Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

New Mexico Comprehensive Program Integrity Review

Final Report

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INTRODUCTION

The Centers for Medicare and Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the New Mexico Medicaid program. The MIG review team conducted the onsite portion of the review at the New Mexico Human Services Department (NMHSD) offices. The review team also visited the office of the State's Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Quality Assurance Bureau (QAB), which is primarily responsible for program integrity. This report describes four effective practices, four regulatory compliance issues, and four vulnerabilities in the State's program integrity operations.

THE REVIEW

Objectives of the Review

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

Overview of New Mexico's Medicaid Program

The NMHSD administers the New Mexico Medicaid program. As of September 2007, the program served 408,628 recipients, approximately 61 percent of whom were enrolled with a managed care plan. The State had 15,879 providers participating in the fee-for-service (FFS) program. New Mexico contracts with four managed care entities (MCE) that had 14,610 enrolled providers. Medicaid expenditures in New Mexico for the State fiscal year (SFY) ending June 30, 2007 totaled $2,747,377,000. In SFY 2007, the Federal medical assistance percentage was 71.04 percent. Over the past three SFYs, NMHSD processed an average of 5,957,056 claims per year for its FFS providers. In SFY 2007, 85.7 percent of all FFS claims were submitted electronically.

Program Integrity Section

The QAB, located within the Medical Assistance Division, is the organizational component dedicated to the prevention and detection of provider fraud and abuse. The bureau is divided into two units, the Program Integrity Unit and the Program Oversight Unit. At the time of the review, the Program Integrity Unit had one bureau chief, one registered nurse, six auditors/investigators, one program integrity manager and one administrative staff. QAB had a total of six staff and two managers assigned to the surveillance and utilization review function. NMHSD utilizes a contractor to perform post-payment review of claims and to assist in the identification, recovery and prevention of overpayments. During SFY 2005 through SFY 2007, QAB staff conducted an annual

average of 273 preliminary investigations and 38 full audits.

The table below presents the total number of investigations, sanctions, identified overpayments, and amounts recouped in the past three SFYs as a result of program integrity activities.

Table 1

SFY	Number of Preliminary & Full Investigations	Number of State Administrative Actions or Sanctions (Approximation)	Amount of Overpayments Identified	Amount of Overpayments Collected
2005	104	0	$182,466	$182,466
2006	93	0	$4,818,264	$3,632,793
2007	623	5	$2,082,002	$1,914,297

Methodology of the Review

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

During the week of May 19, 2008, the MIG review team visited the NMHSD and MFCU offices. The team conducted interviews with numerous State officials, as well as with contractor representatives from the State's fiscal agent. Finally, to determine whether managed care contractors were complying with contract provisions and other Federal regulations relating to program integrity, the MIG team reviewed the contract provisions, gathered information from MCEs through interviews with representatives of four MCEs, and met with State staff responsible for managed care oversight.

Scope and Limitations of the Review

This review focused on the activities of the QAB. New Mexico's State Children's Health Insurance Program operates under Title XXI of the Social Security Act and was, therefore, not included in this review. Unless otherwise noted, NMHSD 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 NMHSD provided.

RESULTS OF THE REVIEW

Effective Practices

The State has highlighted several practices that demonstrate its commitment to program integrity. These practices involve comprehensive written policies and procedures, utilization of a contractor's data capabilities, and communication with MCEs and the MFCU.

Utilization of comprehensive written policies and procedures
The QAB has dedicated significant time and staff resources to develop comprehensive policies and procedures to guide all aspects of the division's work, as well as interactions with other State divisions, MCEs, and other stakeholders. The State relies heavily on these policies and procedures to ensure standards and protocols are followed, to actively train new employees, and to continually develop and update their program integrity work plans.

Utilization of a contractor's data capabilities
The QAB compensates for limited staff resources by utilizing advanced data mining and claims analysis software. The fiscal agent maintains a proprietary data warehouse and decision support system which can be used to rank providers, generate standard reports or develop customized reports. The State's SURS within the Medicaid Management Information System utilizes the capabilities of enhanced review products, which provides a peer to peer analysis across a provider-specific claim type, and an advanced data analysis and filtering tool which analyzes the global universe of claims for abnormalities.

