basis against the LEIE or the MED to determine if any of those individuals are excluded.

This approach toward exclusion checking in both the FFS and managed care programs does not comport with the guidance issued by CMS in two State Medicaid Director Letters (SMDLs) of June 12, 2008 (SMDL#08-003) and January 16, 2009 (SMDL# 09-001). In these letters, CMS advised States of their obligation to screen for excluded individuals and entities prior to and during provider enrollment, and to direct providers to screen their own employees and contractors for excluded persons. In 2007, Nevada had similar issues with exclusion checking of owners and managing employees.

Recommendation: Develop a system to add owners and managing employees of Medicaid FFS and MCO network providers to DHCFP's monthly exclusion checking procedure.

Not maintaining a centralized program integrity function.
Although Nevada has made significant progress in reorganizing some program integrity responsibilities since the MIG program integrity review in 2007, it still appears to face challenges inherent in a structure which does not include a dedicated program integrity unit. Program integrity activities continue to be divided among multiple units with no single unit having overall responsibility for program integrity compliance and implementation. The varied units perform key program integrity functions and often present different competing priorities, although they all report to the State Medicaid Director who indicated he mobilizes staff as needed. Challenges to efficiently meet all Medicaid program integrity needs and program requirements include:

- State staff noted that situations occur when policies are unsupported because, without focused advocacy, the needed MMIS edits are often delayed. The State indicated this delay was due to focusing limited information technology staff on the most critical programmatic needs, and that while program integrity edits were important, they may not be the most pressing or economically critical at a given time.
- When DHCFP has turnover in critical staff, the new staff person has little documentation of specific program integrity processes because there is no detailed program integrity plan that identifies how to get critical elements done. Staff noted that a comprehensive

program integrity manual detailing specific operational processes would improve productivity and build the store of institutional knowledge.

- During a demonstration and interview related to SURS operations, it appeared that the Decision Support System (DSS) did not access all information from the MMIS to use in comprehensive data analysis. When the SURS team offered to show the MIG review team how the DSS system worked, the review team presented a scenario asking for an analysis of physicians in specialties who were billing high end office visits. The review team was told that the system would not allow an analysis by physician specialty. However, in discussions with the MMIS staff, they indicated that physician specialty information is retained and available in the system. Either the programming has not been done to make that information available to the SURS team using the DSS system or the SURS team did not know how to use the system to extract the requested information. Specialty information is essential when conducting a valid review. This issue is even more problematic because although the stand-alone SURS tracking system is a very good product, it has limited ability to communicate with either the DSS system or the MMIS system. Failure of these systems to be able to electronically share information decreases their effectiveness and increases staff time to input data necessary to complete their analyses.

To address some of its challenges, DHCFP reorganized some program integrity responsibilities. A new unit was established in February 2010, which focuses on audits and spans all Medicaid agency programs. The State Medicaid Director indicated that the diffusion of program integrity responsibilities was a conscientious effort to maximize resources, and the State felt it was the most efficient use of limited staff available. However, the new organizational structure has not been in place long enough to determine whether it can resolve the issues that arose in a decentralized program integrity structure.

Recommendation: Organize all program integrity activities in a centralized unit.

Not reporting to HHS-OIG adverse actions taken on managed care provider applications.
The regulation at 42 CFR §1002.3(b) requires reporting to HHS-OIG of any adverse actions a State takes on provider applications for participation in the program. The State Medicaid agency does not require its MCOs to inform the agency when the MCOs have denied enrollment or credentialing of a provider due to program integrity concerns and in interviews with both Nevada MCOs, the MCOs acknowledged that they did not report adverse actions such as program integrity-related network provider enrollment denials to the State. The State is therefore unable to make the required report to the HHS-OIG.

Recommendation: Require MCOs to report all denials of enrollment or credentialing or terminations of providers based on program integrity concerns to the State Medicaid agency.

CONCLUSION

The State of Nevada applies some noteworthy and effective practices that demonstrate program strengths and the State's commitment to program integrity. These practices include:

- use of PERM-type audits by DHCFP's Audit Unit,
- enhanced enrollment procedures for high risk provider types,
- enhanced oversight of personal care services,
- requiring that all MCO providers be enrolled in the Medicaid program,
- State's commitment to program integrity, and
- development of a versatile SURS tracking database.

The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity.

However, the identification of six areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, six areas of vulnerability were identified. The CMS encourages DHCFP to closely examine the vulnerabilities that were identified in this review.

It is important that these issues be rectified as soon as possible. To that end, we will require Nevada to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerabilities identified in this report.

The corrective action plan should address how the State of Nevada will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the regulatory compliance issues or vulnerabilities will take more than 90 calendar days from the date of the letter. If Nevada has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

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