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AMENDMENTS TO LB956

Introduced by Health and Human Services.

1. Strike the original sections and insert the following new sections:

Section 1. Section 68-901, Revised Statutes Supplement, 2019, is amended to read:

68-901 Sections 68-901 to 68-994 and section 2 of this act shall be known and may be cited as the Medical Assistance Act.

Sec. 2. (1) For purposes of this section:

(a)(i) Material change means a change to a provider contract, the occurrence and timing of which is not otherwise clearly identified in the provider contract, that decreases the provider's payment or compensation for services to be provided or changes the administrative procedures in a way that may reasonably be expected to significantly increase the provider's administrative expense, including altering an existing prior authorization, precertification, or notification.

(ii) Material change does not include a change implemented as a result of a requirement of state law, rules and regulations adopted and promulgated or policies established by the Department of Health and Human Services, or policies or regulations of the federal Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services; and

(b) Provider means a provider that has entered into a provider contract with a managed care organization to provide health care services under the medical assistance program.

(2) Each managed care organization shall establish procedures for changing an existing provider contract with a provider that include the requirements of this section.

(3) If a managed care organization makes any material change to a

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provider contract, the managed care organization shall provide the provider with at least sixty days' notice of the material change. The notice of a material change required under this section shall include:

(a) The effective date of the material change;

(b) A description of the material change;

(c) The name, business address, telephone number, and electronic mail address of a representative of the managed care organization to discuss the material change, if requested by the provider;

(d) Notice of the opportunity for a meeting using real-time communication to discuss the proposed changes if requested by the provider, including any mode of telecommunications in which all users can exchange information instantly such as the use of traditional telephone, mobile telephone, teleconferencing, and videoconferencing. If requested by the provider, the opportunity to communicate to discuss the proposed changes may occur via electronic mail instead of real-time communication; and

(e) Notice that upon three material changes in a twelve-month period, the provider may request a copy of the provider contract with material changes consolidated into a single document. The provision of the copy of the provider contract with the material changes incorporated by the managed care organization (i) shall be for informational purposes only, (ii) shall have no effect on the terms and conditions of the provider contract, and (iii) shall not be construed as the creation of a new contract.

(4) Any notice required to be delivered pursuant to this section shall be sent to the provider's point of contact as set forth in the provider contract and shall be clearly and conspicuously marked "contract change". If no point of contact is set forth in the provider contract, the insurer shall send the requisite notice to the provider's place of business addressed to the provider.

Sec. 3. Section 68-914, Reissue Revised Statutes of Nebraska, is

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amended to read:

68-914 (1) An applicant for medical assistance shall file an application with the department in a manner and form prescribed by the department. The department shall process each application to determine whether the applicant is eligible for medical assistance. The department shall provide a determination of eligibility for medical assistance in a timely manner in compliance with 42 C.F.R. 435.911, including, but not limited to, a timely determination of eligibility for coverage of an emergency medical condition, such as labor and delivery.

(2) The department shall notify an applicant for or recipient of medical assistance of any decision of the department to deny or discontinue eligibility or to deny or modify medical assistance. Except in the case of an emergency, the notice shall be mailed on the same day as or the day after the decision is made. In addition to mailing the notice, the department may also deliver the notice by any form of electronic communication if the department has the agreement of the recipient to receive such notice by means of such form of electronic communication. Decisions of the department, including the failure of the department to act with reasonable promptness, may be appealed, and the appeal shall be in accordance with the Administrative Procedure Act.

(3) Notice of a decision to discontinue eligibility or to modify medical assistance shall include an explanation of the proposed action, the reason for the proposed action, the information used to make the decision including specific regulations or laws requiring such action, contact information for personnel of the department to address questions regarding the action, information on the right to appeal, and an explanation of the availability of continued benefits pending such appeal.

Sec. 4. Section 68-973, Reissue Revised Statutes of Nebraska, is amended to read:

68-973 (1) The Legislature finds that the medical assistance

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program would benefit from increased efforts to (a) ~~(1)~~ prevent improper payments to service providers, including, but not limited to, enforcement of eligibility criteria for recipients of benefits, enforcement of enrollment criteria for providers of benefits, determination of third-party liability for benefits, review of claims for benefits prior to payment, and identification of the extent and cause of improper payment, (b) ~~(2)~~ identify and recoup improper payments, including, but not limited to, identification and investigation of questionable payments for benefits, administrative recoupment of payments for benefits, and referral of cases of fraud to the state medicaid fraud control unit for prosecution, and (c) ~~(3)~~ collect postpayment reimbursement, including, but not limited to, maximizing prescribed drug rebates and maximizing recoveries from estates for paid benefits.

(2) The Legislature further finds that (a) the medical assistance program was established under Title XIX of the federal Social Security Act and is a joint federal-state-funded health insurance program that is the primary source of medical assistance for low-income, disabled, and elderly Nebraskans and (b) the federal government establishes minimum requirements for the medical assistance program and the state designs, implements, administers, and oversees the medical assistance program.

