Progress Report

Program Evaluation Unit
Legislative Finance Committee
July 2022

Medicaid Fraud, Waste, and Abuse Controls

Summary

Increased risks of Medicaid fraud, waste, and abuse associated with Medicaid expansion and Covid-19 call for continued progress to protect taxpayer dollars. Since a 2011 LFC evaluation found the state's fraud oversight efforts did not pay for themselves, the state has implemented most of the report's recommendations and has begun to see a positive return on investment (ROI) in addressing Medicaid fraud. The Office of the Attorney General's (NMAG) Medicaid Fraud Control Unit's (MFCU) ROI is now above the national median. However, while recoveries of outright fraud have increased, the proportion of investigations resulting in convictions and recoveries has decreased. MFCU could improve collaboration with sister agencies and federal partners to increase the quantity and quality of fraud referrals. The Human Services Department's (HSD) recovery of improper payments have generally declined since FFY17. HSD can improve on this measure by recovering from managed care organizations (MCOs) all improper capitation payments made on behalf of the 18 thousand New Mexico Medicaid recipients who were also enrolled in other states' public assistance programs in 2021. In addition, HSD and MFCU should update agreements and contracts to clarify Medicaid program integrity roles and responsibilities. Finally, NMAG and HSD should work with the Legislature to bring New Mexico into compliance with the federal False Claims Act to increase the state's portion of fraud recoveries.

The Evaluation: *LFC's 2011 Human Services Department (HSD) and Office of the Attorney General (NMAG) Medicaid Fraud, Waste, and Abuse Controls evaluation found the state's investments in these controls did not pay for themselves and recommended structure, function, and oversight changes. In 2013, four of LFC's nine key recommendations were implemented. In 2022, all but two of these recommendations have been implemented.*

Progress Reports foster accountability by assessing the implementation status of previous program evaluation reports, recommendations and need for further changes.

NEW MEXICO LEGISLATIVE FINANCE COMMITTEE

Key Medicaid Terms:

Managed care organizations (MCO) are entities that provide benefits to enrollees through a network of providers in exchange for capitation payments.

Capitation payments are monthly fixed amounts paid by HSD to MCOs on behalf of each Medicaid beneficiary.

Federal Medical Assistance Percentage (FMAP) is the percentage of Medicaid expenditures the federal government reimburses to a state.

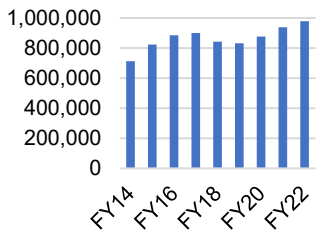
Background

Medicaid for New Mexico's nearly one million beneficiaries is primarily federally funded, but state general revenue contributes over $1 billion annually.

New Mexico's Medicaid program provides critical healthcare access to vulnerable New Mexicans who would otherwise struggle to receive medical care. The state has a higher proportion of its population enrolled in Medicaid than any other state in the country (46 percent compared with 26 percent nationally). Enrollment has increased substantially over the years as a result of Medicaid expansion and the Covid-19 public health emergency and is now at an all-time high of 977,269 enrolled individuals as of July 2022.

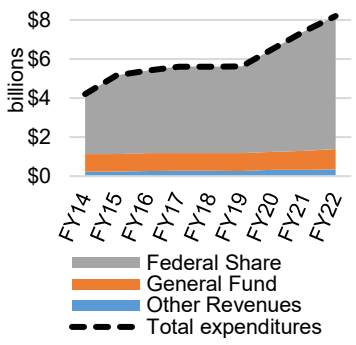
Most Medicaid healthcare coverage in New Mexico is provided through managed care organizations (MCOs), and the state's contracts with MCOs represent 78 percent of Medicaid spending, or $6.379 billion in FY22 (March 2022 MAD Budget Projection). Since 2019, New Mexico has had three MCOs—Blue Cross Blue Shield of New Mexico, Presbyterian, and Western Sky Community Care. HSD pays these MCOs a capitation payment, or monthly fee, on behalf of each Medicaid beneficiary in exchange for the provision of Medicaid benefits through a network of providers. The remainder of Medicaid funding in FY22 pays for the fee-for-service program ($878 million), waiver programs ($511 million), and other programs ($430 million).

Chart 1. NM Medicaid enrollment increased 37 percent from FY14 to FY22



Source: HSD-MAD Medicaid enrollment projections

Chart 2. NM Medicaid program expenditures have grown 95 percent since FY14, primarily from federal funds



Source: HSD projections May 2022

In FY22, federal funds accounted for 83 percent of the $8.2 billion budget. The percentage of Medicaid expenditures the federal government reimburses to a state, the Federal Medical Assistance Percentage (FMAP), varies depending on the Medicaid population served. In March 2020, the Families First Coronavirus Response Act increased the FMAP by 6.2 percentage points for states that maintain Medicaid eligibility through the duration of the public health emergency, bringing New Mexico's FMAP to 79.91 percent in FFY22. The remainder of Medicaid funding is provided by the general fund (13 percent) and other revenue sources (4 percent). Although contributions from the general fund make up a lesser portion of overall Medicaid spending, the state contributed $1.04 billion in FY22, or 13.9 percent of recurring general fund appropriations. With so much at stake, New Mexico bears the responsibility of safeguarding taxpayers' dollars while ensuring vulnerable New Mexicans have access to medical care.

Three New Mexico entities are responsible for detecting and addressing Medicaid fraud, waste, and abuse.

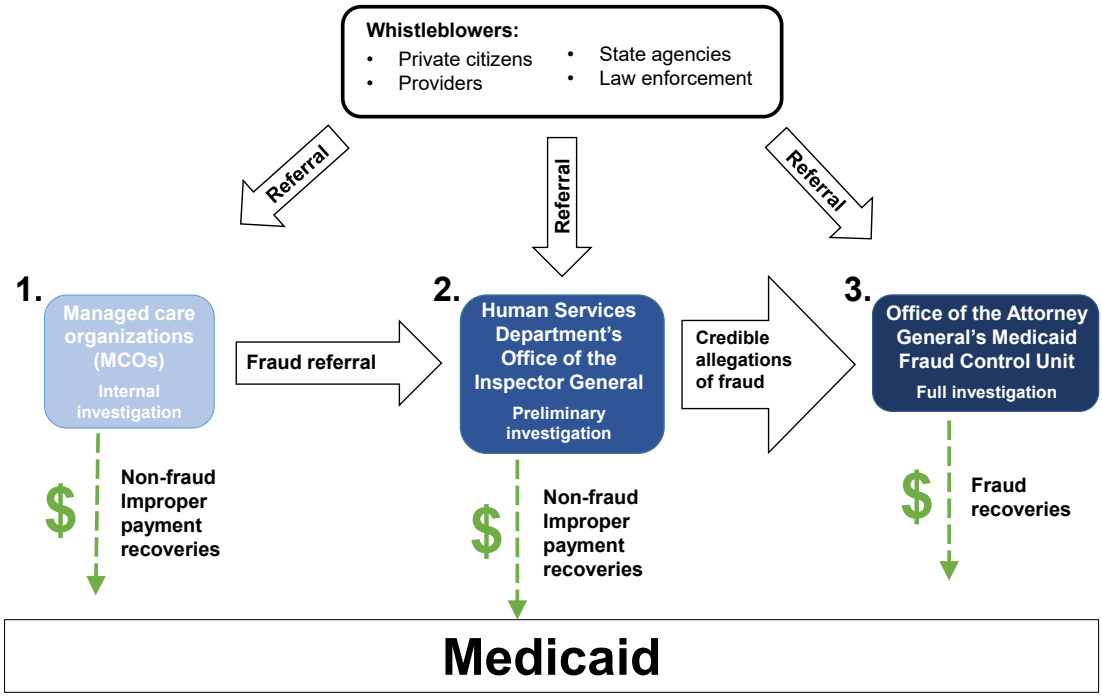
MCOs, HSD's Office of the Inspector General (OIG), and the state Medicaid Fraud Control Unit (MFCU) of NMAG all work to identify Medicaid fraud, waste, and abuse. In addition, whistleblowers such as private citizens, medical providers, law enforcement, and state agencies can notify these entities of potential issues. MCOs search for fraud, waste, and abuse through data mining and audits. OIG and MFCU also conduct data mining. In addition, OIG audits

