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Medicaid Integrity Program

New Mexico Focused Program Integrity Review

Final Report

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Executive Summary

During the week of August 18, 2014, the Centers for Medicare & Medicaid Services (CMS) conducted a focused onsite review of the New Mexico Medicaid program. The review focused on whether the state has implemented the enhanced provider screening and enrollment provisions of the Affordable Care Act, the extent of the state's program integrity oversight of the managed care program, and the extent of selected managed care organizations (MCOs) oversight of their own programs. As detailed in Section 3 of this report, the review also included a follow up on the state's progress in implementing its corrective action plan (CAP) that resulted from CMS's 2011 program integrity review of the state. This report summarizes the findings and results of the New Mexico program integrity review and the status of the CAP.

Relative to provider screening and enrollment, the review focused on whether or not the state is in compliance with the federal regulations found at 42 CFR 455 Subpart E. The state is in compliance with six (6) of the eleven (11) provisions that New Mexico was subject to at the time of the review. Five (5) areas, New Mexico's treatment of the enrollment and screening of providers (42 CFR 455.410), site visits (42 CFR 455.432), Federal database checks (42 CFR 455.436), National Provider Identifier (42 CFR 455.440) and screening levels (42 CFR 455.450) do not comply with Affordable Care Act requirements. Additionally, CMS reviewed the state's oversight of its managed care operations and also evaluated program integrity activities for all four of the state's MCOs. New Mexico and the MCOs have some weaknesses. Specifically, for example, given the size and scope of New Mexico's managed care program, there are a low number of fraud referrals, overpayments identified and collected, and providers terminated for cause. CMS suggests that the state mitigate these vulnerabilities by enhancing and increasing case referral training for the MCOs and developing policies and procedures to ensure and validate that all for cause terminations are effectuated and reported to the state in a timely manner. New Mexico would benefit from developing and implementing policies and procedures to facilitate stronger oversight of MCO program integrity activities including case referral, terminations and overpayment identification and recovery.

Although New Mexico has taken steps to comply with the requirements of 42 CFR 455.436 that were identified as an issue in the 2011 program integrity review, their current processes do not fully address all elements of the regulation. Specifically, the state only checks the List of Excluded Individuals and Entities (LEIE) and Excluded Parties List System (EPLS) for the names of enrolled providers on a monthly basis and monthly checks are not conducted for persons with an ownership or control interest in the provider, or for agents and managing employees as required by the regulation.

CMS is working closely with the state to ensure that all issues are satisfactorily resolved as soon as possible. These issues and CMS's recommendations for improvement are described in detail in this report.

Background: State Medicaid Program Overview

The Medical Assistance Division (MAD), a component of the New Mexico Human Services Department (HSD), administers the New Mexico Medicaid program. As of May 2014, the program served a total of 688,187 beneficiaries with approximately 79 percent enrolled in one of four managed care plans. New Mexico opted to expand Medicaid coverage in 2014, and its total Medicaid expenditures in FY 2014 were $4,241,348,086. The proportion of these expenditures
for the state's managed care program was $1,568,256,987[1] (or approximately 37 percent). New Mexico's Federal Medical Assistance Percentage (FMAP) was 69.2%. It is important to note that 100% FMAP existed for the expansion population.

Methodology of the Review

In advance of the onsite visit, CMS requested that MAD and each of its four MCOs complete a review guide that provided the review team detailed insight into the operational activities of the areas that were subject to the focused review. A four-person CMS review team reviewed the responses and materials that the state provided in advance of the onsite visit.

During the week of August 18, 2014, the CMS review team visited MAD. The team also interviewed the Special Investigation Units (SIUs) of Molina Health Care of New Mexico, Inc. and Presbyterian Health Plan, Inc. while onsite at MAD. The review team interviewed the SIUs of Blue Cross and Blue Shield of New Mexico and United Health Care Community Plan (UHC) by telephone prior to arriving onsite. The CMS review team conducted interviews with staff involved in program integrity, provider enrollment, and managed care. In addition, the team conducted sampling of provider enrollment applications, program integrity cases, and other primary data to validate MAD and the MCOs' program integrity practices.

