Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

New Mexico Comprehensive Program Integrity Review

Final Report

May 2012

Reviewers:
Barbara Davidson, Review Team Leader
Richard Colangelo
Eddie Newman
Gloria Rojas
Joel Truman, Review Manager

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Introduction

The Centers for Medicare & 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's (NMHSD) Medical Assistance Division (MAD). The review team also met with the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Program Integrity Unit (PI Unit) within the Quality Assurance Bureau (QAB), which is responsible for Medicaid program integrity in New Mexico. This report describes two effective practices, five 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 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 January 1, 2011, the program served a total of 500,339 beneficiaries, with 375,187 of those beneficiaries enrolled with a managed care plan. New Mexico has seven managed care entities (MCEs). At the time of the review, NMHSD had 18,698 Medicaid fee-for-service (FFS) providers. Medicaid expenditures in New Mexico during State fiscal year (SFY) 2010 were $2,875,707,887.

Program Integrity Section

The PI Unit, located within the QAB, is the organizational component dedicated to fraud and abuse detection activities. At the time of the review the PI Unit had nine full-time equivalent staff focusing on Medicaid program integrity. The table below represents the total number of investigations, identified overpayments, and amounts recouped in the past four SFYs as a result of program integrity activities. In SFY 2008, New Mexico's audit contractor completed a last set of algorithms prior to the expiration of its contract. In SFYs 2009 and 2010, QAB's limited staff conducted audits without the assistance of a contractor.

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Amount of Overpayments Identified	Amount of Overpayments Collected
2007	9	9	$1,286,134.36	$1,286,134.36
2008	20	20	$4,864,637.05	$4,788,302.42
2009	20	20	$1,394,999.01	$1,408,393.57
2010	71	71	$2,960,124.58	$2,972,123.41

*Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation.
**Full investigations are resolved through a referral to the MFCU or administrative or legal disposition. In 2010, the MFCU directed the PI Unit to forward all cases where allegations of fraud were suspected so MFCU could determine whether a full investigation was necessary.

Methodology of the Review

In advance of the onsite visit, the review team requested that New Mexico complete a comprehensive review guide and supply documentation to support 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 onsite visit.

During the week of May 16, 2011, the MIG review team visited the QAB and the State Office of the Attorney General which housed the MFCU acting director. The team conducted interviews with numerous MAD officials, the State's provider enrollment contractor and the MFCU acting director. In order to determine whether managed care plans were complying with the contract provisions and Federal regulations relating to program integrity, the MIG team reviewed the State's MCE contracts. The team also conducted in-depth interviews with representatives from four MCEs and met separately with MAD staff to discuss managed care oversight and monitoring efforts. Additionally, the team conducted sampling of provider enrollment applications, case files, selected claims and other primary data to validate the State's program integrity practices. To determine whether non-emergency medical transportation (NEMT) providers were complying with contract provisions and other Federal regulations relating to program integrity, the MIG review team interviewed additional MAD staff.

Scope and Limitations of the Review

This review focused on the activities of the QAB. New Mexico operates an expansion Medicaid Children's Health Insurance Program (CHIP) under Title XIX of the Social Security Act. The CHIP program operates under the same billing and provider enrollment policies as the New Mexico Medicaid program. The same findings, vulnerabilities, and effective practices discussed in relation to the Medicaid program also apply to CHIP.

Unless otherwise noted, New Mexico 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 MAD provided.

Results of the Review

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. New Mexico reported its self-audit program and criminal history background checks for providers.

Provider self-audit program

New Mexico's self-audit program enables the State to capture more improper payments than program integrity staff could do alone through State-initiated audits and investigations. The Medicaid agency does not require providers to conduct self-audits, however if the provider chooses not to participate in the self-audit then the PI Unit conducts a full audit of that provider.

In 2010, the PI Unit identified 65 providers that were not in compliance with billing requirements. The unit mailed letters to all 65 providers. All were informed as to which claims were being questioned and were required to conduct a self-audit to explain the rationale for the claims. The providers that agreed that the claims were incorrect were instructed to adjust the claim or refund the money to the State agency. If the provider agreed to the self-audit and identified an overpayment, but did not respond within the time frame specified by the State, the funds were automatically recovered. At the time of the review, 82 percent of the providers had responded and the State had recovered $38,197.

Criminal history background checks for providers

As part of the provider application (certification) process, the State requires that any individual (specifically owners and their administrative staff) who will have "direct, unsupervised contact with clients" must adhere to the Caregivers Criminal History Screening Act, 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. The Caregivers Criminal History Screening Act requires employees and caregivers to submit consent form documents, personal identification documents, fingerprints and fees required for a nationwide criminal history screening in order to be employed.