(3) It is the intent of the Legislature to establish and maintain integrity procedures and guidelines for the medical assistance program that meet minimum federal requirements and that coordinate with federal program integrity efforts in order to provide a system that encourages efficient and effective provision of services by Nebraska providers for the medical assistance program.

Sec. 5. Section 68-974, Revised Statutes Supplement, 2019, is amended to read:

68-974 (1) One ~~The department may contract with one~~ or more program integrity ~~recovery audit~~ contractors may be used to promote the integrity of the medical assistance program, ~~and~~ to assist with investigations and

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audits, or to investigate the occurrence of fraud, waste, or abuse ~~cost-containment efforts and recovery audits~~. The contract or contracts may include services for (a) cost-avoidance through identification of third-party liability, (b) cost recovery of third-party liability through postpayment reimbursement, (c) casualty recovery of payments by identifying and recovering costs for claims that were the result of an accident or neglect and payable by a casualty insurer, and (d) reviews of claims submitted by providers of services or other individuals furnishing items and services for which payment has been made to determine whether providers have been underpaid or overpaid, and to take actions to recover any overpayments identified or make payment for any underpayment identified.

(2) Notwithstanding any other provision of law, all program integrity ~~recovery audit~~ contractors ~~retained by the department~~ when conducting a program integrity ~~recovery~~ audit, investigation, or review shall:

(a) Review claims within four ~~two~~ years from the date of the payment;

(b) Send a determination letter concluding an audit within one hundred eighty ~~sixty~~ days after receipt of all requested material from a provider;

(c) In any records request to a provider, furnish information sufficient for the provider to identify the patient, procedure, or location;

(d) Develop and implement with the department a procedure in which an improper payment identified by an audit may be resubmitted as a claims adjustment, including (i) the resubmission of claims denied as a result of an interpretation of scope of services not previously held by the department, (ii) the resubmission of documentation when the document provided is incomplete, illegible, or unclear, and (iii) the resubmission of documentation when clerical errors resulted in a denial of claims for

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services actually provided. If a service was provided and sufficiently documented but denied because it was determined by the department or the contractor that a different service should have been provided, the department or the contractor shall disallow the difference between the payment for the service that was provided and the payment for the service that should have been provided;

(e) Utilize a licensed health care professional from the specialty area of practice being audited to establish relevant audit methodology consistent with (i) ~~established practice guidelines, standards of care, and~~ state-issued medicaid provider handbooks and (ii) established clinical practice guidelines and acceptable standards of care established by professional or specialty organizations responsible for setting such standards of care;

(f) Provide a written notification and explanation of an adverse determination that includes the reason for the adverse determination, the medical criteria on which the adverse determination was based, an explanation of the provider's appeal rights, and, if applicable, the appropriate procedure to submit a claims adjustment in accordance with subdivision (2)(d) of this section; and

(g) Schedule any onsite audits with advance notice of not less than ten business days and make a good faith effort to establish a mutually agreed upon time and date for the onsite audit.

(3) A program integrity contractor retained by the department or the federal Centers for Medicare and Medicaid Services shall work with the department at the start of a recovery audit to review this section and section 68-973 and any other relevant state policies, procedures, regulations, and guidelines regarding program integrity audits. The program integrity contractor shall comply with this section regarding audit procedures. A copy of the statutes, policies, and procedures shall be specifically maintained in the audit records to support the audit findings.

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(4) The department shall exclude from the scope of review of recovery audit contractors any claim processed or paid through a capitated medicaid managed care program. ~~(3)~~ The department shall exclude ~~the following~~ from the scope of review of program integrity ~~recovery audit~~ contractors~~: (a) Claims processed or paid through a capitated medicaid managed care program; and (b)~~ any claims that are currently being audited or that have ~~already~~ been audited by a program integrity ~~the recovery audit~~ contractor, by the department, or ~~currently being audited~~ by another entity. Claims processed or paid through a capitated medicaid managed care program shall be coordinated between the department, the contractor, and the managed care organization. All such audits shall be coordinated as to scope, method, and timing. The contractor and the department shall avoid duplication or simultaneous audits. No payment shall be recovered in a medical necessity review in which the provider has obtained prior authorization for the service and the service was performed as authorized.

(5) Extrapolated overpayments are not allowed under the Medical Assistance Act without evidence of a sustained pattern of error, an excessively high error rate, or the agreement of the provider.

(6) ~~(4)~~ The department may contract with one or more persons to support a health insurance premium assistance payment program.

(7) ~~(5)~~ The department may enter into any other contracts deemed to increase the efforts to promote the integrity of the medical assistance program.