Status of Corrective Action Plan

As part of the focused review, the CMS review team evaluated the status of the state's CAP submitted in response to CMS's last review of the MAD in 2011. On September 19, 2012, CMS held a conference call with MAD concerning their CAP for the 2011 Comprehensive Review.
At that time, the following issues still remained as concerns for the state's CAP.

1. Payment suspension policies and procedures: The policy did not reference documentation and record retention requirements according to 42 CFR 455.23 and

[1] Amount reported on CMS form 64 for FY2014 through the fourth quarter.

the policy did not indicate that the provider would be notified in writing of the effective date the payment suspension would end.

2. Provider Participation Agreement:
   - MAD was not conducting database searches of the EPLS as required by 42 CFR 455.436.
   - The agreement incorrectly referenced Title V, XVII, and XX of the Social Security Act instead of Title XVIII, XIX, and XX.
   - The Agreement did not fully capture the enhanced business addresses for corporate entities as required by 42 CFR 455.104(b)(1)(iii).

At the time of the 2014 Focused Review, the team found that New Mexico had corrected all of the above areas of concern except for adherence to full requirements of 42 CFR 455.436. The fiscal agent performs manual screening and verification functions for owners, managing employees, agents, and parties with controlling interest at enrollment and reenrollment. The team confirmed that the state only conducts monthly checks against the LEIE and EPLS for the provider. And, they are not conducting monthly exclusion checks of the LEIE and EPLS on persons with ownership interests, agents, and managing employees of the provider. After this report and a request for a CAP for these continued repeat findings is issued, CMS will conduct a desk review to determine whether New Mexico has come into full compliance. If not, CMS will consider other appropriate next steps.

Regarding payment suspensions, a review of MAD referrals to the Medicaid Fraud Control Unit (MFCU) was conducted as part of the CAP follow-up. The files sampled consisted of all referrals made between January and August of 2014. Of the referrals reviewed, approximately 43 percent were cases initiated by New Mexico's MFCU. Regardless, HSD followed its own policies and procedures for receipt, documentation and tracking for each of these cases. There appear to be no systemic issues with these cases.

The balance of the sample consists of cases that were initiated by HSD and referred to the MFCU after a determination of a credible allegation of fraud. As in the cases above, New Mexico is adhering to federal regulations for these referrals as well.

Results of the Review

The review of MAD's program integrity activities found the state is in compliance with many of the program integrity requirements. However, the review team also identified areas of concern and instances of regulatory non-compliance in the MAD's program integrity activities, including repeat findings from the 2011 review that are included in the CAP.

Section 1: Affordable Care Act Provider Screening and Enrollment

Overview of the State's Provider Enrollment Process

Provider enrollment and screening is completed by the state's fiscal agent with oversight by MAD. The fiscal agent reviews the provider's application, ensures its completeness, and performs screening and verification processes. MAD provider enrollment staff members review the application with the results of the screening and verification processes to determine the provider's eligibility for participation as a Medicaid provider under current federal guidelines.
The process is complete when MAD approves or disapproves the provider's enrollment in the Medicaid program. In May 2014, MAD had 20,339 actively enrolled Medicaid providers.

As of January 1, 2014, MAD required all new managed care network providers to be enrolled in the Medicaid program. The table below details the status of MAD's compliance with the requirements of 42 CFR 455 Subpart E and their CMS approved state plan amendment.

MAD's 42 CFR 455 Subpart E Compliance Status

42 CFR 455.410: Enrollment and screening of providers
The regulation at 42 CFR 455.410 requires that the State Medicaid agency: (a) screen all enrolled providers; and (b) enroll all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan as participating providers; and (c) the State Medicaid agency may rely on the results of the provider screening performed by any of the following: (1) Medicare contractors. (2) Medicaid agencies or Children's Health Insurance Programs of other states.
The state is not in compliance with this regulation.
New Mexico requires all fee-for-service (FFS) and managed care providers to be enrolled as participating providers; including ordering, referring, and prescribing providers. Although claims for items and services ordered or referred are required to include the ordering or referring provider's NPI, the state confirmed that the associated edits and audits are not active due to system issues. The state anticipates having the edits fully operational in August 2015.
Recommendation: Implement systems edits and audits to ensure that only claims for enrolled providers are processed and paid correctly.
42 CFR 455.412: Verification of provider licenses
The regulation at 42 CFR 455.412 requires that the State Medicaid agency: (a) have a method for verifying that any provider purporting to be licensed in accordance with the laws of any state is licensed by such state; and (b) confirm that the provider's license has not expired and that there are no current limitations on the provider's license.
The state is in compliance with this regulation.