providers, operates a fraud hotline, and participates in the federal Public Assistance Reporting Information System program that identifies individuals concurrently enrolled in more than one state's public assistance program. When these activities uncover improper payments, they go through a filtering process of investigations to determine whether they are fraudulent. MCOs and OIG may attempt to recover non-fraudulent improper payments. HSD investigates and recovers recipient fraud, and conducts preliminary investigations of potential provider fraud before referring credible allegations to MFCU for a full investigation and prosecution. When prosecution of fraud results in recoveries, the federal share (proportional to the FMAP) is remitted to the federal Centers for Medicare and Medicaid Services (CMS). The remaining share reverts to state Medicaid funds minus HSD's reimbursement for recovery costs and any amount owed to MCOs or to those who reported the fraud.

Improper payments (IPs) are payments that do not meet program requirements. They may be overpayments, underpayments, or correct payments with documentation errors.

Fraudulent payments are a subset of improper payments that result from intentional deception.

Figure 1. While referrals of potential fraud enter the system at several points, all credible allegations are funneled to MFCU for full investigation, prosecution, and recovery.



Source: LFC analysis of HSD and NMAG documentation

LFC's 2011 evaluation found New Mexico's investments in fighting Medicaid fraud, waste, and abuse did not pay for themselves.

Neither MFCU nor OIG had a positive return on investment (ROI) in FY10, with MFCU ranking 49th in the nation in ROI (recovering only 53 cents for every $1 spent to administer the work) and dollars recovered. Although Medicaid expenditures represent the majority of HSD's budget, OIG focused the majority of its efforts on non-Medicaid programs in FY10, with only 2 percent of its recoveries attributable to Medicaid recipient fraud. To increase recoveries and improve ROI, LFC recommended HSD and MFCU make staffing changes and improve collaboration to increase efficiency and reduce conflict of interest, as well as take measures to strengthen policies and

procedures around referrals and the roles of MCOs. LFC staff recommended revising state statute to comply with the federal False Claims Act, which would increase New Mexico's share of Medicaid fraud recoveries.

Two years later, an LFC progress report found HSD had reorganized bureaus to consolidate selected staff from the Quality Assurance Bureau into a new Medicaid Program Integrity Bureau in OIG to serve as a single point of contact for allegations of fraud and abuse. HSD also moved OIG to report directly to the secretary, reducing potential conflicts of interest. Recommendations for HSD's administration of MCOs, such as instituting certain performance measures related to fraud and program integrity, remained unaddressed. MFCU successfully reallocated staffing to improve efficiency and updated referral guidelines. However, ROI performance measures were not implemented. MFCU's ROI improved substantially from the 2011 evaluation (a return of 53 cents in FFY10 to $2.73 in FFY12), though it remained below the national average of $13.47. This progress report seeks to assess the current status of Medicaid fraud and overpayments in New Mexico.

Expanded enrollment, federal waivers, and flexibilities for state Medicaid programs during the Covid-19 pandemic increase risks of fraud, waste, and abuse.

Examples of NM Medicaid Flexibilities During the Federal Public Health Emergency

- Relax and expedite certain credentialing requirements for out-of-state providers,
- Suspend HSD and MCO provider site visit and revalidation activities,
- Waive some prior authorization requirements, and
- Waive some provider enrollment requirements, such as background checks in certain cases.

Source: NM MAD LOD #30 and GAO

Since the 2013 progress report, New Mexico has seen increased enrollment as a result of Medicaid expansion and the Covid-19 public health emergency. Enrollment growth escalate the potential for fraud, waste, and abuse—particularly when staffing in agencies responsible for detecting such occurrences does not keep pace with growth. Pandemic-related waivers increased flexibility for states but may have also increased risk of improper payment or fraud. To reduce obstacles to healthcare throughout the Covid-19 pandemic, the federal government approved over 600 waivers and other flexibilities for state Medicaid programs and MCOs. These measures may have also created new avenues for fraud, waste, and abuse. Some changes aimed to increase provider supply by relaxing screening requirements, such as criminal background checks in certain circumstances. Others are aimed to reduce obstacles to care, such as suspending certain prior authorizations and expanding telehealth. While telehealth increased access to care, concerns about adequacy of care, patient privacy, and potential for double-billing remain. In 2020, the federal Department of Justice found $4.5 billion in allegedly false and fraudulent claims connected to telehealth nationally. Likewise, CMS reported a record-breaking number of administrative actions related to telemedicine fraud. Changes to the healthcare landscape during the Covid-19 pandemic led to the federal Department of Justice reporting in April 2022 over $149 million in fraudulent billings to federal programs through schemes that exploited the pandemic, including use of personal information collected through fraudulent Covid-19 tests to bill for more expensive and unrelated medical procedures.

Better federal collaboration, data mining, and training could help address increased risks. The federal Healthcare Fraud Prevention Partnership recommends three primary strategies for preventing and identifying fraud: (1) increase collaboration between state and federal Medicaid agencies, MCOs, and law enforcement; (2) strategically use algorithms to monitor encounter data for Covid-19 and telehealth modifiers, as well as geographical and timeline discrepancies; and (3) train providers on new waivers and billing codes. Recent federal reviews of HSD and MFCU

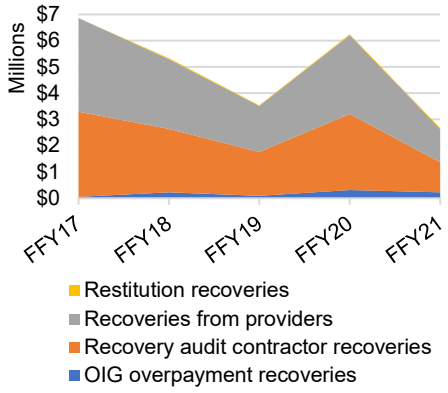
have highlighted these areas—federal collaboration, data mining, and training—as needing improvement. At a moment when New Mexico faces unprecedented levels of Medicaid enrollment and spending in an environment ripe with risk, OIG, MFCU, and MCOs must work together with the federal government and wider public to address fraud, waste, and abuse.

HSD and MFCU Implemented Many LFC Recommendations, but Opportunities Exist to Increase Recoveries

Since 2011, HSD and MFCU have implemented the majority of LFC staff recommendations. Recent reviews of MFCU and MCOs by the U.S. Human Services Department's OIG and the Centers for Medicare and Medicaid Services yielded additional improvements in the state's Medicaid program integrity efforts. These changes likely contributed to recent increases in MFCU's recovery of fraud and OIG's Medicaid overpayment recoveries. This progress is commendable. However, opportunities to further improve recoveries exist. HSD should update MCO contracts to provide specific policies and procedures for program integrity operations. MFCU should improve collaboration with sister agencies and federal partners to increase the quantity and quality of referrals. HSD and MFCU should update agreements and contracts to clarify the Medicaid program integrity roles and responsibilities of HSD, MFCU, and MCOs.

