Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

New Mexico Focused Program Integrity Review

Final Report

March 2020

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Executive Summary

The Centers for Medicare & Medicaid Services (CMS) is committed to performing program integrity reviews with states in order to identify risks and vulnerabilities to the Medicaid program and assist states with strengthening program integrity operations. The significance/value of performing onsite program integrity reviews include: (1) assess the effectiveness of the state's PI efforts, including compliance with certain Federal statutory and regulatory requirements, (2) identify risks and vulnerabilities to the Medicaid program and assist states to strengthen PI operations, (3) help inform CMS in developing future guidance to states and (4) help prepare states with the tools to improve PI operations and performance.

The CMS conducted a focused review of New Mexico to determine the extent of program integrity oversight of the managed care program at the state level and to assess the program integrity activities performed by selected managed care organizations (MCOs) under contract with the state Medicaid agency.

During the week of August 6, 2019, the CMS review team visited the offices of New Mexico's single state Medicaid agency, the New Mexico Human Services Department (HSD). The Medical Assistance Division (MAD) administers the Medicaid program with support from other HSD Divisions such as the Behavioral Health Services Division (BHSD) who manages behavioral health components and the Office of Inspector General (OIG) who provides Program Integrity functions. The onsite review involved conducting interviews with the OIG's Internal Audit Bureau and Program Integrity Unit (PIU), other HSD officials, as well as numerous staff from MAD's twelve Bureaus and two contracted MCOs. In addition, the CMS review team conducted sampling of program integrity cases referred by the MCOs special investigations units (SIUs), as well as other primary data in order to validate the state and the selected MCOs' program integrity practices.

Summary of Recommendations

The CMS review team identified a total of 10 recommendations for the state of New Mexico based upon their responses to the completed focused review modules and supporting documentation, as well as discussions and/or interviews with key stakeholders. The recommendations were in the following areas: State Oversight of Managed Care Program Integrity Activities, MCO Investigations of Fraud, Waste, and Abuse, Overpayments and Recoveries and Terminated Providers and Adverse Action Reporting. The recommendations will be detailed further in the next section of the report.

Overview of New Mexico Medicaid

- The HSD is the single state agency charged with overseeing the medical assistance plans in New Mexico.
- The HSD OIG-PIU is the organizational unit responsible for the overall program integrity operations, although other units within the organization maintain specific delegated program integrity related responsibilities.
- In 2018, New Mexico's total Medicaid program expenditures were approximately $5.43 billion. The Federal Medical Assistance Percentage matching rate was 78.87 percent.
- The Medicaid enrollment increased to approximately 824,000 beneficiaries in federal fiscal year (FFY) 2018. This includes the "Medicaid-expansion" population through the Affordable Care Act of 2014.

Overview of Managed Care in New Mexico

- In 2018 New Mexico's managed care Medicaid expenditures exceeded $4 billion.
- New Mexico managed care serves approximately 662,000 beneficiaries or approximately 80

- percent of the Medicaid population. Through 2018 New Mexico beneficiaries were enrolled in four MCOs through a five-year 1115 Waiver, Centennial Care (1.0). Two of the MCOs were no longer contracted with HSD at the time of this 2019 review. New Mexico contracted with a new MCO through a five-year renewal of its 1115 Waiver, Centennial Care (2.0), which began in 2019.
- Approximately 20 percent of the Medicaid beneficiaries are enrolled in the state's fee-for-service (FFS) program receiving both full (8 percent) and partial (12 percent) Medicaid services. Approximately 90% of the population receiving full FFS Medicaid services are Native Americans.
- During the onsite review, New Mexico's current MCOs were interviewed; Presbyterian Health Plan (PHP), Blue Cross Blue Shield of New Mexico (BCBSNM) and Western Sky Community Care. However, since Western Sky Community Care was inactive during the review period, they are not included in this review report. Enrollment/SIU and expenditure data for each MCO is provided in Table 1 and Table 2 below.

Table 1.

	PHP	**BCBSNM**
Beneficiary enrollment total	365,580	147,486
Provider enrollment total	4,056	18,472
Year originally contracted	1997	2008
Size and composition of SIU	12	2
National/local plan	Local	National

Table 2.