The state uses a vendor to verify the licenses of newly enrolling providers. The fiscal agent manually verifies any license that the vendor was unable to verify. Manual verifications are done through licensing boards or agency websites or the fiscal agent contacts the licensing entity directly. MAD indicated that the license verification process is the same for both in- state and out-of-state providers to determine that a provider's license is active, has no limitations, and has not been terminated or revoked. When a provider license is due for renewal, a report is sent to the appropriate enrollment specialist to verify the status of the license with the appropriate licensing board.
Recommendations: None
42 CFR 455.414: Revalidation of enrollment
The 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 5 years.
The state is in compliance with this regulation.
Providers are revalidated every two years based on their enrollment anniversary, which has been an ongoing process in New Mexico since 2001. Provider revalidations are handled the same way as new enrollments, including the requirement that providers must submit updated disclosures. Providers that fail to revalidate are automatically terminated. New Mexico revalidated the enrollment of 14,590 providers between July, 1 2012 and August 18, 2014. The number of providers not reenrolled due to failure to revalidate is 6,978 at the time of the review (August 2014).
Recommendations: None
42 CFR 455.416: Termination or denial of enrollment
The regulation at 42 CFR 455.416 describes several conditions under which a State Medicaid agency must terminate or deny enrollment to any provider. These include situations in which the Medicare program or another state Medicaid or Children's Health Insurance Program has terminated a provider for cause on or after January 1, 2011 unless the State Medicaid agency determines that denial or termination of enrollment is not in the best interests of the Medicaid program and documents that determination in writing.
The state is in compliance with this regulation.
The review team confirmed that the state is terminating or denying enrollment to providers that were terminated for cause by Medicare, Medicaid or a state's Children's Health Insurance Program. Yet, New Mexico is not submitting for cause terminations to CMS even though they have access to the database that houses the Medicare and Medicaid for-cause terminations.
Recommendation: Submit all final for cause terminations to CMS so that they can be included in the Medicaid terminations database for Medicare and other states to review.
42 CFR 455.420: Reactivation of provider enrollment
The regulation at 42 CFR 455.420 requires that the State Medicaid agency, after denial or termination of a provider for any reason, require the provider to undergo rescreening and pay the associated application fees pursuant to 42 CFR 455.460.
The state is in compliance with this regulation.
New Mexico providers that are reactivated are required to go through the complete enrollment and screening process. The review team examined a sample of reactivated provider files and confirmed that these providers undergo a complete rescreening process.

Recommendations: None
42 CFR 455.422: Appeal rights
The regulation at 42 CFR 455.422 requires that the State Medicaid agency give providers terminated or denied pursuant to 42 CFR 455.416 any appeal rights available under state law or regulations.
The state is in compliance with this regulation.
The state provides appeal rights to providers terminated or denied enrollment pursuant to 42 CFR 455.416 as evidenced by state statue and regulatory citations as well as policies and procedures for provider appeal rights. MAD provided the review team with a sample denial letter sent to a provider terminated for cause in another state. The letter included appeal rights according to New Mexico's state statue.
Recommendations: None
42 CFR 455.432: Site visits
The regulation at 42 CFR 455.432 required that the State Medicaid agency conduct pre-enrollment and post-enrollment site visits of providers who are designated as ''moderate'' or ''high'' categorical risks to the Medicaid program.
The state is not in compliance with this regulation.
New Mexico's State Plan Amendment indicates the state will ensure that pre-enrollment and post-enrollment site visits of providers who are in "moderate" or "high risk" categories will occur as required by 42 CFR 455.432. Yet, the state has not developed a process to conduct pre or post-enrollment site visits. New Mexico indicated that travel time and staffing were issues preventing the implementation of this requirement. At the time of the review, the state was developing a site visit checklist tool for use when site visits commence. Although the team found documentation inconsistent, the state has also initiated use of the Provider Enrollment Chain and Ownership System to validate whether or not a site visit was performed by Medicare within the last twelve months.
Recommendations: • Develop a site visit screening process and associated policies and procedures to perform pre and post-enrollment site visits of providers designated as ''moderate'' or ''high'' categorical risks to the Medicaid program. If travel and staffing continue to prevent MAD from performing these visits, it should work with other state and county partners that could potentially perform site visits to meet the requirements of 42 CFR.455.432. • Document use of the Provider Enrollment Chain and Ownership System to determine whether Medicare performed a site visit.
42 CFR 455.436: Federal database checks
The regulation at 42 CFR 455.436 requires that the State Medicaid agency must check the exclusion status of the provider, persons with an ownership or controlling interest in the provider, and agents and managing employees of the provider on the U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG), the LEIE, the EPLS, the System for Award Management (SAM), the Social Security Administration Death Master File, the National Plan and the Provider Enumeration System (NPPES) upon enrollment and reenrollment; and check the LEIE and EPLS no less frequently than monthly thereafter.

