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AMENDMENTS TO LB380

Introduced by Health and Human Services.

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

Section 1. Section 68-974, Revised Statutes Cumulative Supplement, 2024, is amended to read:

68-974 (1) One or more program integrity contractors may be used to promote the integrity of the medical assistance program, to assist with investigations and audits, or to investigate the occurrence of fraud, waste, or abuse. 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 contractors when conducting a program integrity audit, investigation, or review shall:

(a) Provide clear written justification to the provider for commencing an audit;

(b) Review claims within three ~~four~~ years from the date of the payment;

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

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(d) Furnish ~~(c) In any records request to a provider, furnish~~ information sufficient for the provider to identify the patient, procedure, or location in any records request to a provider. A records request shall be limited to relevant documents proportional to the services being audited as provided in subsection (12) of this section;

(e)(i) ~~(d)~~ Develop and implement ~~with the department~~ a procedure with the department in which an improper payment identified by an audit may be resubmitted as a claims adjustment, including (A) ~~(i)~~ the resubmission of claims denied as a result of an interpretation of scope of services not previously held by the department and (B) ~~, (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 services actually provided~~.

(ii) 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 (A) disallow the difference between the payment for the service that was provided and the payment for the service that should have been provided or (B) allow ninety days after the notice of overpayment for the provider to adjust a claim if the service was provided and sufficiently documented, but denied because it was determined by the department or contractor that a different service should have been billed;

(f) ~~(e)~~ Utilize a licensed health care professional from the specialty area of practice being audited to establish relevant audit methodology consistent with (i) 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;

(g) Schedule onsite audits with advance notice of not less than ten

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business days and make a good faith effort to establish a mutually agreed-upon time and date for the onsite audit; and

(h) ~~(f)~~ Provide a detailed written notification and explanation of an adverse determination that would result in partial or full recoupment of payment. The written notification and explanation shall include: (i) The full name of the beneficiary who received the health care services for which overpayment was made; (ii) the dates of service; (iii) the amount of the overpayment; (iv) the claim number or other identifying numbers; (v) a detailed explanation of the basis for the overpayment determination, including each finding and supporting evidence upon which the determination is based; (vi) the method in which payment was made, including, the date of payment and, if applicable, the check number; (vii) the appropriate procedure to submit a claims adjustment under subdivision (e) of this subsection; (viii) a statement that the provider may appeal the determination as provided in subsection (16) of this section; (ix) the method by which recovery of the overpayment will be made if recovery is initiated; and (x) a statement that an overpayment shall not be recouped for at least sixty days after the date of notice of adverse findings. ~~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) Any provision of a contract between a third-party payer and a provider or beneficiary that violates subsection (2) of this section is unenforceable.

(4) ~~(3)~~ A program integrity contractor retained by the department or the federal Centers for Medicare and Medicaid Services shall work with

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the department at the commencement ~~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.

(5)(a) ~~(4)~~ The department shall exclude from the scope of review of recovery audit contractors:

(i) A ~~any~~ claim processed or paid through a capitated medicaid managed care program;

(ii) A claim that is not a primary insurance claim; and

(iii) A claim ~~. The department shall exclude from the scope of review of program integrity contractors any claims~~ that is ~~are~~ currently being audited or that has ~~have~~ been audited by a program integrity contractor, by the department, or by another entity.

(b) 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.

(c) 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.

(6) ~~(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.

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

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

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program.

(9) A contract ~~(8) Contracts~~ entered into under the authority of this section may be on a contingent fee basis if (a) the contract is in compliance with federal law and regulations, (b) the contingent fees are not greater than twelve and one-half percent of the amounts recovered, and (c) the contract provides that contingency fee payments are based on amounts recovered, not amounts identified. ~~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 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 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.~~

(10) The payment or fee for identification of overpayments shall be the same as that for identification of underpayments in any contract between the department and a program integrity contractor. The contractor shall not recover an overpayment by the department until all appeals have been exhausted unless there is a credible allegation of provider fraud and: (a) The contractor provides the provider with a statement of the reasons for the decision, including a determination on each finding upon which such decision was based, (b) the contractor refers the claim to the

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department for investigation, and (c) an investigation has commenced.

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

(12) ~~(10)~~ Records requests made by a program integrity contractor in any one-hundred-eighty-day period shall be limited to not more than 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 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.

(13) ~~(11)~~ On an annual basis, the department shall require the recovery audit contractor to compile and publish on the department's Internet website 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 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.

(14) ~~(12)~~ The program integrity contractor, in conjunction with the department, shall perform educational and training programs for providers that encompass a summary of audit results, a description of common

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issues, problems, and mistakes identified through audits and reviews, and opportunities for improvement.

(15) A provider ~~(13) 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.

(16)(a) ~~(14)(a)~~ A provider shall have the right to appeal a determination made by a ~~the~~ program integrity contractor. The program integrity contractor shall not recoup an overpayment until all appeals have been exhausted unless there is a credible allegation of fraud and the contractor complies with the requirements in subsection (10) of this section. A program integrity contractor shall provide (i) appeal procedures and timelines at the commencement of any audit and (ii) a contact telephone number and an email address or physical address for submission of written questions regarding an audit and the appeal process. A program integrity contractor shall respond to a question submitted by a provider no later than ten business days after the date of submission.