This program is an essential piece in the enforcement of the Department of Health's policy of "Zero tolerance of abuse, neglect and exploitation" and is part of the Division of Health Improvement's mission of enhancing the quality of health systems for all New Mexicans. This prevents persons who have been convicted of certain crimes from working with individuals receiving health care services. The law is very specific about the conviction history and the care provider's responsibility, as well as the types of crimes and convictions covered. However, New Mexico has other disclosure issues which are discussed in the Regulatory Compliance Issues section of this report.

Regulatory Compliance Issues

New Mexico is not in compliance with Federal regulations related to disclosure requirements, suspension of payments when referring cases to the MFCU and exclusion searches.

The State has not implemented the new provisions of the regulation to suspend payments in cases of credible allegations of fraud.

The program integrity regulation at 42 CFR § 455.23 has been substantially revised and the amendment was effective March 25, 2011. The regulation as amended requires payment suspension pending investigations of credible allegations of fraud and referral to the MFCU, or other law enforcement agency if there is no certified MFCU in the State. The CMS released an Informational Bulletin and Frequently Asked Questions to States on March 25, 2011. In addition, CMS has provided States numerous opportunities, including national teleconferences and sessions during two Medicaid Integrity Institute courses, to learn more about the payment suspension regulation since it became effective on March 25.

According to the State, the PI Unit referred two cases to the MFCU since March 25, 2011. At the time of the onsite review, the State had not suspended payment to those providers as required under § 455.23(a)(1). The total amount that was paid since March 25, 2011 was reported to be $282,354.30 as of June 27, 2011. These payments should have been suspended after the case was referred to the MFCU, unless the MFCU requested a good cause exception to not suspend payments or the PI Unit exercised one of the other good cause exceptions not to suspend payments in whole or in part. The team found no documentation that a good cause exception was invoked.

Recommendation: Suspend payment upon referring cases to the MFCU based on credible allegations of fraud unless a good cause exception is exercised and documented accordingly.

The State is not collecting complete ownership and control information from FFS providers, MCEs, and the fiscal agent. (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 42 CFR§ 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 42 CFR§ 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 42 CFR§ 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 42 CFR § 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.

Of the familial relationships that must be disclosed, the State's FFS provider enrollment documents do not request the disclosure of any parent as required by § 455.104(a)(2). The State's FFS provider participation agreement is missing the date of birth (DOB) information for managing employees. The State's provider participation agreement also does not solicit the DOB information from persons with an ownership or control interest in the disclosing entity, and enhanced address information for corporate entities that have an ownership or control interest in the disclosing entity: primary business address, every business location, and P.O. Box address.

Additionally, the State does not collect the required ownership and control disclosures from its fiscal agent and MCEs. The State's fiscal agent and managed care contracts do not solicit the names of managing employees, their Social Security Number (SSN), address and DOB.

This is a repeat finding from the 2008 CMS program integrity review.

Recommendation: Develop and implement policies and procedures and modify provider enrollment forms and contracts to require and collect all required disclosure information.

The State does not require FFS providers and MCEs to submit business transaction information, upon request. (Uncorrected Repeat Finding)

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.

This is a repeat finding from CMS' 2008 review. The State agency currently uses the same FFS provider agreement that was used in 2008, which does not have the language required by 42 CFR § 455.105. In addition, the State-MCE contracts do not require submission of business transaction information upon request by the State or the HHS Secretary.

Recommendation: Modify provider agreements and contracts to include language specific to 42 CFR § 455.105.

The State's FFS enrollment forms and MCE contracts do not request health care-related 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 application 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 State's FFS provider enrollment application does solicit health care-related criminal conviction information from key parties affiliated with the provider applicant. However, the FFS application and MCE contracts do not ask for the required disclosures from persons with ownership and control interests and only request this information from agents or managing employees of the provider at the time of enrollment.

Recommendation: Modify the provider enrollment application and contracts to require solicitation and disclosure of health care-related criminal convictions from FFS providers and MCEs.

The State does not conduct complete searches for individuals and entities excluded from participating in Medicaid.

Effective March 25, 2011, the Federal regulation at 42 CFR § 455.436 requires that the State Medicaid agency must check the HHS-OIG's List of Excluded Individuals/Entities (LEIE) and the General Services Administration's Excluded Parties List System (EPLS) no less frequently than monthly.