The state is not in compliance with this regulation.
The state conducts complete database checks on providers, persons with an ownership or controlling interest in the provider, and agents and managing employees of the provider at enrollment and reenrollment. The state also checks the LEIE and EPLS for the names of enrolled providers on a monthly basis. Yet, while making improvements based on the 2011 Program Integrity Review, the state is not conducting monthly checks for the other disclosed parties of the provider as required by the regulation. The review team confirmed these practices by reviewing provider enrollment files and by participating in a provider enrollment demonstration while onsite. This is a repeat finding.
Recommendation: Develop and implement provider screening procedures to check the LEIE and EPLS on a monthly basis for persons with an ownership or control interest and agents and managing employees of the provider.
42 CFR 455.440: National Provider Identifier
The regulation at 42 CFR 455.440 requires that the State Medicaid agency must require all claims for payment for items and services that were ordered or referred to contain the National Provider Identifier (NPI) of the physician or other professional who ordered or referred such items or services.
The state is not in compliance with this regulation.
Claims for items and services ordered or referred are required to include the ordering or referring provider's NPI. The review team confirmed that the state has some system edits to prevent payment for claims that do not contain the ordering or referring provider's NPI. However, these edits are not active due to a system issue. The state anticipates having the edits fully operational in August 2015.
Recommendations: Implement policies, procedures and system edits and audits to comply with the requirements of this regulation.
42 CFR 455.450: Screening levels for Medicaid providers
The regulation at 42 CFR 455.450 requires that the State Medicaid agency must screen all initial applications, including applications for a new practice location, and any applications received in response to a re-enrollment or revalidation of enrollment request based on a categorical risk level of ''limited,'' ''moderate,'' or ''high.''
The state is not in compliance with this regulation.
The state has established screening levels for limited, moderate, and high risk providers, but is not performing site visits for moderate and high risk providers as required by the regulation. Further, the state does not have a process to adjust a provider's risk level in instances where the provider has an existing overpayment; when the state imposes a payment suspension based on a credible allegation of fraud; or when the provider has been excluded by HHS-OIG or by another State Medicaid agency within the previous 10 years, in accordance with the requirements of the regulation.
Recommendations: Develop a process to adjust the risk level of providers who have an existing overpayment; providers who have had payments suspended in cases with a credible allegation of fraud, and providers who have been excluded by HHS-OIG or another State Medicaid agency within the previous 10 years.

42 CFR 455.460: Application fee
The regulation at 42 CFR 455.460 requires the States Medicaid agency to collect the applicable application fee prior to executing a provider agreement from certain prospective or re-enrolling Medicaid-only providers as stipulated in the regulation.
The state is not required to be in compliance with this regulation.
CMS granted a waiver to MAD from meeting this requirement.
Recommendations: None
42 CFR 455.470. Temporary moratoria
The regulation at 42 CFR 455.470 requires the State Medicaid agency to impose temporary moratoria on enrollment of new providers or provider types identified by the Secretary as posing an increased risk to the Medicaid program unless the State Medicaid Agency determines that imposition of a temporary moratorium would adversely affect beneficiaries' access to medical assistance.
The state is in a position to comply with this regulation.
The state indicated that it has not yet used a temporary enrollment moratorium; however, the state is prepared to initiate a temporary moratorium if imposed by the Secretary unless the State Medicaid agency determined it would adversely affect beneficiaries' access to medical care.
Recommendations: None