MCOs	**FFY 2016**	**FFY 2017**	**FFY 2018**
PHP	$1,128,125,612	$1,138,794,463	$1,221,994,536
BCBSNM	$892,500,000	$1,013,700,000	$1,056,100,000

*****Expenditure amounts depicted were verified by the MCOs.

Results of the Review

The CMS review team identified one managed care regulatory compliance issue and nine areas of concern for a total of ten areas of risk related to the state's Medicaid managed care program integrity activities. CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved as soon as possible.

These issues and CMS' recommendations for improvement are described in detail in this report.

State Oversight of Managed Care Program Integrity Activities

The state Medicaid agency oversees the Medicaid managed care program with limited program integrity staffing. There are currently five positions filled in the OIG-PIU. The OIG-PIU workload is predominately FFS although they do have program integrity responsibility in the state's managed care program. At the time of this review, there was an acting Program Integrity Director in place and one of the OIG-PIU's FTEs was vacant. Therefore, the CMS review team acknowledged that the OIG-PIU has limited staffing in place in order to best accomplish the responsibilities of administering its program integrity activities, as it relates to auditing MCOs and providers, conducting preliminary provider investigations, and the processing of referrals.

New Mexico's general Medicaid managed care contract with its MCOs is comprised of a seven-page program integrity section (Section 4.17 Program Integrity). The contract contained general language but did not have specific policies and procedures in key areas of program integrity operations. The state's oversight of program integrity would be positively impacted when managed care contracts clearly define and outline operational requirements for MCOs. The New Mexico MCOs comply with the standard requirements relative to 42 CFR 438.608 in regards to having a general compliance plan. Staff from the MCOs discuss components of the compliance plan with HSD staff at the monthly program integrity meeting. The MCOs also provided CMS with a customized and detailed statewide fraud, waste, and abuse plan, which address the unique nature of the state's program integrity environment.

Occasionally, the MCOs understanding the performance of their program integrity requirements for the Medicaid program varied across plans based upon the pre- review documentation submitted by the MCOs and their responses to the onsite interview questions. The CMS review team determined that improvements in the state's managed care contractual language would help reduce and /or eliminate the inconsistencies across the MCOs in operationalizing program integrity activities.

The CMS review team identified a lack of state program integrity oversight due to the state not independently conducting preliminary investigations on any managed care providers in the past three FFYs. During the review, the OIG-PIU mentioned they were not independently conducting any preliminary investigations of managed care cases of suspected fraud, waste, and abuse. However, NM's Medicaid Recovery Audit Contractor (RAC) is contracted to conduct audits on managed care providers. In addition, the RAC is expanding its audits and may submit referrals to the OIG Investigations Bureau for review. The OIG Investigations Bureau conducts investigations as a result of receiving referrals involving fraud, waste, and abuse. At the time of the review, the state had not conducted any preliminary investigations as a result of a RAC referral. Furthermore, since HSD is not conducting any state-initiated managed care preliminary investigations, it relies solely on the MCO's to refer and investigate suspected fraud, waste, and abuse in its managed care program. In light of the number of risk identified in this report, the state should conduct its own managed care provider preliminary investigations. The CMS review team noted that HSD has a shortage of FTEs assigned to its program integrity unit, which may be a barrier to conducting independent managed-care preliminary investigations.

Recommendation#1 - The state should implement a plan that permits the performance of independent preliminary investigations of its contracted MCO providers.

The state currently has a contract with Optum Insight and Qlarant to conduct algorithms, run data analysis and perform audits for the state. Optum Insight performs algorithms to identify provider outliers for the PIU and stores the case tracking system that the PIU uses for its fraud waste and abuse referrals. The CMS team did not review the case tracking system associated with Optum Insight. However, the state reported it tracks all cases that are reported by the MCOs, including referrals to the

Medicaid Fraud Control Unit (MFCU), in the Fraud Abuse Detection System (FADS). Qlarant, performs data analysis, identifies potential audit areas, and performs provider audits on behalf of the PIU. The PIU, at times, uses the results from Optum Insight's algorithms to help direct Qlarant.