HSD's improper payment recoveries have generally declined since FFY17. The majority of these improper payments were recoveries from providers or those identified by recovery audit contractors. OIG overpayment recoveries, also a subset of HSD recoveries, increased from $221,823 in FFY21 to $839,530 in FFY22. In addition, when HSD identifies potential fraud committed by providers, it must refer those allegations it deems credible to MFCU for full investigation and recovery. Recoveries resulting from those referrals have varied widely since FFY17, amounting to $29,585 in FFY21.

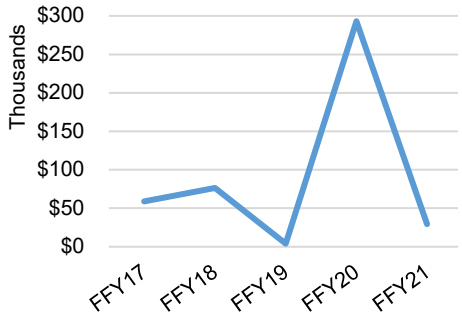
Chart 3. With the exception FFY20, HSD improper payment recoveries have decreased since FFY17



Note: In FFY22, OIG overpayment recoveries increased to $839,530. FY22 values for other categories were not available.

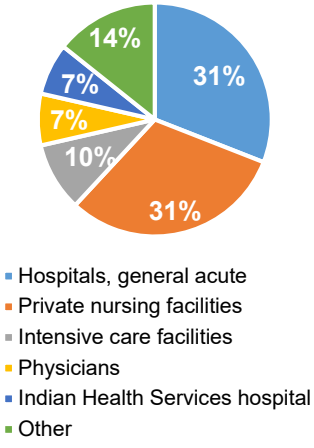
Source: LFC analysis of HSD data

Chart 4. Medicaid Fraud Recoveries yielded from HSD Referrals to MFCU have varied widely since FFY17



Source: LFC analysis of MFCU data

Chart 5. Hospitals and private nursing facilities account for 62 percent of providers with the highest amounts of recovered improper payments



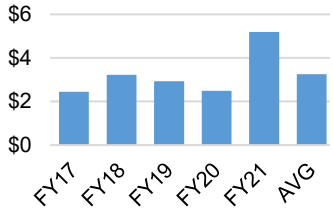
Note: Analysis includes data from FFY17 to FFY22 (Q1). The top 10 percent of providers who repaid the highest portion of HSD funding. N=42.

Source: LFC analysis of HSD data

Private nursing facilities account for a large proportion of recovered improper Medicaid payments from providers. The majority of providers who paid the greatest recovery amounts were hospitals and private nursing facilities. Because these providers tend to receive the greatest funding from HSD (more than half received over $10 million), it is unsurprising they paid more in improper payment recoveries. However, when controlling for provider size, the percentage of HSD funds recovered due to improperly made payments ranged substantially, from below 0.01 percent to 85 percent (though the majority were below 1 percent). Of the 10 percent of providers who repaid the highest proportion of their funding, all were relatively small (generally funded under $1 million) and 60 percent were private nursing facilities. HSD should consider enhancing training for private nursing facilities and hospitals to target providers with the highest dollar amounts of recoverable improper payments and those who repay the highest proportion of payments.

MCOs are responsible for monitoring Medicaid fraud internally, but efforts yield highly variable ROI. MCOs process the majority of Medicaid dollars within New Mexico, accounting for up to 72 percent of the state's estimated $5.5 billion Medicaid expenditures over the first three-quarters of FY21. Despite this, OIG does not directly investigate MCOs for fraud. Instead, each MCO's program integrity unit identifies and reviews improper payments, referring suspected fraud to OIG for preliminary investigation. Each MCO uses different tactics and devotes varying amounts of resources to monitoring fraud. A 2020 federal Centers for Medicare and Medicaid Services (CMS) report highlighted a lack of accountability and inconsistent program integrity policies across New Mexico's MCOs.

Chart 6. The average ROI for MCOs ranged from $2.45 to $5.19 from FY17 to FY21



Source: LFC analysis of MCO report 56

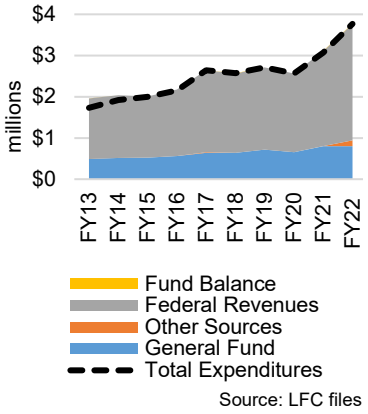
Return on investment varied substantially over time and by MCO from FY17 to FY21. Average ROI ranged from $2.45 for every dollar spent on fraud recovery in FY17 to $5.19 in FY21. However, the average does not capture the large range in ROI between MCOs. For instance, in FY21, one MCO had an ROI of almost $10 for every dollar spent on fraud recovery while another had a return of only $1.40. The variability is mainly due to differences in recoveries rather than MCO costs. For example, in FY21 the difference in recoveries between the MCO with the highest recoveries and the MCO with the lowest recoveries was $5.5 million, while the differences in unit costs was only $300 thousand. This variability may be related to the number of investigations conducted by each MCO. In 2011, LFC recommended HSD establish staffing guidelines for MCO program integrity units. In 2020, CMS recommended the same, as well as that HSD ensure adequate funding allocated to MCO program integrity. Nevada, for example, requires a staffing ratio of one MCO program integrity unit FTE for every 50 thousand enrolled Medicaid beneficiaries. In 2021, New Mexico MCOs ranged from employing one program integrity FTE per 80 thousand beneficiaries, to one FTE per seven thousand beneficiaries. In addition, both LFC and CMS have highlighted the need to ensure specific policies and procedures for MCOs regarding key areas of program integrity activities to reduce operational inconsistencies.

Since FFY10, New Mexico's return on investment for MFCU has varied widely, mirroring national trends.

Since FFY10, New Mexico's Medicaid Fraud Control Unit (MFCU) within the Office of the Attorney General has had an average ROI of $1.94 for every dollar spent, but the rate of return—like that nationally—has been highly variable. New Mexico's highest return on investment of $5 for every dollar spent on MFCU occurred in FFY14, while its lowest return on investment was the next year, FFY15, at 17 cents for every dollar spent.

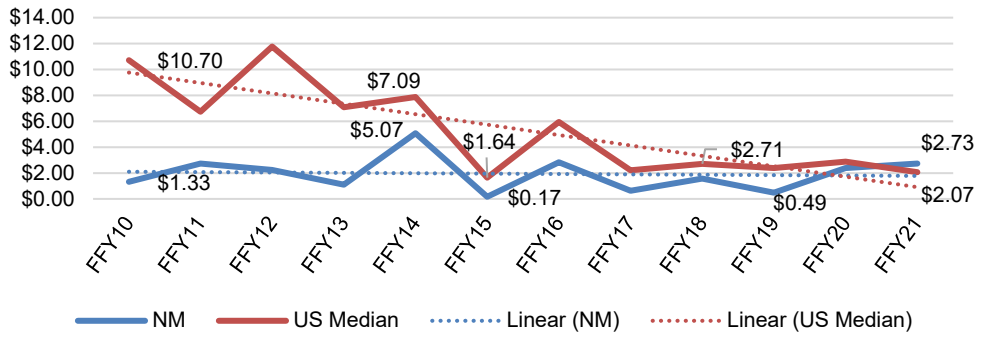
After a negative return on invesment in FFY19, MFCU's ROI increased to $2.73 in FFY21. Over the past decade, MFCU's ROI generally fell below the national median. However, in FFY21, the Unit's ROI of $2.73 for each dollar spent is above the national median of $2.07, placing the state at 20th nationally— a notable improvement from its ranking of 49th in FFY10. The variability in the unit's ROI is driven by fluctuating fraud recoveries. In FFY21, recoveries increased to $8.6 million—$4.7 million more than in FFY19. These recent improvements should be recognized. A 2021 evaluation of MFCU by the U.S. Health and Human Services' Office of the Inspector General, identified specific ways the unit's recoveries could improve, such as reducing high turnover and collaboration with HSD and federal partners. In April 2022, HHS-OIG found the unit has made improvements in these areas.