Section 2: Managed Care Program Integrity

Overview of the State's Managed Care Program

Becoming operational on January 1, 2014, New Mexico reorganized their Medicaid managed care program by consolidating three programs into one to improve access and coordination of care for Medicaid beneficiaries. The state contracted with four MCOs who provide all required services to Medicaid managed care enrollees under one umbrella. Previously, certain services, such as behavioral health were provided by one specific MCO.

The current Medicaid managed care program is called Centennial Care and is operated under a Section 1115 demonstration waiver approved by CMS in 2013. Under Centennial Care, all contracted MCOs provide physical health, behavioral health, long-term care, and community benefits to Medicaid managed care enrollees. The state pays all MCOs a capitated amount to provide all required healthcare related services to beneficiaries enrolled in each plan. As reported by the state, capitation rates are developed based on financial and encounter data reported by the MCOs that include revisions or corrections for overpayments. The Centennial Care program, specifically, has an annual budget of approximately $1.6 billion for healthcare services provided to approximately 542,000 beneficiaries.

Summary Information on the Plans Reviewed

For this review, the CMS review team met with staff from the SIUs of all four MCOs and detailed the highlights of these visits within this review. The four MCOs use a variety of payment methods including capitation and FFS for their provider networks.

Three of the four plans are part of national parent organizations. They are as follows: United Healthcare of New Mexico, Inc., Molina Health Care of New Mexico, Inc., and Blue Cross Blue Shield of New Mexico.

The fourth MCO is Presbyterian Health Plan, Inc. PHP is a locally owned MCO. PHP's Special Investigative Unit (SIU) has 10 full-time equivalent employees that consist of nurses, certified professional coders, certified medical auditors, health care fraud investigators and a behavioral health specialist.

The Centennial Care MCOs all have distinct SIUs. Limited and varying functions are completed locally for the national plans. These functions often include data analysis and preliminary investigations that are sent to the company's national SIU component.

As of June 2014, enrollment information in each plan is summarized as follows:

Enrollment Data Table 1

	UHC	**MHC**	**BCBSNM**	**PHP**
Beneficiary enrollment total	57,653	197,083	87,282	184,057
Provider enrollment total	7, 443	12,714	11,248	7062
Year originally contracted	2008	2007	2008	1997
National/Local plan	National	National	National	Local

State Oversight of Managed Care

The MAD Centennial Care Bureau is responsible for MCO programmatic oversight and managed care contract monitoring. Cases of suspected fraud are referred to MAD Program Integrity (PI) for further investigation and collaboration with law enforcement agencies. When an MCO makes a referral to a law enforcement agency, that agency collects the overpayment. New Mexico's managed care contract PI section 4.17 requires the MCOs to comply with "section 6401 Enhance provider screening and enrollment" and "section 6501 Termination of provider participation". The state contracts with an External Quality Review Organization to validate the MCOs' compliance with Medicaid fraud and abuse-related contract provisions. The External Quality Review Organization conducts an annual document review of New Mexico's MCOs policies and procedures developed to comply with New Mexico Administrative Code fraud and abuse regulations, and Sections 6401, 6402, 6501 of the Affordable Care Act and 42 CFR Part 455.

MCO Compliance Plans

MCOs are required by contract to have a compliance plan that meets the requirements of 42 CFR 438.608 and include monitoring activities designed to prevent, detect, and correct potential fraud, waste, and abuse in the New Mexico Medicaid Centennial Care program.

Each MCO submits a compliance plan to MAD for review. The MAD PI staff review each MCO's compliance plan annually. The review team found no issues with the MCOs' compliance with this contract requirement.

Meetings and Training

The New Mexico's HSD program integrity manager meets monthly with the program integrity directors from each MCO to discuss potential fraud and abuse within the MCO and audit review activities. These meetings also entail collaborative training for the MCOs and HSD staff.