(8) ~~(6)~~ Contracts entered into under the authority of this section may be on a contingent fee basis. Contracts entered into on a contingent fee basis shall provide that contingent fee payments are based upon amounts recovered, not amounts identified. Whether the contract is a contingent fee contract or otherwise, the contractor shall not recover overpayments by the department until all appeals have been completed unless there is a credible allegation of fraudulent activity by the

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provider, the contractor has referred the claims to the department for investigation, and an investigation has commenced. In that event, the contractor may recover overpayment prior to the conclusion of the appeals process. In any contract between the department and a program integrity ~~recovery audit~~ contractor, the payment or fee provided for identification of overpayments shall be the same provided for identification of underpayments. Contracts shall be in compliance with federal law and regulations when pertinent, including a limit on contingent fees of no more than twelve and one-half percent of amounts recovered, and initial contracts shall be entered into as soon as practicable under such federal law and regulations.

(9) ~~(7)~~ All amounts recovered and savings generated as a result of this section shall be returned to the medical assistance program.

(10) ~~(8)~~ Records requests made by a program integrity ~~recovery audit~~ contractor in any one-hundred-eighty-day period shall be limited to not more than ~~five percent of the number of claims filed by the provider for the specific service being reviewed, not to exceed~~ two hundred records for the specific service being reviewed. The contractor shall allow a provider no less than forty-five days to respond to and comply with a records ~~record~~ request. If the contractor can demonstrate a significant provider error rate relative to an audit of records, the contractor may make a request to the department to initiate an additional records request regarding the subject under review for the purpose of further review and validation. The contractor shall not make the request until the time period for the appeals process has expired.

(11) ~~(9)~~ On an annual basis, the department shall require the recovery audit contractor to compile and publish on the department's Internet web site metrics related to the performance of each recovery audit contractor. Such metrics shall include: (a) The number and type of issues reviewed; (b) the number of medical records requested; (c) the number of overpayments and the aggregate dollar amounts associated with

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the overpayments identified by the contractor; (d) the number of underpayments and the aggregate dollar amounts associated with the identified underpayments; (e) the duration of audits from initiation to time of completion; (f) the number of adverse determinations and the overturn rating of those determinations in the appeal process; (g) the number of appeals filed by providers and the disposition status of such appeals; (h) the contractor's compensation structure and dollar amount of compensation; and (i) a copy of the department's contract with the recovery audit contractor.

(12) ~~(10)~~ The program integrity ~~recovery audit~~ contractor, in conjunction with the department, shall perform educational and training programs ~~annually~~ for providers that encompass a summary of audit results, a description of common issues, problems, and mistakes identified through audits and reviews, and opportunities for improvement.

(13) ~~(11)~~ Providers shall be allowed to submit records requested as a result of an audit in electronic format, including compact disc, digital versatile disc, or other electronic format deemed appropriate by the department or via facsimile transmission, at the request of the provider.

(14)(a) ~~(12)(a)~~ A provider shall have the right to appeal a determination made by the program integrity ~~recovery audit~~ contractor.

(b) The contractor shall establish an informal consultation process to be utilized prior to the issuance of a final determination. Within thirty days after receipt of notification of a preliminary finding from the contractor, the provider may request an informal consultation with the contractor to discuss and attempt to resolve the findings or portion of such findings in the preliminary findings letter. The request shall be made to the contractor. The consultation shall occur within thirty days after the provider's request for informal consultation, unless otherwise agreed to by both parties.

(c) Within thirty days after notification of an adverse

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determination, a provider may request an administrative appeal of the adverse determination as set forth in the Administrative Procedure Act.

(15) ~~(13)~~ The department shall by December 1 of each year report to the Legislature the status of the contracts, including the parties, the programs and issues addressed, the estimated cost recovery, and the savings accrued as a result of the contracts. Such report shall be filed electronically.

(16) ~~(14)~~ For purposes of this section:

(a) Adverse determination means any decision rendered by a program integrity contractor or ~~the~~ recovery audit contractor that results in a payment to a provider for a claim for service being reduced or rescinded;

(b) Extrapolated overpayment means an overpayment amount obtained by calculating claims denials and reductions from a medical records review based on a statistical sampling of a claims universe;

(c) ~~(b)~~ Person means bodies politic and corporate, societies, communities, the public generally, individuals, partnerships, limited liability companies, joint-stock companies, and associations; ~~and~~

(d) Program integrity audit means an audit conducted by the federal Centers for Medicare and Medicaid Services, the department, or the federal Centers for Medicare and Medicaid Services with the coordination and cooperation of the department;

(e) Program integrity contractor means private entities with which the department or the federal Centers for Medicare and Medicaid Services contracts to carry out integrity responsibilities under the medical assistance program, including, but not limited to, recovery audits, integrity audits, and unified program integrity audits, in order to identify underpayments and overpayments and recoup overpayments; and

(f) ~~(c)~~ Recovery audit contractor means private entities with which the department contracts to audit claims for medical assistance, identify underpayments and overpayments, and recoup overpayments.

Sec. 6. Original sections 68-914 and 68-973, Reissue Revised

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Statutes of Nebraska, and sections 68-901 and 68-974, Revised Statutes Supplement, 2019, are repealed.