Chart 7. Growth in NM Medicaid Fraud Control Unit expenditures has primarily been federally funded



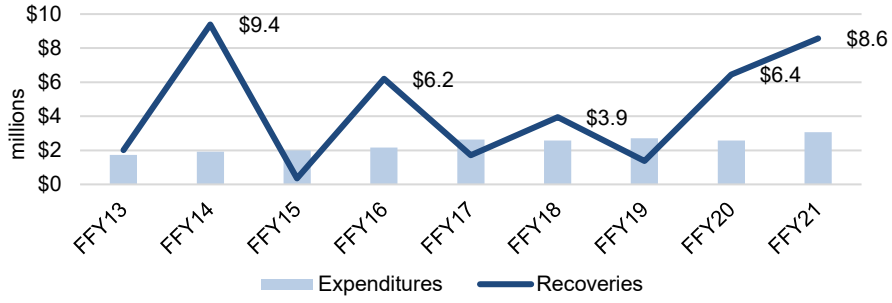
Source: LFC files

Chart 8. New Mexico MFCU's ROI rose above the national median in FFY21



Source: HHS OIG

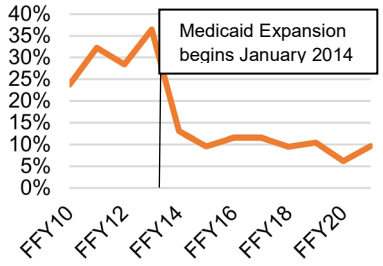
Chart 9. MFCU expenditures have gradually increased, but fraud recoveries are highly variable



Source: LFC analysis of HHS-OIG data

Following Medicaid expansion, MFCU's percentage of fraud investigations resulting in criminal or civil convictions declined. MFCU's fraud investigations more than doubled shortly after the Medicaid expansion in FFY14, while staffing levels increased only 50 percent between FY10 and

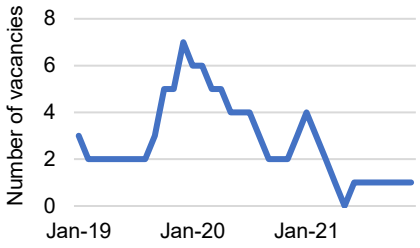
Chart 10. Percent of MFCU fraud investigations that resulted in criminal and civil convictions



Note: Clearance rate was calculated as the number of criminal and civil convictions divided by the number of fraud investigations reported to the OIG.

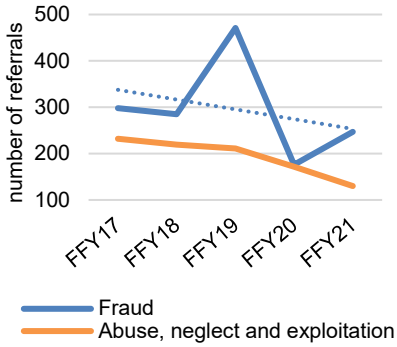
Source: OIG data

Chart 11. MFCU struggled with turnover prior to mid-2021



Source: LFC analysis of SPO Tools, FY19-FY21

Chart 12. After peaking in FFY19, referrals of fraud, abuse, neglect and exploitation plummeted in FFY20



Source: MFCU referral data

FY21. The year prior to expansion, 36 percent of MFCU's investigations resulted in criminal or civil convictions. The following year, the percentage dropped to 13 percent and has remained low since. MFCU staff increases have not kept pace with Medicaid enrollment. These figures suggest MFCU staff may not have the capacity to meet increased demand for fraud investigation and prosecution.

While MFCU'S vacancy rate was below the state average from FY19-FY21, the unit struggled with turnover. From FY19 to FY21, MFCU's vacancy rate ranged from 6 percent to 13 percent—below the state average of 20 percent during the same period and notably improved from MFCU's vacancy rate of 24 percent in 2011. However, the unit's turnover rate is high, with some positions cycling through several new employees over a year. A 2020 review of MFCU by the U.S. Department of Health and Human Services' Office of Inspector General (HHS-OIG) cited high turnover among management and staff from FY17 to FY19 as the main driver of the unit's low fraud recoveries.

Since this study, turnover has improved. However, in FY19, the turnover rate approached 40 percent before declining to a low of 24 percent in FY21. As recommended by HHS-OIG in 2020, MFCU instituted a new employee retention action plan to hire well-suited employees and to provide sufficient training and support. These changes have likely contributed to the decline in turnover in 2021. As recommended, MFCU also created more detailed policies and procedures to reduce upheaval during leadership transitions. An April 2022 update from HHS-OIG recognized improvements in addressing turnover, but suggested adding more specific measures to ensure continuity of unit operations should turnover occur. MFCU should make these additions and continue to prioritize the activities outlined in its retention action plan, carefully monitor turnover, and adjust recruitment and retention strategies as necessary.

In FFY21, MFCU received fewer referrals of fraud, abuse, and neglect from fewer types of sources than in FFY17.

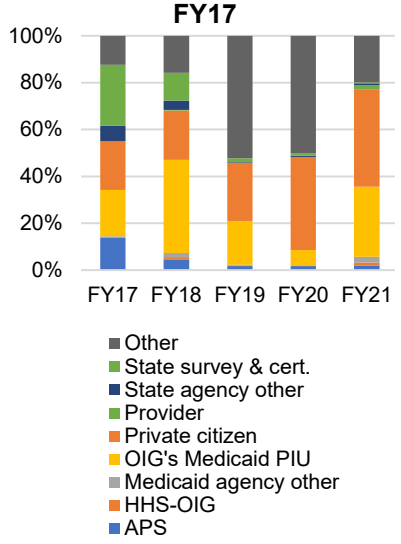
Referrals of suspected fraud, abuse, neglect, and exploitation to MFCU from FY18 to FY21 have followed a gradual downward trend except for a steep increase of fraud referrals in FY19. The following year, referrals decreased 91 percent, despite an increased risk of fraud associated with the Covid-19 pandemic. Throughout the period of analysis, suspected fraud made up a slight majority of referrals (51 percent to 69 percent).

Once diverse, MFCU's sources of referrals are now driven largely by private citizens and unidentified sources. Despite increased risk of Medicaid fraud in FY20 due to the Covid-19 pandemic, MFCU received fewer fraud referrals than any other year of analysis. MFCU noted the Covid-19 pandemic negatively impacted the activities of referral sources. Of these

referrals, 90 percent were contributed by private citizens and "other" sources. Referrals by private citizens go through no preliminary investigation before arriving at MFCU and vary in quality, requiring large investments of staff time. In contrast, in FY17 MFCU received fraud referrals from a wide variety of sources, including substantial contributions from state survey and certification processes (26 percent), private citizens (20 percent), OIG's Medicaid Program Integrity Unit (20 percent), Adult Protective Services (14 percent), "other" sources (12 percent), and state agencies (7 percent). These sources have since dwindled.