The state's PI unit and the MFCU both provided training to the MCOs during the past Federal Fiscal Year (FFY). Recently, for example, training on making referrals to the MFCU was provided to state MCO SIU personnel.

Finally, each MCO has an employee/provider fraud and abuse training program. The state's HSD also promotes an effective fraud and abuse training program that focuses on the different functions within the organization. For example, the Utilization Review Management Department provides training to detect providers that over-prescribe procedures or over-utilize services, the Pharmacy Department tracks utilization of controlled substances and the Customer Service Department provides training on techniques for listening to complaints that may identify suspicious provider practices.

Terminated Providers and Adverse Action Reporting

MCOs are required to report all adverse actions (including terminations for cause). Although reporting procedures are contained in the state's *Letter of Direction* #21, interviews with each of the MCOs revealed inconsistencies in how they characterize and report licensing issues, enrollment denials and or adverse actions due to issues like quality of care. The lack of consistency in the reporting of adverse actions prevents the state in turn from reporting some actions to HHS-OIG that would be reportable in the FFS Medicaid program under 42 CFR

It also potentially limits the ability of New Mexico Medicaid to prevent problem providers from enrolling in other plans that may not be aware of their prior adverse actions.

Also, as reflected in the chart below, the MCOs in New Mexico have reported a dis-proportionately low number of for cause terminations relative to the number of providers

terminated not for cause during the last three federal fiscal years. This finding may indicate a potential weakness in the state's Medicaid program.

Provider Termination Table 1

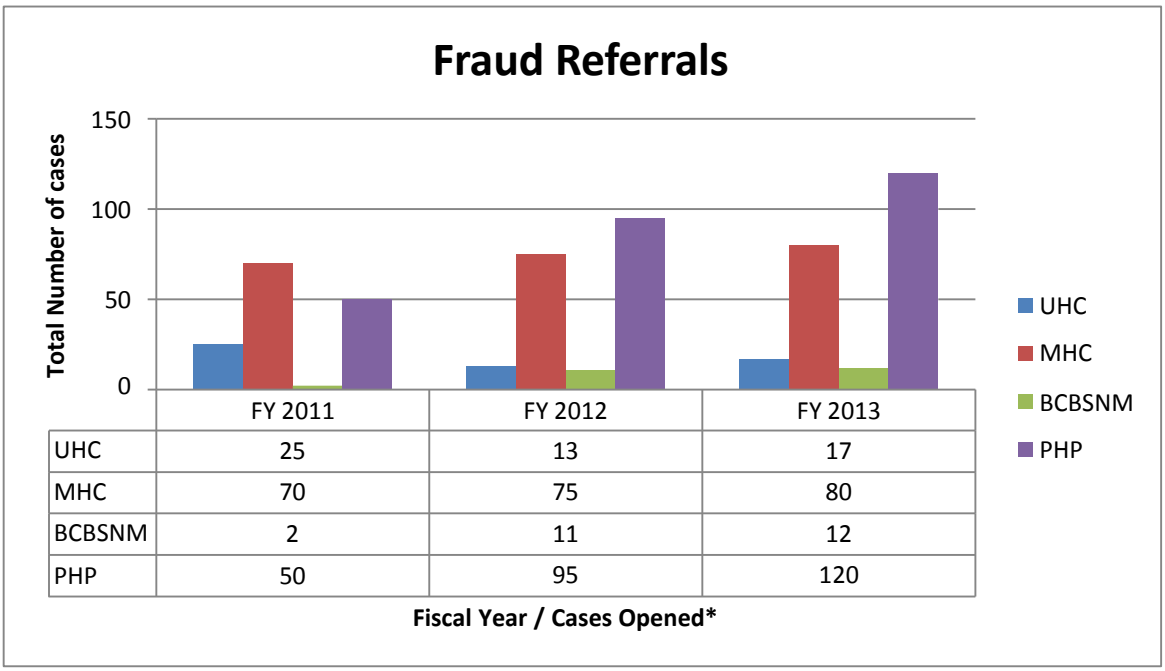
MCO	# of providers enrolled in the last 3 completed FFYs	# of providers dis- enrolled or terminated not for cause in the last 3 completed FFYs	# of providers terminated for cause in the last 3 completed FFYs
UHC	FY13 9439 FY12 8102 FY11 7247	FY13 47 FY12 75 FY11 31	FY13 4 FY12 9 FY11 37
MHC	FY13 * FY12 * FY11 *	FY13 6 FY12 4 FY11 1	FY13 * FY12 * FY11 *
BCBS NM	FY13 2308 FY12 1937 FY11 1876	FY13 149 FY12 40 FY11 73	FY13 4 FY12 0 FY 11 0
PHP	FY13 * FY12 * FY11 *	FY13 1234 FY12 1477 FY11 3	FY13 1 FY12 3 FY11 5