Although the FADS appeared to be an adequate case tracking system for the state, the MCOs tracking of cases was less than adequate. The case tracking system used by the MCOs did not allow the MCOs to provide the CMS review team with the detailed information about the many facets of each case including specifics on the original source, as well as the current disposition of the case. During on-site interviews, both MCOs mentioned having problems with the level of detail their case tracking system allowed the user to obtain. Therefore, the state should improve its oversight by requiring MCOs to improve their case tracking system to allow the MCOs to provide the level of case detail required by the state during all phases of the lifecycle of a case, including the final disposition of the case. This action will allow the MCO to provide a detailed status update of all cases from the initiation of a case through the final disposition.

Recommendation#2 - The State should require MCOs to improve their case tracking system in order to maintain detailed tracking elements for all cases from the initiation of a case through the final disposition, in order to have a reliable auditing trail for all managed care cases investigated by its MCOs.

Relative to the concern with the case tracking system, BCBSNM reported that the source field was not always captured, and specifically as it relates to the MCOs requirement to verify with beneficiaries that services are being rendered appropriately and billed accurately. For example, if the call center at BCBSNM receives a call resulting from a verification of services letter previously mailed to the beneficiary the source information is not captured.

Therefore, the SIU is unable to identify whether or not the verification of services process produces any case referrals or investigations. Since the source information is not maintained, the state nor the MCO has the ability to measure the effectiveness of the verification process being performed within its managed care program.

Recommendation#3 - The state should consider the following actions in order to improve the MCO beneficiary verification of services : (1) require the MCOs to develop and implement procedures to ensure the source information for MCO beneficiary verification of services process is obtained (2) the state should require MCOs to track the source, analyze the effectiveness of the EOB verification method in place and share lessons learned across the plans and (3) the MCOs should maintain the capability to provide the state with the number of cases resulting from the EOB beneficiary verification process in place.

In addition, the current *Annual Audit Tool* that was provided to the CMS review team was limited in scope as it contains only nine program integrity elements. The tool did not address the program integrity areas of risk that are identified in this report. Therefore, the state should enhance its annual auditing tool in order to cover all program integrity activities as required by the general managed-care contract, amendments and other policies and procedures. An enhanced auditing tool will allow the state to have greater assurance towards holding the MCOs accountable in meeting all contract-related program integrity activities.

Recommendation#4 - The state should consider revising, implementing and updating as necessary, an improved HSD program integrity auditing tool, as well as revising the program integrity section of the contract as needed in order to ensure all elements of the auditing tool are connected to a contract

requirement.

Provider Enrollment

All New Mexico providers who seek participation in the Medicaid managed care program must first enroll in Medicaid through an online provider portal. The state performs all of the required provider enrollment activities in accordance with the requirements of 42 CFR 455, subparts B and E. Upon HSD's approval of the application, the providers may seek to secure contracts with participating MCOs.

The CMS review team identified several oversight concerns, including one regulatory compliance issue pertaining to the lack of revalidating its participating providers within the required time period. The State does not revalidate enrollment of all provider types every five years. The federal regulation at 42 CFR 455.414 requires that the State Medicaid agency revalidate the enrollment of all providers regardless of provider type at least every five years. Revalidation of enrollment is a critical activity and impacts other enrollment requirements therefore, the state should address this regulatory requirement promptly.

Recommendation#5 - The state should ensure compliance with the requirements at 42 CFR 455.414 revalidation of enrollment for all provider types at least every five years.

MCO Investigations of Fraud, Waste, and Abuse

As required by 42 CFR 455.13, 455.14, 455.15, 455.16, 455.17, and supported by the Medicaid Managed Care Final Rule (42 CFR 438.608), the state does have an established process for the identification, investigation, referral and reporting of suspected fraud, waste, and abuse by providers and MCOs. The OIG-PIU stated that program integrity meetings to discuss processes and procedures, status of cases, and referral best practices are held monthly and include the MCOs SIU, various HSD divisions and bureaus, New Mexico Department of Health, New Mexico Children Youth and Families Department, and the MFCU.

The MCOs conduct preliminary investigations, full investigations and audits and refer cases of suspicious provider activity to the OIG-PIU. The OIG-PIU primarily considers these referrals by the MCOs as preliminary investigations. The MCOs report the start of a preliminary investigation within 5 days and in general, referrals occur daily.