To increase the number of quality fraud referrals—those within MFCU jurisdiction and with investigational merit—MFCU should diversify its any given year of analysis. In response to similar recommendations made by the U.S. Health and Human Services Department's Office of the Inspector General in 2020, MFCU developed a plan to meet quarterly with state and federal partners, collaboratively develop resources, and deliver training on fraud detection and reporting. In April 2022, HHS-OIG recognized MFCU had improved its collaboration with Federal partners. In addition, MFCU indicates there is room for improvement in OIG's preliminary investigations of fraud, requiring MFCU to invest additional time and investigative resources. CMS' 2020 report acknowledged vacancies within OIG challenged preliminary investigations and the processing of referrals. MFCU should continue and expand on its efforts to improve collaboration with state and federal partners. sources of referrals. For example, collaboration with federal partners could yield additional referrals, from which MFCU received no more than three in

Chart 13. MFCU's referral sources decreased after FY17



Note: Adult Protective Services (APS).
Source: LFC analysis of MFCU referral data

Increasing recoveries requires clarifying the roles of HSD, MFCU, and MCOs

In 2011, LFC reported a fragmented Medicaid program integrity system in New Mexico that fostered jurisdictional confusion, duplication of effort, and ineffectiveness. The report recommended structural changes to staffing in both the HSD and MFCU to streamline work and improve efficiency. To reduce jurisdictional confusion and improve collaboration, LFC recommended formalizing the work between HSD-OIG and MFCU through memoranda of understanding (MOUs). In addition, MCO contracts with the state lacked adequate oversight and incentives for program integrity activities.

While HSD's OIG now reports directly to the cabinet secretary to reduce potential conflict of interest, the position has not been codified in statute. In 2013, in response to a 2011 LFC recommendation, HSD moved its Office of the Inspector General (OIG) from under the deputy secretary who also oversaw the Medicaid Assistance Division to directly under the cabinet secretary to avoid potential conflicts of interest in fraud investigation. In 2013, 2014, and 2015, bills were introduced that would have codified the location of OIG directly under the cabinet secretary. In addition, the bills would have ensured all staff and funding for program integrity functions flowed through OIG, further reducing potential conflict of interest in the agency. Finally, the bills would have required OIG to submit reports and plans to the Legislature annually. These practices could increase agency transparency, helping ensure the state provides adequate program accountability and controls. However, none of these bills were passed by the Legislature. The Legislature should

Table 1. Bills Regarding State Offices of the Inspector General

Year	Bill	Actions
2013	SB13	No action taken
2013	SB227	Passed one committee
2014	SB207	No action taken
2015	SB204	Passed one committee

Source: NM Legislation Tracker

consider reviving this legislation to reduce conflicts of interest, increase transparency, and improve program integrity functions.

The 2020 memorandum of understanding between HSD and NMAG falls short of federal requirements.

In 2011, LFC found the memorandum of understanding (MOU) regarding Medicaid fraud and abuse between HSD and the New Mexico Attorney General (NMAG) conflicted with federal law. While the MOU required HSD to refer suspected fraud to MFCU for investigation, OIG had begun conducting its own preliminary investigations. LFC recommended the MOU be revised to reflect OIG's supportive role in fraud investigations. In 2020, the U.S. Department of Health and Human Services' Office of the Inspector General (HHS-OIG) recommended the same change. Later that year, HSD and NMAG updated their MOU to reflect HSD's preliminary investigations of suspected fraud prior to referring credible allegations to MFCU.

The current MOU between HSD and MFCU does not include a mechanism by which MCOs can refer cases of suspected fraud to MFCU. One recommendation from HHS-OIG, however, remains unaddressed in the MOU—there is no mechanism by which managed care organizations (MCOs) can refer suspected fraud to MFCU. Federal regulations require the MOU between a state's MFCU and Medicaid agency to establish procedures for the MFCU to receive referrals from MCOs either directly or through the Medicaid agency. MFCU agreed with the report's recommendation to amend the MOU to bring it into compliance with federal law. At present, fraud detected by MCOs is referred to OIG, who conducts preliminary investigations and forwards credible allegations of fraud to MFCU for full investigation. However, nearly two years after HHS-OIG's identification of the problem, the MOU continues to lack clear procedures by which MCOs may refer suspected or confirmed fraud to MFCU either directly or through HSD. MFCU and HSD should prioritize bringing this agreement into federal compliance.

Table 2. Three agreements must be modified to allow MCOs to make referrals directly to MFCU

HSD and NMAG MOU
Joint Protocol for Coordination of Referrals of Fraud by Medicaid Providers
MCO contracts with the state

Source: LFC analysis of NMAG documents and listed documents

New Mexico MCOs are not permitted to refer potential fraud directly to MFCU. MFCU's response to HHS-OIG's 2020 review noted the practice of routing MCO referrals of potential fraud through HSD results in investigative delays that make full investigations difficult or impossible to complete within the statute of limitations, potentially constraining recoveries and convictions. Specifically, the Unit indicates delays provide a "heads-up" to providers under investigation. MFCU proposed amendments to its MOU with OIG to allow MCOs to refer potential fraud to HSD and MFCU simultaneously. MFCU indicates in discussions with OIG, the agencies determined the amendments would conflict with MCO contracts. The contracts specify MCOs should report all confirmed, credible, or suspected fraud, waste, and abuse to HSD and it is HSD's responsibility to report credible allegations to MFCU. In addition, the state's MOU between the Department of Health, the Children, Youth and Families Department, the Aging and Long-Term Services Department, HSD, and MFCU (the *Joint Protocol for Coordination of Referrals of Fraud by Medicaid Providers*) conflicts with the proposed changes.

MFCU drafted amendments to these agreements and submitted the revisions to agencies at the end of 2021 (see appendices B, C, and D for drafted

amendments). HSD indicates allowing MCOs to report potential fraud to HSD and MFCU simultaneously would prevent the department from protecting Medicaid dollars when a credible allegation of fraud against a provider is made, and prohibits due process providers are entitled to (Section 27-11 NMSA 1978). While federal regulation allows states to choose whether MCOs send fraud referrals directly to the MFCU or through the state Medicaid agency, some states, such as Washington, report increased MCO fraud referrals after allowing MCOs to send referrals to the MFCU.

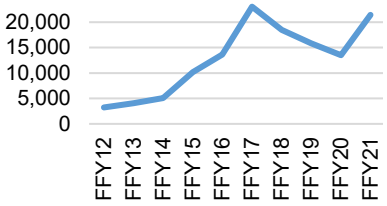
Clarifying program integrity procedures and expectations could help reduce Medicaid MCOs' substantial variation in recoveries.

LFC's 2011 report recommended HSD amend contracts with MCOs to create consistent Medicaid fraud monitoring and recovery procedures to reduce variability in practice and increase recoveries. Nearly a decade later, a 2020 report from the federal Centers for Medicare and Medicaid Services (CMS) found New Mexico's MCO contracts lacked specific policies and procedures in key areas of program integrity operations, indicating Medicaid MCO contracts and policies continue to require revision to ensure consistent fraud monitoring and recovery.

MCO contracts lack specific policies and procedures in key areas of program integrity operations. According to a 2020 CMS report, New Mexico's MCO contracts contain general language about program integrity, but fall short of providing specific policies and procedures that could help reduce inconsistencies across MCOs' operationalizing of program integrity activities. In particular, the report recommended HSD: (1) amend contract language to increase the reliability of MCO overpayment and recovery activities, (2) adopt a comprehensive adverse action policy that complies with federal regulation, and (3) provide requirements for sufficient allocation of resources to prevention, detection, and referral of suspected fraud. HSD should update MFCO contracts with these specific policies and procedures, as recommended by CMS.