**State did not provide numbers*

MCO Program Integrity Activities

The New Mexico contract requires the MCOs to investigate fraud, waste and abuse and to identify and recoup overpayments for non-qualified services paid for with Medicaid dollars. Interviews with the MCOs and review of documents and sample cases revealed that the four MCOs have increased the number of fraud referrals from FYs 2011 – 2014. However, the number of cases referred to the state remains low for two of the plans over the last three FYs.

The chart below represents the number of fraud referrals each MCO made to the state for FY 2011 to FY 2013.



	FY 2011	FY 2012	FY 2013
UHC	25	13	17
MHC	70	75	80
BCBSNM	2	11	12
PHP	50	95	120

*MCO cases of suspected fraud, waste, and abuse are reported to HSD/MAD, who reviews the case in accordance with the state's Credible Fraud Referral Guidelines and tracks all referrals to the MFCU.

Overpayments Identified and Recovered

The current MCO contract requires detection, recoupment, and prevention of overpayments made to providers in accordance with federal and state laws and regulations. Claims identified for overpayment recoupment are reported to the MAD at a regularly scheduled interval and in a format agreed to by the HSD and reflected in the encounter data. The HSD may require an HSD-contracted Recovery Audit Contractor to review paid claims that are over 360 calendar days old and pursue overpayments for claims that do not indicate recovery amounts in the encounter data. The federal portion of those recoupments is returned via the CMS-64 reporting process each quarter.

Based upon information received from the MCOs as of June 2014, the four MCOs interviewed have collected and reported overpayments to the state from 2011 to 2013 as seen in the table below.

Reported Overpayments Table 1

MCO	Overpayments Identified 2011	Overpayments Collected 2011	Overpayments Identified 2012	Overpayments Collected 2012	Overpayments Identified 2013	Overpayments Collected 2013
UHC	$143,271	$7,384	$21,399	$21,399	$101,128	$101,128
MHC	**	**	**	$57,517	$278,806	$125,516
BCBS NM	$5,477	$499	$39,048	$4,451	$18,394	$12,509
PHP Total	$220,096	$69,060	$458,090	$160,864	$843,943	$187,109
Total	$368,844	$76,943	$518,537	$244,231	$1,242,271	$426,262

Total Medicaid expenditures reported by the MCOs as of June 2014.
***Information not available for the specified time period*

Review of the overpayment figures reported by New Mexico's MCOs for FY 2013 revealed that the MCOs are identifying a small number of overpayments relative to its aggregate managed care expenditures. Based on the state's total managed care expenditures for 2014, they only identified approximately 0.02 to 0.08 percent of expenditures as overpayments between 2011 and 2013.
With approximately 79% of the New Mexico Medicaid population enrolled in managed care, failure to identify overpayments can add up to significant financial losses and ultimately weaken the integrity of the state's Medicaid program.

Although the MCOs have increased their identification of overpayments recently, the review team determined that inadequate fraud and abuse outcomes, including a low number of for cause provider terminations, fraud referrals, and overall identified overpayments creates significant vulnerabilities for New Mexico's Medicaid program.

Recommendation:

- New Mexico should review its policies, procedures, resources and outcomes to obtain reasonable assurance that the state's program integrity operations and initiatives meet all rules, regulations and requirements.

Noteworthy Practices

As part of its focused review process, the CMS review team identified one practice that merits consideration as a noteworthy or "best" practice. CMS recommends that other states consider emulating this activity.

All managed care providers are required to be enrolled by the State Medicaid agency as managed care providers.