The state should require MCOs to improve their MCO SIU staffing requirements. The state's contract with its MCOs declares that the MCO shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the MCOs in preventing and detecting potential fraud, waste, and abuse. The contract does not specifically describe what constitutes adequate staffing, nor does it identify a minimum staffing ratio for MCO SIUs. The state should research common industry trends, tailor the results to fit their particular state Medicaid population and unique dynamics and ultimately determine if a staffing ratio is warranted. Therefore, based on these MCO SIU staffing concerns, the state should review its contract language and determine if SIU staffing ratio should be incorporated into its contract with MCOs.

Recommendation#6 - The state should ensure that MCOs are allocating sufficient resources to the prevention, detection, investigation, and referral of suspected provider fraud and determine appropriate staffing ratios for the MCOs to ensure adequate staffing and resources are maintained to assist the MCOs in preventing and detecting potential fraud, waste, and abuse.

New Mexico's contract with its MCOs includes broad language that states, "the MCOs program integrity

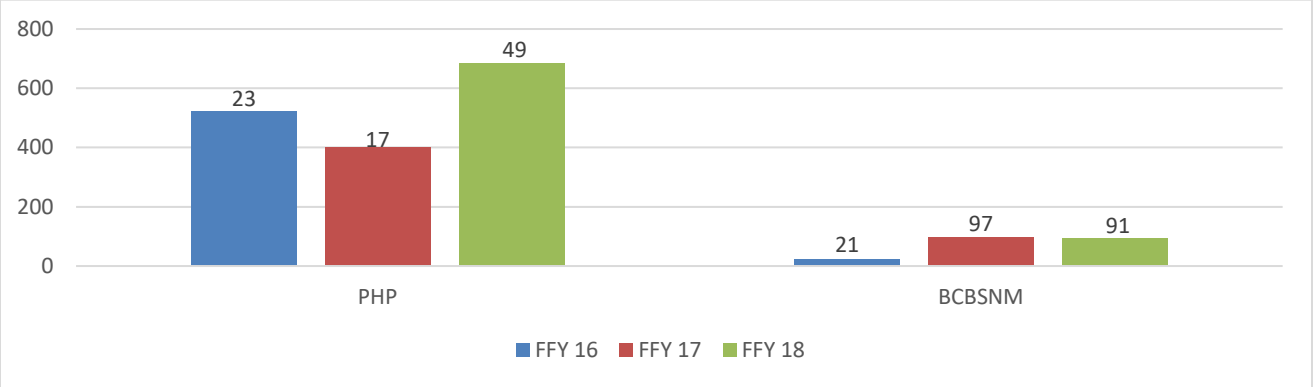
program shall comply with all program integrity provisions regarding Fraud, Waste and Abuse, including but not limited to, sections 1128, 1156 and 1902(a)(68) of the Social Security Act, section 6402(h) of Patient Protection and Affordable Care Act, the CMS Medicaid integrity program and the Deficit Reduction Act of 2005". In addition, the state's general MCO contract Section 4.17.3.2.8 states, that MCOs must include work plans for conducting both announced and unannounced site visits and field audits to contracted providers defined as high risk to ensure services are rendered and billed correctly. During the review period, the MCOs did not conduct routine unannounced site visits to proactively pursue and develop cases, as well as observe the quality of care being delivered by their Medicaid providers. Since this is a standard activity for program integrity units during the investigation/audit process, it should likewise be a standard practice for SIUs who are contracted to conduct preliminary provider reviews.

Recommendation#7 - The state should ensure MCOs develop work plans for conducting both announced and unannounced site visits to ensure services are rendered and billed correctly and develop potential cases. In lieu of state staffing and resource constraints, the state should also analyze and determine the feasibility of partnering with MCOs in conducting joint unannounced visits during the investigation/audit process.

The PIU maintains programmatic control of all the managed care fraud referrals from the MCOs. The MCOs make referrals of possible credible allegations of fraud to the PIU. The MCOs do not make referrals directly to the MFCU. The PIU reviews each case, may submit a referral to OIG Investigations Bureau to conduct preliminary investigative work and determines if cases warrant a referral to the MFCU. The contract states that the MCOs shall submit fraud, waste, and abuse referrals to PIU using the PIU standardized referral form.