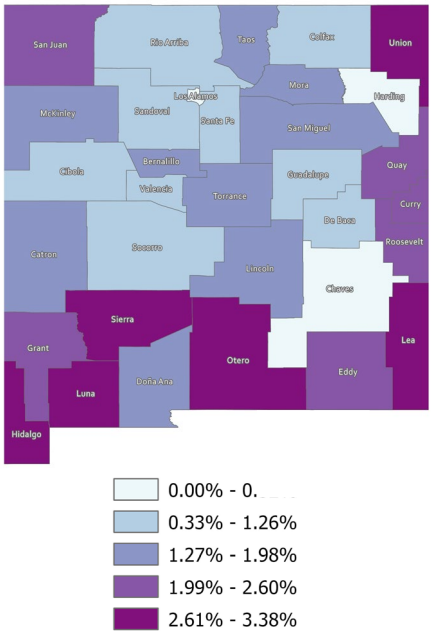
MCO contracts lack performance measures for program integrity activities. Following LFC's recommendation, in 2015, HSD began requiring MCOs to report program integrity metrics quarterly. However, HSD has not adopted LFC's recommendation to institute performance measures for MCO detection and recovery of fraud, waste, and abuse. Establishing performance measures would set clear expectations for MCOs and communicate the importance of program integrity activities.

Chart 13. From FFY12 to FFY21, New Mexico beneficiaries matched with recipients in other states increased more than five-fold



Source: LFC analysis of PARIS Interstate

Figure 2. PARIS-matched ineligible Medicaid beneficiaries as a percentage of county population



Note: PARIS matched beneficiary-reported NM residence zip codes.

Source: LFC analysis of FFY21 HSD-OIG PARIS data and U.S. Census Bureau July 2021 county populations

In 2021, Over 18 Thousand New Mexico Medicaid Enrollees Were Also Enrolled in Another State's Public Assistance Program

Federal Medicaid guidelines allow enrollees to self-attest their state of residency, which may result in the enrollment of ineligible people. The federal Public Assistance Reporting Information System (PARIS) operates an interstate match that helps states identify beneficiaries concurrently enrolled in another state's public assistance program. States may submit beneficiary data to the federal program on a quarterly basis and are returned data detailing which individuals are concurrently enrolled in other state public assistance programs. In New Mexico, HSD takes these data, verifies the individual's residency, and disnerolls individuals who are not living in New Mexico from Medicaid.

In FFY21, 18,170 individuals were ineligible for Medicaid coverage due to concurrent enrollment in another state. Matched New Mexico beneficiaries began to decrease after 2017 before climbing again in 2020, likely due in part to expanded Medicaid eligibility associated with the Covid-19 public health emergency. In FFY21, HSD verification determined 18,170 individuals received New Mexico Medicaid coverage despite being ineligible. While some of these individuals may be defrauding Medicaid, in many cases individuals moved out of New Mexico and failed to notify the state. When controlling for county population, these individuals' reported zip codes were concentrated in counties near New Mexico's border with Texas. More New Mexico beneficiaries matched with Texas than with any other state, followed by Arizona and Colorado. Although we cannot be certain, this could potentially be related to Texas' decision to not expand Medicaid coverage to low-income adults.

HSD could have recouped an estimated $27.3 million in FFY21 by recovering capitation payments made on behalf of ineligible beneficiaries. A 2009 analysis by the U.S. Department of Health and Human Services of New Mexico's follow-up on PARIS matches described New Mexico's efforts as "limited." Over a decade later, follow-up activities remain deficient. New Mexico's matches are reviewed and converted to an accessible format by HSD's contracted PARIS management analyst, Deloitte, and entered into HSD's beneficiary data system, ASPEN. ASPEN generates a letter to the beneficiary requesting residency documentation within 14 days and provides notification of their right to contest. After 14 days, an HSD Income Services Division caseworker determines whether or not to discontinue or change the beneficiaries' benefits. During this timeframe, HSD Income Services Division line managers contact other state agencies to verify enrollment and residency (see "Appendix A" for PARIS flowchart). Although matched beneficiaries might become ineligible and payments to MCOs on their behalf stopped, not all improper capitation payments are recovered.

From FFY19 to FFY21, HSD's Office of the Inspector General (OIG), used the PARIS data to identify individuals likely ineligible for the Medicaid benefits they received. The office estimated in FY21 the potential to recover $27.3 million from MCOs for inappropriate payments, as permitted in MCO contracts. Over a three year period these recoveries could have been $39 million. The office shared this information with the Income Support Division, which conducts additional verification activities and disenrolls beneficiaries. Once the individuals are determined ineligible and for which months, the Medical Assistance Division can recover capitation payments from MCOs, but the department does not recover all improper capitation payments made on behalf of these individuals. HSD indicated it recovers the capitation payment made for the month in which the individual is determined by HSD to be ineligible, but not for prior months of ineligibility. HSD was not able to provide the amount of these recoveries. HSD should begin recovering all improper capitation payments made on behalf of ineligible PARIS-identified beneficiaries.

Table 2. From 2019-2021, HSD could have recovered an estimated $39 million in recoverable capitation payments

Year	Clients	Estimated Recoverable Capitation Fees	Estimated Cost Avoidance from Dis-enrolling Client
2019	926	$3,503,797	$1,594,443
2020	1,676	$8,264,281	$4,329,973
2021	4,256	$27,278,365	$9,899,041

Note: Cost avoidance refers to future Medicaid costs avoided by disenrolling clients.
Source: LFC analysis of HSD-OIG data

New Mexico's state Medicaid plan does not require HSD to recover overpayments made on behalf of beneficiaries determined ineligible through the PARIS matching system. Since 2009, states have been required to participate in PARIS to receive Medicaid funding for automated data systems. The federal Centers for Medicare and Medicaid Services (CMS) clarified states must amend their state Medicaid plans to document participation in PARIS to meet this requirement, which New Mexico completed in 2010. Although CMS did not define what "participation" should include in state plans, the Health and Human Services Department Office of the Inspector General recommends states include four steps of PARIS participation: (1) submit data for matching, (2) verify eligibility of matched beneficiaries, (3) discontinue benefits as appropriate, and (4) recover improper Medicaid payments. New Mexico's plan requires the state possess an eligibility determination system that allows data to be matched through PARIS and requires New Mexico to provide information requested by other states consistent with PARIS agreements (4.32-A).

However, New Mexico's Medicaid plan fails to articulate critical follow-up activities required for any potential savings or recovery of improper payments. HSD standard operating procedures suggest the department disenrolls clients but does not seek repayment for ineligible clients. HSD indicates it is awaiting guidance from CMS with regard to which state holds liability to recover the capitation payments for members deemed eligible appropriately by each state and there is no utilization of services by the member. NMAC stipulates HSD may recover ineligible payments, as articulated in 8.100.640.11 (D) NMAC:

Federal regulation restricts states from disenrolling most Medicaid enrollees during the public health emergency.

The 2020 Families First Coronavirus Response Act temporarily increased the FMAP for states that maintain Medicaid enrollment through the end of the public health emergency. Sates may not disenroll individuals unless they request to be disenrolled, no longer reside in the state, or are deceased.

The public health emergency was recently extended to October 2022 by the U.S. Human Services Department.

> If the individual is deemed ineligible for any category, the department shall determine which months the individual was not eligible and forward the documentation to the medical assistance division for the determination of repayment of fee for service payments or the capitation payments made to the health maintenance organization on behalf of the individual for months the individual was not eligible for the category of assistance.

MCO contracts with the state stipulate the same (6.2.6.3). HSD should amend the state's Medicaid plan to include language and appropriate procedures regarding verification of eligibility, discontinuation of benefits, and recovery of improper payments.

In 2020, 43 percent of New Mexico Medicaid eligibility decisions reviewed through the federal program, Medicaid Eligibility Quality Control (MEQC), were made correctly. MEQC allows states to evaluate their Medicaid eligibility determination process. Of the 822 cases New Mexico examined in 2020 (including both active cases and those determined to be ineligible), 21 percent contained errors and 45 percent contained technical deficiencies. HSD identified staff errors in calculating income, failing to document verification of income or citizenship, and complexity of the electronic data system, as contributing factors. HSD's corrective action plan focused on staff training and creation of reference documents. At present, six of the 20 action items have been implemented. HSD should implement the remaining items to ensure eligibility decisions are made correctly.