New Mexico clarified for the review team that as of January 1, 2014 no Centennial Care MCO can contract with a provider unless that provider has been approved through the enrollment process through the New Mexico State Medicaid agency. It should be noted that the HSD/MAD enrollment process allows a provider to elect to be “managed care only” meaning the provider is eligible to contract with any of the Centennial Care MCOs, but the provider could not be reimbursed for services rendered to a FFS (non-managed care) Medicaid recipient. Providers also have the option of enrolling as FFS providers.

The CMS review team considers this practice noteworthy because it contractually requires all MCO providers to the provider enrollment and screening regulations of 42 CFR 455 Subpart E. However, as noted above, the state is out of compliance on some of these requirements.

Technical Assistance Resources

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

- Use the program integrity review guides posted in the Regional Information Sharing Systems as a self-assessment tool to help strengthen the state’s program integrity efforts. Access the managed care folders in the Regional Information Sharing Systems for information provided by other states including best practices and managed care contracts.
- 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 assistance as needed to conduct exclusion searches and training of managed care staff in program integrity issues.
- 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 based on its identified risks include those related to provider enrollment and oversight of managed care. More information can be found at http://www.justice.gov/usao/training/mii/training.html.

- 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.
- Access the annual program integrity review summary reports on the CMS's website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html. These reports contain information on noteworthy and effective program integrity practices in states. We recommend that New Mexico review the noteworthy practices on provider enrollment and disclosures and the effective practices in program integrity and consider emulating these practices as appropriate. The state should also review effective practices related to the handling of terminated providers to address the issues identified in the Affordable Care Act section of this report.
- Consult CMS guidance on payment suspensions including the Medicaid Payment Suspension Toolkit located at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf and the March 25, 2011 Informational Bulletin located at http://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/payment-suspensions-info-bulletin-3-25-2011.pdf to ensure the state's payment suspension process is consistent with federal regulations and guidance.
- 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 assistance as needed to conduct exclusion searches and training of managed care staff in program integrity issues. Refer to CMS's Managed Care Plan Compliance Toolkits at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Provider-Education-Toolkits/managedcare-toolkit.html. These toolkits cover a wide range of topics intended to enhance the prevention and detection of fraud, waste and abuse in managed care and should be shared with the MCOs.
- Engage with CMS to identify potential fraud, waste, and abuse and address through collaborative audits.

Conclusion

MAD applies one noteworthy practice that demonstrates program capabilities and the state's commitment to program integrity. CMS supports New Mexico's efforts and encourages it to look for additional opportunities to improve overall program integrity. Notwithstanding the state's accomplishments, CMS identified areas of concern and instances 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 plan should identify those corrections as well.

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

HUMAN SERVICES DEPARTMENT

October 26, 2015

Susana Martinez, Governor
Brent Earnest, Secretary
Nancy Smith-Leslie, Director

Letitia D. Leaks, Director
Division of State Program integrity
Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop AR-21-55
Baltimore, Maryland 21244-1850

Dear Ms. Leaks:

Our State team has carefully reviewed the Final Report of the New Mexico Focused Program Integrity Review, dated September 2015, which summarized the visit from the Investigations and Audits Group conducted during the week of August 18, 2015.

As there were identified areas of concern and instances of regulatory non-compliance in the final report and the many program integrity activities improvement recommendations noted, the enclosed corrective action plan is submitted for each identified risk area, ensuring that risk areas are rectified and not recur. Timeframes and specific action steps are also outlined in the corrective action plan being submitted.

Should you and your colleagues have any questions in your review of this material, please do not hesitate to contact myself at (505) 827-1344 or Russell.Toal@state.nm.us.

Thank you for your recognition of our State's compliance with many of the program integrity requirements and of course, we are committed to addressing all concerns that the final report has outlined.

Sincerely,

Russell Toal, MPH
Deputy Director for Operations

Enclosure

Cc: Bill Brooks, DMCHO Associate Regional Administrator
Mark Majestic, Director, CMS Investigations and Audits Group
Patricia Tucker, Director, MFCU
Jackie Garner, CMCHO Consortium Administrator
Nancy Smith-Leslie, Director, Medical Assistance Division, NM Human Services Department
Adrian Gallegos, NM Office of Inspector General