The PIU mentioned they review each MCO referral in order to determine whether there is a credible allegation of fraud prior to referring investigation cases to the MFCU. Table 3 lists the number of referrals that PHP's SIU and BCBSNM's SIU made to the state in the last three FFYs. Because of the way PHP defines a referral, the "total" number of Medicaid provider investigations and referrals comprehensively by the MCOs appear to be adequate with 544 in FFY16, 697 in FFY17 and 576 in FFY18; however, there is a huge disparity between the amount of referrals by PHP and the amount of referrals by BCBSNM. Overall, the level of investigative activity has remained relatively consistent for the New Mexico MCOs, with the exception of BCBSNM in FFY16.

Table 3.



*PHP and BCBSNM refer all preliminary investigations to the state in preliminary investigative status. These referrals become full investigations within two weeks unless directed otherwise by the state, which was standard for all referrals during the review period.

As illustrated above, there is a large disparity between the referrals by PHP and BCBSNM. The amount of

referrals by BCBSNM is of particular concern and was also a concern in the state's previous September 2015 program integrity review report. As depicted in table 3 above, PHP appeared to have substantial referrals, although, the number of MFCU referrals resulting from PHP's referrals to HSD were significantly lower. The state mentions this is primarily due to the state accepting MCO referrals of cases that may not have completed a full investigation. Since MCOs can refer preliminary investigations, as well as full investigations, larger variances in referrals among the MCOs may result, as depicted in Table 3. The PIU should incorporate a specific referral policy and procedure that provides a detailed description of the MCOs internal procedures for the SIU to identify and report possible acts of fraud, waste, and abuse by providers to the PIU. In addition, the policy and procedure should clarify the way referrals are defined and tracked since preliminary investigations are currently regarded as making a suspected fraud referral by the MCOs.

Recommendation#8 - The state should ensure that MCOs are provided program integrity policies and procedures related to suspected fraud referrals and that MCO SIUs are adequately informed and/or trained in the prevention, detection, investigation and referral of suspected provider fraud.

Overpayments and Recoveries

Although the HSD performs capitation payment reconciliation to account for the overpayments that Medicaid has paid to the MCOs, the HSD does not perform their own case analysis of MCO investigations in order to verify and validate the MCOs' overpayment figures. Since overpayments are not audited by the HSD, there is no way of verifying and validating the appropriateness and accuracy of the overpayment amounts claimed by the MCOs.

The overpayments identified and recovered are depicted below in Table 4 for the previous 3 FFYs for both MCOs.

The HSD should ensure it maintains information on all types of recoveries to ensure accurate figures are being factored into the rate-setting process and all Medicaid improper payments are accounted for appropriately. The state is primarily relying on the MCOs to report overpayments and recoveries that are appropriate and correct. Furthermore, since MCOs are allowed to negotiate the overpayment amount with providers, recoveries may be further lowered. The state should independently review the audit activity of the MCOs in particular to ensure that potential cases of fraud, waste, and abuse are identified and addressed correctly. In addition, the state should consider the feasibility of developing metrics to measure the appropriateness and accuracy of MCO overpayments.

Table 4-A. PHP's Recoveries from Program Integrity Activities

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2016	523	523	$71,756	$106,072
2017	600	600	$7,946	$44,173
2018	349	349	$399,285	$78,053

Table 4-B. BCBSNM Recoveries from Program Integrity Activities

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2016	21	21	$152,737	$102,006
2017	97	97	$95,068	$24,288
2018	91	91	$109,198	$95,115

A concern was raised by BCBSNM regarding interpretation of the investigation and overpayment reporting requirements at a monthly Program Integrity meeting in FFY 2016. The MCO was concerned that the reporting instructions for recording the dollars identified and recovered as an overpayment resulting from an investigation were subject to different interpretations. In addition, as the reporting instructions did not define "investigation," BCBSNM raised the concern that there may have been inconsistent reporting among the MCOs.

Toward the end of FFY 2016, HSD met with BCBSNM and the other MCOs to discuss the reporting tool. The HSD provided clear direction for use of the tool, which included clarification of the types of investigations and overpayments that met the reporting requirements. The BCBSNM plan applied this clarification to its reporting, and from the second quarter of FFY 2017 forward, BCBSNM has reported investigation and overpayment data consistent with HSD's clarification. The initial data submitted by BCBSNM reflecting greater overpayment recoveries than identified overpayments in FFY 2016-2017 was due to BCBSNM's interpretation of the data reporting requirements prior to HSD's clarification. The CMS review team suggested continued oversight in order for the state to have better visibility and a comprehensive understanding regarding the complete Medicaid overpayment and recovery activities taking place within its managed care program.