Prior to implementation of this new regulation, CMS issued a State Medicaid Director Letter (SMDL) #08-003 dated June 16, 2008 providing guidance to States on checking providers and contractors for excluded individuals. That SMDL recommended that States check either the LEIE or the Medicare Exclusion Database (MED) upon enrollment of providers and monthly thereafter. States should check for providers' exclusions and those of persons with ownership or control interests in the providers. A follow-up SMDL (#09-001) dated January 16, 2009 provided further guidance to States on how to instruct providers and contractors to screen their own employees and subcontractors for excluded parties.

The State checks FFS providers and disclosed persons with ownership and control against the LEIE database at the time of enrollment and then on a monthly basis. However, disclosures about persons with ownership and control interests in MCE contractors and managing employees were not being collected, leaving the range of the exclusion checking incomplete. In addition, at the time of the review, the State had not begun checking the EPLS for individuals and entities debarred from Federal contracting per the regulation at 42 CFR § 455.436.

Recommendations: Develop policies and procedures for appropriate collection and maintenance of disclosure information required under 42 CFR § 455.436. Search the LEIE (or the MED) and the EPLS upon enrollment, reenrollment, and at least monthly thereafter, by the names and other identifying information of the above persons and entities, to ensure that the State does not pay Federal funds to excluded persons or entities.

Vulnerabilities

The review team identified six areas of vulnerability in New Mexico's program integrity practices. These related to verification of services billed by providers, collection of disclosure information, reporting adverse actions to HHS-OIG, and exclusion searches.

Not verifying with managed care beneficiaries whether services billed by providers were received.
While New Mexico meets the requirements of 42 CFR § 455.20 by sending explanations of medical benefits (EOMBs) to FFS beneficiaries, one of the MCEs does not send EOMBs to its beneficiaries. During an interview, the MCE indicated that it does not perform any verification of beneficiary services.

Recommendation: Develop and implement policies and procedures for verifying with managed care beneficiaries whether billed services were received.

Not collecting ownership and control disclosure information from MCE network providers.
The MCEs do not collect all ownership and control disclosures from network providers that Federal regulations at 42 CFR § 455.104 would otherwise require for FFS.

The MCEs' applications do not collect the full range of ownership and control disclosures from their network providers. One of the State's MCEs does not solicit managing employee information in its credentialing applications. Thus, the State would have no way of knowing if excluded individuals are working for providers or health care entities in such positions as billing managers and department heads. Another MCE does not capture this information on the application but requires the provider to do the exclusion checks. However, the MCE does not verify that the providers are performing the exclusion checks.

The provider applications for two of the three MCEs do not require providers to provide complete ownership, control, and relationship information specified under 42 CFR§ 455.104. They are not capturing the information of any person who might be a spouse, parent, child, or sibling of the provider. Additionally, these applications are not capturing the DOB or SSN as required effective March 25, 2011 in the updated regulations. They are also not capturing enhanced address information for corporate entities that have an ownership or control interest in the disclosing entity.

Recommendation: Modify the managed care network provider applications to require the full range of disclosures at 42 CFR § 455.104.

Not requiring the disclosure of business transaction information from MCE network providers.
The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or HHS, information about certain business transactions with wholly owned suppliers or any subcontractors.

Two of the three MCEs do not require network providers to disclose the business transaction information on request. Specifically, the MCEs do not require providers to agree to submit, within 35 days of the date of the request, information about the ownership of any subcontractor

with whom the provider has had business transactions totaling more than $25,000 during the previous 12 month period and any significant business transactions between the provider and any subcontractor during the 5-year period ending on the date of the request.

Recommendation: Modify the MCE contracts to require disclosure upon request of the information identified in 42 CFR § 455.105(b)(2).

Not capturing the full range of criminal conviction information from MCE network providers.

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. Pursuant to 42 CFR § 455.106(b)(1), States must report criminal conviction information to HHS-OIG within 20 working days.

Two of the three MCE network provider applications do not require the providers to disclose the health care-related criminal conviction information which Federal regulations at 42 CFR § 455.106 would otherwise require of FFS providers. The application does not contain language with sufficient specificity to meet the regulatory requirement. In addition, persons with ownership or control interest in network providers and managing employees and agents are not asked for similar disclosures.

Recommendation: Develop and implement policies and procedures to collect health care-related criminal conviction information from MCE network providers and to report relevant disclosures submitted by all providers to HHS-OIG as required.

Not reporting all adverse actions taken on provider applications to HHS-OIG.

Although the State contractually requires MCEs to report provider terminations to MAD, all three of the MCEs interviewed reported that neither the State nor HHS-OIG is notified whenever the MCE denies credentialing or enrollment of a provider where denial of credentialing or enrollment is due to concerns other than fraud, such as integrity or quality. One MCE reported that there was no contractual requirement to report denial of credentialing or enrollment where integrity or quality was a concern. The State is therefore unable to make the required report to the HHS-OIG, as the regulation at 42 CFR §1002.3(b)(3) would require for FFS.