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

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(17) No later than ~~(15) The department shall by~~ December 1 of each year, the department shall submit an electronic report to the Legislature on 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.~~

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

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

(b) Credible allegation of fraud means an allegation, which has been verified by the department, from any source, including, but not limited to, the following: (i) A fraud hotline tip verified by further evidence; (ii) claims data mining; or (iii) a pattern identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are credible when they have indicia of reliability and the department has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis;

(c) ~~(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;

(d) Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in an unauthorized benefit to any person. It includes an act that constitutes fraud under applicable federal or state law;

(e) Fraud hotline tip means a complaint or other communication submitted through a fraud reporting telephone number or website, including a fraud hotline administered by a health plan or the federal Department of Health and Human Services Office of Inspector General;

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

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(g) ~~(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;

(h) ~~(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

(i) ~~(f)~~ 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. 2. Section 68-995, Revised Statutes Cumulative Supplement, 2024, is amended to read:

68-995 (1) All contracts and agreements relating to the medical assistance program governing at-risk managed care service delivery for health services entered into by the department and existing on or after August 11, 2020, shall:

(a) ~~(1)~~ Provide a definition and cap on administrative spending such that (i) ~~(a)~~ administrative expenditures do not include profit greater than the contracted amount, (ii) ~~(b)~~ any administrative spending is necessary to improve the health status of the population to be served, and (iii) ~~(c)~~ administrative expenditures do not include contractor incentives. Administrative spending shall not under any circumstances exceed twelve percent. Such spending shall be tracked by the contractor and reported quarterly to the department and electronically to the Clerk of the Legislature;

(b) ~~(2)~~ Provide a definition of annual contractor profits and losses and restrict such profits and losses under the contract so that profit shall not exceed a percentage specified by the department but not more

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than three percent per year as a percentage of the aggregate of all income and revenue earned by the contractor and related parties, including parent and subsidiary companies and risk-bearing partners, under the contract;

(c) ~~(3)~~ Provide for return of (i) ~~(a)~~ any remittance if the contractor does not meet the minimum medical loss ratio, (ii) ~~(b)~~ any unearned incentive funds, and (iii) ~~(c)~~ any other funds in excess of the contractor limitations identified in state or federal statute or contract to the State Treasurer for credit to the Medicaid Managed Care Excess Profit Fund;

(d) ~~(4)~~ Provide for a minimum medical loss ratio of eighty-five percent of the aggregate of all income and revenue earned by the contractor and related parties under the contract;

(e) ~~(5)~~ Provide that contractor incentives, in addition to potential profit, be up to two percent of the aggregate of all income and revenue earned by the contractor and related parties under the contract; and

(f) ~~(6)~~ Be reviewed and awarded competitively and in full compliance with the procurement requirements of the State of Nebraska.

(2) A contractor shall:

(a) Not impose quantitative treatment limitations, or financial restrictions, limitations, or requirements, on the provision of mental health or substance use disorder services that are more restrictive than the predominant restrictions, limitations, or requirements imposed on substantially all benefit coverage for other conditions;

(b) Maintain an adequate provider network to provide mental health and substance use disorder services;

(c) Apply criteria in accordance with generally recognized standards of care and make utilization review policies available to the public, providers, and recipients through electronic or paper means when performing a utilization review of mental health or substance use disorder services; and

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(d) Not rescind or modify an authorization for a mental health or substance use disorder service after the provider renders the service pursuant to a determination of medical necessity, except in cases of fraud or a violation of a provider's contract with a health insurer.

Sec. 3. Section 68-996, Revised Statutes Cumulative Supplement, 2024, is amended to read:

68-996 (1) The Medicaid Managed Care Excess Profit Fund is created. The fund shall contain money returned to the State Treasurer pursuant to subdivision (1)(c) ~~(3)~~ of section 68-995.

(2) The fund shall first be used to offset any losses under subdivision (1)(b) ~~(2)~~ of section 68-995 and then to provide for (a) services addressing the health needs of adults and children under the Medical Assistance Act, including filling service gaps, (b) ~~providing~~ system improvements, (c) ~~providing~~ evidence-based early intervention home visitation programs, (d) ~~providing~~ medical respite services, (e) translation and interpretation services, (f) ~~providing~~ coverage for continuous glucose monitors as described in section 68-911, (g) ~~providing~~ other services sustaining access to care, (h) the Nebraska Prenatal Plus Program, and (i) ~~providing~~ grants pursuant to the Intergenerational Care Facility Incentive Grant Program as determined by the Legislature. The fund shall only be used for the purposes described in this section.

(3) Any money in the fund available for investment shall be invested by the state investment officer pursuant to the Nebraska Capital Expansion Act and the Nebraska State Funds Investment Act. Beginning October 1, 2024, any investment earnings from investment of money in the fund shall be credited to the General Fund.

Sec. 4. The Division of Medicaid and Long-Term Care of the Department of Health and Human Services shall:

(1) Require contractor compliance with federal and state laws and rules and regulations applicable to coverage for mental health or substance use disorder services including early and periodic screening

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and diagnostic and treatment services for children and youth in the medical assistance program;

(2) Make public the surveys, financial analyses, and contract audits and parity reports prepared by a contractor and the results of parity compliance reports;

(3) Ensure access to mental health and substance use disorder service providers, including access parity with medical and surgical service providers, through regulation and review of claims, provider reimbursement procedures, network adequacy, and provider reimbursement rate adequacy;

(4) Establish a monthly electronic communication system with all health care providers in the medical assistance program relating to any amendment or other change in the contracts with medicaid managed care organizations;

(5) Define network adequacy; and

(6) Annually post criteria used by the Division of Medicaid and Long-Term Care to assess network adequacy and each managed care organization's compliance on the Department of Health and Human Services website.

Sec. 5. Original sections 68-974, 68-995, and 68-996, Revised Statutes Cumulative Supplement, 2024, are repealed.