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LEGISLATURE OF NEBRASKA

ONE HUNDRED NINTH LEGISLATURE

FIRST SESSION

LEGISLATIVE BILL 381

Introduced by Fredrickson, 20.

Read first time January 16, 2025

Committee: Health and Human Services

A BILL FOR AN ACT relating to the Medical Assistance Act; to amend section 68-974, Revised Statutes Cumulative Supplement, 2024; to change requirements relating to program integrity and recovery audit contractors and program integrity audits as prescribed; to harmonize provisions; and to repeal the original section.

Be it enacted by the people of the State of Nebraska,

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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 one year ~~four years~~ from the date of the payment. After one year from the date of payment, a payment shall not be subject to adjustment, except in the case of fraud by a provider;

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

(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;

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(e) ~~(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 (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 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;

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

(h) Not require any requested documentation following an onsite audit sooner than ninety days from the date of the request to the provider for such information; and

(i) ~~(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

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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 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

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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. 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.

(b) No payment shall be recovered (i) in a medical necessity review in which the provider has obtained prior authorization for the service and the service was performed as authorized, (ii) for any part of a payment that the audit recovery contractor determines to be an overpayment if the recovery process is initiated later than one year after the payment was made to the provider, or (iii) for reimbursement based on a clerical error made by the provider.

(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 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

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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 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

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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 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

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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.

(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

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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) Clerical error means a minor mistake made while writing, typing, or copying, including typographical errors, missing signatures, miswritten numbers, word misspellings, mathematical errors, computer malfunctions, printing errors, or data entry errors;

(c) 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;

(d) ~~(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;

(e) 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;

(f) 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;

(g) ~~(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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(h) ~~(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;

(i) ~~(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

(j) ~~(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. Original section 68-974, Revised Statutes Cumulative Supplement, 2024, is repealed.