The advanced data analysis and filtering tool is the primary tool for data analysis and reports can be generated in-house using defined filters. The fiscal agent provides QAB with access to all canned filters developed from their experience nationally and the fiscal agent is contractually required to add six new filters annually based on unique experiences in the State.

Monthly meetings with MCEs and the MFCU
The QAB has regular, scheduled monthly meetings in which the MCEs and the MFCU discuss fraud and abuse cases and provider compliance issues.

Additionally, the MIG review team identified one practice that is particularly noteworthy. The MIG recognizes the State's requirement for criminal history background checks for providers.

Criminal history background checks for providers
The State has implemented both statutory and administrative rules and regulations that require national criminal history background checks for direct care providers

and medical services providers. These requirements must be met prior to licensure or enrollment in Medicaid and include: The Caregivers Criminal History Screening Act (CCHS), Title 16, Chapter 10, Part 2, Part 7 of the New Mexico Governing Statutes and Rules, Provisions 61-6-11(G) of the Medical Practice Act and Provisions 61-3 of the Nursing Practice Act. New Mexico demonstrates a strong commitment to the prevention of abuse, neglect or financial exploitation of individuals receiving care.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations related to required disclosure and reporting requirements.

The State's MCE credentialing forms do not request ownership and control disclosures. The State's FFS provider enrollment forms do not request disclosure of any parent.
Under 42 CFR § 455.104(a)(1), a provider or "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. New Mexico's MCE provider credentialing forms do not request these disclosures prior to contracting with providers. In addition, the FFS provider enrollment documents do not request the disclosure of any parent as required by the regulation.

Recommendations: Require MCEs to modify their provider credentialing applications to request information required to be disclosed under 42 CFR § 455.104. Modify FFS enrollment applications to include parent disclosure.

The State's FFS provider enrollment packages and MCE contracts and credentialing applications do not require disclosure of business transactions.
The regulation at 42 CFR § 455.105(b) requires that, upon request, providers must furnish to the State or HHS information about certain business transactions with wholly owned suppliers or any subcontractor. New Mexico's FFS enrollment forms and MCE credentialing applications and contracts do not require disclosure of the specified business transactions.

Recommendations: Modify FFS enrollment forms to include disclosure upon request of the information identified in 42 CFR § 455.105. Require MCEs to modify credentialing applications and contracts to require such disclosure.

The State's MCE credentialing applications and contracts do not capture criminal conviction information.

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 HHS-OIG whenever such disclosures are made. A review of MCE credentialing applications and contracts, in addition to follow-up interviews with State and MCE staff, revealed that the MCEs are not collecting required disclosures on owners, agents, or managing employees. In addition, MCE contracts do not require MCEs to report such disclosures to the State agency. Therefore, the State is unable to report information disclosed during MCE provider credentialing to the HHS-OIG.

Recommendations: Require MCEs to modify their credentialing applications to request information required to be disclosed under 42 CFR § 455.106. Develop and implement a procedure to obtain relevant information from the managed care programs, and refer that information to HHS-OIG as required.

The State does not report adverse actions it takes on MCE provider applications and MCEs do not always inform the State of adverse actions in MCE provider credentialing.

The regulation at 42 CFR §1002.3(b) requires reporting to the U.S. Department of Health & Human Services, Office of Inspector General (HHS-OIG), any adverse actions a State takes on provider applications for participation in the program. A review of New Mexico's MCE contracts, in addition to follow-up interviews with State and MCE staff, demonstrated that the State does not require MCEs to report adverse action taken on a credentialing application. Without being notified of adverse actions in MCE credentialing, the State cannot report appropriate adverse actions to HHS-OIG.

Recommendations: Require MCEs to notify the State when the MCE takes adverse action against a provider's participation in the program, including when it denies credentials for fraud-related concerns. Develop and implement procedures to report to HHS-OIG all adverse actions and limitations placed on providers applying to participate in the program.

Vulnerabilities

The review team identified four areas of vulnerability in New Mexico's practices regarding limits placed on the ability of the MFCU to prosecute fraud cases, MCE reporting of suspected fraud and abuse, verification of receipt of managed care services, and providers employing or contracting with excluded individuals.