Table 3. State false claims acts must comply with five components of the federal False Claims Act

State false claims act must	NM
Establish liability to the state for false claims, with respect to Medicaid spending	✓
Contain provisions that are at least as effective as the FCA at rewarding and facilitating actions filed by citizens on behalf of the government	X
Contain a requirement for filing an action under seal for 60 days with review by the state attorney general	✓
Contain a civil penalty that is not less than the amount of the civil penalty authorized under the federal FCA	✓
Authorize civil penalties that adjust with inflation to ensure the penalties increase at the same rate as those authorized under the federal FCA	X

Source: HHS-OIG

Since FFY11, New Mexico Forfeited $4.7 Million in Fraud Recoveries due to Noncompliance With the Federal False Claims Act

One key recommendation of the 2011 LFC evaluation was to bring New Mexico's statute covering the False Claims Act (FCA) in compliance with federal law which would allow the state to recover a higher percentage of civil settlements. However, despite five attempts to bring state statutes into compliance, New Mexico remains one of only seven states noncompliant with the federal False Claims Act (FCA), foregoing $4.7 million in Medicaid fraud recoveries since FFY11.

When Medicaid fraudulent claim settlements result in recoveries, the funds are shared by whistleblowers, the federal government, and the state government. The federal share is proportional to the federal government's contribution to the cost of the state Medicaid program (its FMAP). In 2005, the federal Deficit Reduction Act created a financial incentive for state legislation to comply with the federal False Claims Act. If a state's statute meets five key requirements, its share of recoveries increases 10 percentage points. New Mexico's FMAP has grown yearly, making it increasingly advantageous for New Mexico to reach compliance. Furthermore, the statutory changes the state must make—strengthening protections for whistleblowers and tying penalties to inflation—serve to increase recoveries in their own right.

Table 4. Federal False Claims Act compliance would have netted New Mexico an estimated $4.7 Million since FFY11

FFY	Total Recoveries	Medicaid FMAP	FMAP if NM Compliant	State Recoveries Expected w/o FCA Compliance	State Recoveries Expected w/ Compliance	Difference
2011	$3,387,516	0.6978	0.5978	**$1,023,707**	**$1,362,459**	**$338,751**
2012	$3,599,264	0.6936	0.5936	**$1,102,814**	**$1,462,741**	**$359,926**
2013	$2,017,386	0.6907	0.5907	**$623,977**	**$825,716**	**$201,738**
2014	$9,389,208	0.692	0.5920	**$2,891,876**	**$3,830,796**	**$938,920**
2015	$351,475	0.6965	0.5965	**$106,672**	**$141,820**	**$35,147**
2016	$6,205,203	0.7037	0.6037	**$1,838,601**	**$2,459,121**	**$620,520**
2017	$1,712,900	0.7113	0.6113	**$494,514**	**$665,804**	**$171,290**
2018	$3,941,930	0.7216	0.6216	**$1,097,433**	**$1,491,626**	**$394,193**
2019	$1,373,807	0.7226	0.6226	**$381,094**	**$518,474**	**$137,380**
2020	$6,449,922	*0.7891	0.6891	$1,360,288	**$2,005,280**	**$644,992**
2021	$8,565,048	*0.7966	0.6966	$1,742,130	**$2,598,635**	**$856,504**
Total						**$4,699,366**

Note: *FFY20 and FFY21 FMAPs reflect the 6.2 percentage point increase provided to states who meet certain requirements through the end of the Public Health Emergency.

Source: HHS-OIG

New Mexico should amend statute to comply with all federal FCA requirements to qualify for financial incentives.

In 2008, New Mexico's application for FCA compliance was rejected because state statute (the New Mexico Fraud Against Taxpayers Act) was found to be less effective than the federal FCA in facilitating and rewarding qui tam actions (filed by whistleblowers). The Office of Inspector General of the U.S. Department of Health and Human Services letter specified New Mexico statute should be amended to ensure the original source of information retains legal rights should a case be publicly disclosed. Nationally, qui tam actions accounted for 75 percent of claims brought under the FCA in FFY21. Additionally, as of 2016, state false claims acts are required to specify civil penalties will increase with inflation at the same rate and time as penalties under the federal FCA.

Qui tam action - when a private citizen files a lawsuit on behalf of the government.

New Mexico's current statute does not include this provision. Both amendments have the potential to increase recoveries. In 2012, 2013, 2016, 2017, and 2018 bills were introduced to address the state's noncompliance with the FCA, but none passed. Achieving compliance is complicated by two

Table 5. Five attempts to comply with the FCA have failed

Bill	FCA compliant?	Where the bill died
2012 HB80	No	Passed House and one Senate committee
2013 SB133	No	Passed one Senate committee
2016 HB201	Update to 2015 inflation act	Passed House, not heard in Senate
2017 SB519	Update to 2015 inflation act	Passed one Senate committee
2018 SB75	Update to 2015 inflation act	Referred to but never heard by Senate committee

Source: LFC staff analysis of NM Legis database, HHS OIG

Table 6. New Mexico must amend two sections of statute

New Mexico statute	Effective qui tam provisions	Penalties tied to inflation
NM Medicaid False Claims Act	Yes	No
Fraud Against Taxpayers Act	No	No

Source: Section 27-14-3 NMSA 1978 and Section 44-9-1 NMSA 1978

New Mexico last submitted draft false claims act legislation for federal review 14 years ago.

Of the noncompliant states, four have submitted multiple applications since rejection. New Mexico has taken the longest to resubmit a new statute for review—last submitted in 2008.

Table 10. New Mexico is one of 7 noncompliant states

Florida
Louisiana
Michigan
New Hampshire
New Jersey
New Mexico
Wisconsin

Source: HHS

factors. First, two separate sections of state statute are relevant to the FCA. New Mexico's Medicaid False Claims Act (Section 27-14 NMSA 1978) was enacted in 2004 to deter false Medicaid claims and provide pathways for recovering damages and civil recoveries for the state. The state's Fraud Against Taxpayers Act (Section 44-9 NMSA 1978), enacted in 2007 and amended in 2015, established liability for persons and entities who knowingly defraud the state, but is not limited to Medicaid. Past attempts to comply with the FCA have differed in whether they proposed amendments to one or both of the acts. Second, prior attempts have included unrelated amendments that may have made the bill more difficult to pass.

Neither of the relevant sections of state statute comply with the FCA. With regard to qui tam actions, both state statutes allow a court to dismiss an action if elements of the alleged false claim have been publicly disclosed in the news media or in a publicly disseminated governmental report at the time the complaint is filed. However, statute must also include an exception for "an original source" (meaning the person who brought the legal action is an original source of information). While the New Mexico Medicaid False Claims Act does this, the Fraud Against Taxpayers Act does not. Additionally, state statute must tie penalties to inflation, consistent with the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015 (Public Law 114-74). Both the New Mexico Medicaid False Claims Act and the Fraud Against Taxpayers Act fall short of tying penalties to inflation.

Because many stakeholders are involved in the recovery of Medicaid fraud, future attempts to pass legislation must include buy-in from all of these stakeholders and focus on bringing statute into compliance. Prior to a formal submission for review, states may request an informal review of draft legislation by the U.S. Department of Health and Human Services' Office of the Inspector General to ensure the proposed amendments will meet the requirements of the federal FCA. HSD and NMAG should work together with the Legislature to draft legislation and submit it for informal review. The Legislature should pass proposed amendments that pass informal review and maximize New Mexico's share of Medicaid fraud recoveries.