The MCOs report their recoveries on provider overpayments quarterly to the state. The HSD and MCOs did not demonstrate consistency with effectively and efficiently tracking and reporting overpayments and recoveries. The review team advised the state that MCOs should have a useful professional resource tool to accurately capture, track, and report overpayments identified and collected. In addition, the tool utilized by the MCOs should also track all reportable program integrity activities including, but not limited to, MCO for-cause terminations.

Recommendation#9 - The state should amend its general contract language and relatable policies and procedures pursuant to the requirements of 42 CFR 438.608(d) in order to increase the reliability of MCO overpayment and recovery activities. In addition, the state should implement MCO training in regards to the reporting requirements to ensure the MCOs understand all revised or newly developed program integrity reporting expectations.

Encounter Data

The HSD collects encounter data from each of the MCOs electronically on a weekly basis as the encounter data requirements are specified in Appendix L of the general managed care contract. New Mexico's submitted managed care encounter data, must comply with HIPAA standards and meet several submission measures monthly and quarterly that are focused on completeness, accuracy, and comparison between data sources.

The MCOs are required to send all paid claims to the state showing all details. In addition, HSD's

Contracts Bureau does have a series of reports it requires of the MCOs related to a variety of financial aspects of the contract and summaries by service areas. Most data mining is done in the area of long-term care, making sure the encounters align with the long-term care span information HSD maintains. The state edits all encounters according to the same edits applied in FFS to ensure the MCOs are paying claims appropriately. Each MCO is required to correct and resubmit all encounters denied by the state. For this reason, the state does not use service algorithms to analyze encounter data.

The recovery audit contractor, HMS, does have algorithms it applies to claims and encounters. Encounters are received via standard electronic formats and are maintained in HSD's mainframe and in their data warehouse.

Payment Suspensions

In New Mexico, Medicaid MCOs are contractually required to suspend payments to providers at the state's request. The state confirmed that there is contract language that directs the MCOs on referring suspected cases of provider fraud. The contract states, "The CONTRACTOR shall report all confirmed, credible or suspected Fraud, Waste and Abuse to HSD as follows within the time frames required by HSD." The contract outlines how this is to be completed and then it concludes with section 4.17.2.8 stating, "The CONTRACTOR shall have a mechanism in place to suspend payments to any provider for which HSD, in accordance with 42 C.F.R. 455.23, has determined that a credible allegation of fraud exists.

The regulation at 42 CFR 455.23(a) requires that when the State Medicaid agency determines that there is credible allegation of fraud, it must suspend all Medicaid payments to a provider, unless the agency has good cause not to suspend payments or to suspend payment only in part. The OIG-PIU informed the review team that they are more likely to accept fraud cases from the MCOs at the earliest signs of suspicious provider activity.

Once a case has been referred by the MCO, the OIG-PIU will determine whether there is a credible allegation of fraud after a careful review of the available facts and evidence. Once that step is complete, the case will then be referred to the MFCU. The OIG-PIU consequently relies on the MFCU to conduct the investigation and decide whether or not to accept the case for further actions.

The payment suspension process and the contract language in New Mexico's contract with its MCOs is in accordance with the regulation at 42 CFR 455.23.

Terminated Providers and Adverse Action Reporting

The MCO contract has minimal language on how to address provider terminations and adverse actions due to program integrity related reasons. The contract does not specifically describe what actions justify a for-cause provider action, which then must be reported to HSD within an appropriate time frame in order for HSD to report those adverse actions to the HHS-OIG in accordance 42 CFR 1002.3(b)(2).

The Program Integrity reporting section of the contract (Section 4.17.2.6) specifically states, "The CONTRACTOR shall notify HSD within five (5) Business Days, via email, when a formal, written action is taken by the CONTRACTOR against a Contract Provider. Such action being defined for purposes of this Section as: (i) denial of credentialing or enrollment, or contract termination, when the denial or termination is "for cause", as such term is defined in the Contract Provider's agreement with the CONTRACTOR; or (ii) due to concerns other than fraud, such as integrity or quality".