Limiting the ability of the MFCU to prosecute fraud cases.
Although the number of referrals to the MFCU has increased over the past three years, the State's process for determining when to refer a case limits the ability of the MFCU to prosecute fraud cases.

State staff indicated that the determination to refer a case to the MFCU is based on: 1) the conclusion of the preliminary investigation; 2) the degree to which it violates policy or law; 3) the merits of the case; and 4) a determination of the intent of the party. Steps 2 through 4 of the above process limit the MFCU's authority to determine the prosecutorial merits of all suspected cases of fraud. While it is true that the definition of "suspected" fraud is vague, the QAB should not make decisions which are under the purview of the MFCU, such as intent. The MFCU needs to determine if it can prove intent.

Recommendations: Work with the MFCU to revise the process for referring potential fraud cases to the MFCU. If necessary, update the current Memorandum of Understanding between the State agency and the MFCU to specifically address the preliminary investigation by the State agency or MCE, the referral, and the roles and responsibilities of each to determine and investigate fraud and abuse.

Not consistently reporting suspected provider fraud and abuse to the State.
The review team identified discrepancies in some MCE quarterly reports of suspicious activity and the QAB database of all cases of suspected fraud and abuse. Both QAB and the MCEs' special investigative units described processes by which all cases of suspected fraud are referred to the QAB and tracked using the QAB's fraud database. The MIG review team chose five cases from the quarterly reports that had an allegation code corresponding to fraudulent activity (e.g. services billed but not rendered.) When these cases were checked against the QAB database, none were currently being tracked. These discrepancies called into question whether the State was being informed by the MCEs, as contractually required, of all cases of suspected fraud and abuse and was, therefore, able to make an informed referral to the MFCU regarding MCE cases.

Recommendation: Strengthen policies and procedures regarding oversight of MCE program integrity efforts to ensure that all cases of suspected fraud identified by the MCEs are reported to the State within the contractually specified timeframes, referred when a preliminary investigation has been completed, and full investigations by the MCEs are halted until the MFCU has determined the merits of the case.

Not having a method for verifying with recipients whether services billed by providers were received.
The regulation at 42 CFR § 455.20 requires the Medicaid agency to have a method to verify with recipients whether they received services billed by providers. The State agency does verify FFS enrollees' receipt of service. However, all four MCEs interviewed

indicated that they were not contractually required to verify receipt of services, nor is the State verifying the receipt of those managed care services using Explanation of Medical Benefits notices or through any other method.

Recommendation: Develop and implement procedures for verifying the receipt of services for Medicaid beneficiaries served through managed care.

Not ensuring that enrolled provider entities are not employing or contracting with excluded individuals.

The New Mexico Bureau of Planning and Program checks a provider seeking enrollment against the List of Excluded Individuals/Entities (LEIE) to determine that the provider entity is not an HHS-OIG excluded entity. However, direct care workers employed or contracted with an enrolled provider entity are not checked for exclusions against the LEIE. Therefore, the State has no assurances that the workers employed by these enrolled provider entities are not excluded. This specifically relates to "entities" enrolled by Medicaid (e.g., home health, personal care) that hire persons to provide direct services to Medicaid recipients.

Recommendation: Ensure that enrolled providers are aware of the prohibition associated with employing or contracting with an excluded individual. Ensure that the provider enrollment process includes the required LEIE or Medicare Exclusion Database searches.

CONCLUSION

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

- comprehensive written policies and procedures
- utilization of a contractor's data capabilities
- monthly meetings with MCEs and the MFCU
- statutory rules and administrative regulations requiring criminal background checks of direct service providers.

CMS encourages the State to look for additional opportunities to improve overall program integrity.

However, the identification of four areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, four vulnerabilities were identified. CMS encourages New Mexico to closely examine each area of vulnerability that was identified in this review.

It is important that these issues be rectified as soon as possible. To that end, we will require the State to provide a corrective action plan for each area of non-compliance within 30 calendar days of the date of the final report letter. Further, we will request that 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 New Mexico will ensure that the deficiencies will not recur. The corrective action plan should include the timeframes for each correction along with the specific steps you expect 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 this letter. If New Mexico 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 New Mexico on building upon effective practices, correcting its regulatory compliance issues, and eliminating its vulnerabilities.