Recommendation: Develop and implement policies and procedures for reporting adverse actions taken on provider applications to HHS-OIG.

Not conducting complete searches for individuals and entities excluded from participating in Medicaid.

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. If the State

neither collects nor maintains complete information on owners, officers, and managing employees in the Medicaid Management Information System, then the State cannot conduct adequate searches of the LEIE or the MED.

The CMS issued SMDL #08-003 dated June 16, 2008 providing guidance to States on checking providers and contractors for excluded individuals. That SMDL recommended that States check either the LEIE or the MED upon enrollment of providers and monthly thereafter. States should check for providers' exclusions and those of persons with ownership or control interests in the providers. A follow-up SMDL (#09-001) dated January 16, 2009 provided further guidance to States on how to instruct providers and contractors to screen their own employees and subcontractors for excluded parties, including owners, agents, and managing employees. A new regulation at 42 CFR § 455.436, effective March 25, 2011, now requires States to check enrolled providers, persons with ownership and control interests, and managing employees for exclusions in both the LEIE and the EPLS on a monthly basis.

Two of the three MCEs interviewed indicated that they were not checking network providers on an ongoing basis in the LEIE and EPLS. As the plans are not collecting the full range of ownership and control disclosures and one does not solicit managing employee information, the MCEs were also not in a position to identify all of the individuals and entities that should be checked on a regular basis. In the NEMT program, which is administered by the MCEs, neither the State's compliance managers nor the contracted NEMT brokers collect the required disclosures that must be checked for exclusions and debarments.

Recommendation: Amend the contract to require the appropriate collection and maintenance of disclosure information about disclosing entities, and about any person with a direct or indirect ownership interest of 5 percent or more, or who is an agent or managing employee of the disclosing entity, or who exercises operational or managerial control over the disclosing entity. Require the contractor to search the LEIE and the EPLS upon enrollment, reenrollment, credentialing or recredentialing of network providers, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded persons or entities.

Conclusion

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

- Provider self-audit program enhanced by the PI Unit, and
- Criminal history background checks for providers

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

However, the identification of five 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 QAB 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 New Mexico 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 New Mexico 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 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 correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.

Official Response from New Mexico
June 2012

New Mexico Human Services Department
Medical Assistance Division
PO Box 2348
Santa Fe, NM 87504-2348

Susana Martinez, Governor
Sidonie Squier, Secretary-Designate

June 12, 2012

Ms. Angela Brice-Smith, Director
Medicaid Integrity Group/Center for Program Integrity
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mailstop: AR-18-15
Baltimore, MD 21244-1850

RE: Response to May 15, 2012 Correspondence regarding the Medicaid Integrity Group Review of the New Mexico Medicaid Program Integrity Procedures and Processes.

Dear Ms. Brice-Smith:

Thank you for the opportunity to review the "Medicaid Integrity Program, New Mexico Comprehensive Program Integrity Review Final Report" that resulted from the Medicaid Integrity Group's May 2011 Review.

Please accept the enclosed corrective action plan in response to your request. This documents our efforts to correct any of the findings or vulnerabilities that were identified in the report. As noted, many of these items have been corrected as part of our modifications to contract language that will become effective July 1, 2012 for contract fiscal year 2013. The implementation date for one of the items identified will exceed your stated ideal 90-day window from the date of your letter. However, implementing the system changes required to comply with the requirement will be addressed during our standard contracting process; it is the most efficient use of limited resources and it will enable us to comply with the identified issue in a time manner.

Per your direction, this communication will also be provided electronically to Robb Miller, Director of the Division of Field Operations, at Robb.Miller@cms.hhs.gov . Should you have any questions or concerns, please contact Paula McGee at (505) 827-6234 or via email at Paula.McGee@state.nm.us .

Sincerely,

Julie B. Weinberg
Medical Assistance Division Director

Ea/sc

Enclosure

c: Sidonie Squire, Secretary, HSD
Brent Earnest, Deputy Secretary, HSD
Jackie Garner, CMCHO Consortium Administrator
Bill Brooks, DMCHO Associate Regional Administrator
Sandra Chavez, Quality Assurance Bureau Chief, MAD
Everet Apodaca, Program Integrity Manager, MAD
Paula McGee, Healthcare Operations Manager, MAD
Jody Curran, Medicaid Fraud Control Unit Director, MN AG