The team did find the OIG-PIU was properly handling adverse actions that were reported to them.

The HSD ensures that all MCO "reported" program integrity related for-cause terminations are reported to the HHS-OIG. The state also uploads the for-cause terminations to the DEX (formerly Tibco) managed file transfer server.

However, as seen in Table 5 below, the amount of for-cause terminations depicted are low in comparison to the terminations depicted, which are classified as not for-cause. For example, BCBSNM had 104 not for-cause adverse actions taken against providers in 2018, yet only two of those actions were categorized as a for-cause provider termination.

Table 5:

MCOs	Total # of Providers Dis-enrolled or Terminated in Last 3 Completed FFYs		Total # of Providers Terminated For Cause in Last 3 Completed FFYs	
PHP	2016	296	2016	1
	2017	146	2017	0
	2018	184	2018	1
BCBSNM	2016	990	2016	8
	2017	995	2017	1
	2018	1074	2018	2

Overall, the number of providers terminated for-cause by both MCOs appear rather low, with no more than one or two for-cause terminations in a given year, with the exception of BCBSNM in 2016 which had a total of eight for- cause terminations. The termination data submitted by PHP indicates very few for-cause terminations were processed in the last three FFY's. Therefore, the for-cause terminations for PHP are especially concerning to the CMS review team considering the high number of suspected fraud referrals that the MCO submits annually (see Table 3).

In view of PHP informing the review team that their systems are problematic as to when state termination notifications are received, along with PHP staff being unclear about state termination reporting and notification requirements, the CMS review team was concerned of the risks involved with not appropriately processing provider adverse actions correctly with the MCO. The state should discuss this subject at length with the MCOs and examine their program integrity definition for determining for-cause terminations, when terminating a provider.

In addition, the MCOs do not seem to have a clear understanding of what constitutes a for-cause action versus a not for-cause action. The for-cause termination totals for the MCOs appear to be the result of terminology differences or the lack of understanding about the definition of a for-cause provider adverse action. The MCOs appear to be indicating that the majority of suspected fraud referrals made by the MCOS do not involve issues of integrity, quality or fraud. If that is the case, the state should look into the accuracy of whether cases being referred involve issues of integrity, quality or fraud. Accordingly, the CMS review team determined that additional education is warranted in order to ensure provider adverse actions are handled appropriately.

Recommendation#10- The state should develop a comprehensive adverse action policy that complies with the regulation at 42 CFR 1002.3(b)(2) as well as monitor MCO program integrity related adverse actions in order to appropriately account for all MCO program integrity related terminations due to fraud, integrity or quality.

Status of Corrective Action Plan from Year Review

New Mexico's last CMS program integrity review was in August 2014, and the report for that review was issued in September 2015. The CMS conducted a Program Integrity CAP desk review in 2017, in which all of New Mexico's 2014 Program Integrity Report CAP issues were satisfied by the state.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for New Mexico to consider utilizing:

- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute which can help address the risk areas identified in this report. Courses that may be helpful to New Mexico are based on its identified risks include those related to managed care. More information can be found at http://www.justice.gov/usao/training/mii/.
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of managed care staff in program integrity issues. Use the Medicaid PI Promising Practices information posted in the Regional Information Sharing Systems (RISS) as tool to identify effective program integrity practices.
- Access the Medicaid Provider Enrollment Compendium (MPEC) for information related to Medicaid Provider Enrollment requirements https://www.medicaid.gov/medicaid/program-integrity/affordable-care-act-program-integrity-provisions/index.html.
- Access the Toolkits to Address Frequent Findings: Payment Suspension Toolkit website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf

Conclusion

The CMS focused review identified 9 areas of concern and 1 instance of non-compliance with federal regulations which should be addressed immediately.

We require the state to provide a CAP for each of the recommendations within 30 calendar days from the date of the final report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction along with the specific steps the state expects will take place, and identify which area of the state Medicaid agency is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the CAP such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of the letter. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the CAP should identify those corrections as well.

CMS looks forward to working with New Mexico to build an effective and strengthened program integrity function.