Finding

New Mexico can increase its share of fraud recoveries by complying with federal law.

Recommendation	Status			Comments
	No Action	Progressing	Complete	
NMAG and HSD should work with the Legislature to propose FCA compliant legislation				Proposed legislation should be revised and submitted for federal informal review to ensure compliance.
The Legislature should pass legislation to bring New Mexico into compliance with the federal FCA				

Finding

New Mexico's recovery of improper payments, including fraud, are highly variable.

Recommendation	Status			Comments
	No Action	Progressing	Complete	
HSD should evaluate the accuracy and appropriateness of MCO overpayment figures and recoveries.				HSD indicates it began these activities in 2021.
MFCU should improve collaboration with its referring sister agencies and federal partners				MFCU created a plan for this after 2020 HHS-OIG review.

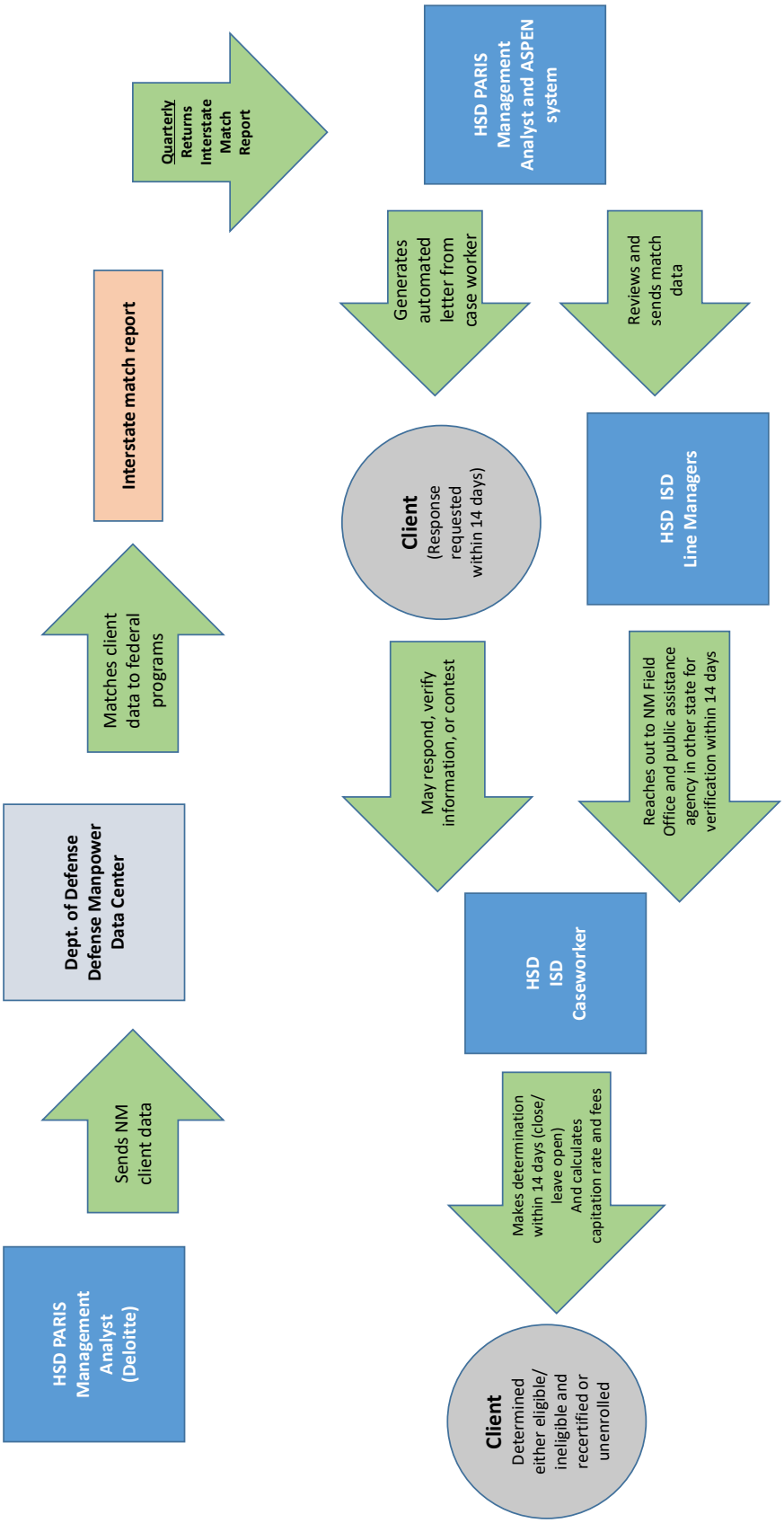
Finding

Increasing recoveries requires clarifying the roles and responsibilities of HSD, MFCU and MCOs.

Recommendation	Status			Comments
	No Action	Progressing	Complete	
HSD should move its Office of the Inspector General directly under the cabinet secretary				
HSD should consolidate its Medicaid fraud activities under OIG				
MFCU should increase its special agent FTE, potentially reallocating one nurse investigator				
MFCU should assign cases to special agents based on geography to improve efficiency				MFCU has implemented an alternative but promising interdisciplinary team model.
MFCU should institute clear referral investigation guidelines				MFCU created detailed guidelines and procedures in 2020 following HHS-OIG review.
HSD and NMAG should update their MOU to include OIG's preliminary investigation of suspected fraud				2020 MOU includes this revision.
HSD and NMAG should update their MOU to provide procedures for MCOs to refer suspected fraud to MFCU				
HSD should amend MCO contracts to create clear expectations regarding program integrity				

activities				
HSD should amend MCO contracts to include performance measures for MCO detection and recovery of fraud, waste and abuse				HSD pointed to program integrity guidelines in MCO contracts, however these are not performance measures as recommended by LFC in 2011. Additionally, OIG initially commented that such measures were not appropriate for MCO program integrity activities.
HSD should require MCOs to regularly report quantitative performance metrics				These are required quarterly through Report 56.
HSD should amend MCO contracts to incentivize improved program integrity activities				MCOs are entitled to certain recoveries.
HSD should provide MCOs clear guidelines for the extent and frequency of data mining activities				Requirements and expectations for data mining frequency should be more specific.
HSD should vet Medicaid providers rather than MCOS				

Appendix A: New Mexico's Human Services Department's follow-up activities for the federal PARIS interstate match



Appendix B: NMAG proposed changes to the Memorandum of understanding between The New Mexico Human Services Department and The New Mexico Office of the Attorney General Regarding Medicaid Fraud and Abuse

V. Duties and responsibilities of the Parties

A. Coordination of the relationship between the parties will be accomplished by:
HSD (including HSD contractors when their presence and participation are needed for an informed discussion regarding the status of complaints or information referred to the MFCU by HSD or referred directly by HSD contractors to MFCU) and the MFCU will designate representatives who shall meet periodically, but not less than quarterly, for the purpose of discussing: pending referrals from HSD or HSD contractors to the MFCU (except where such information sharing could reasonably be deemed to compromise an ongoing investigation), potential referrals and complaints, and the status of pending investigations on referrals made by HSD or HSD contractors (except where such information sharing could reasonably be deemed to compromise an ongoing investigation), appropriate means of proceeding in individual cases under review by HSD, and any other matter regarding efficient case coordination.
Responsibilities of the MFCU

7. As soon as is practicable upon the determination of the MFCU, notify HSD in writing of the acceptance or declination of a case referred by HSD or HSD contractors (except where such information sharing could reasonably be deemed to compromise an ongoing investigation). See 42 CFR §1007.9(g).

8. Provide, at least quarterly a certification to HSD whether any matter accepted on the basis of a referral from HSD or HSD contractors (except where such information sharing could reasonably be deemed to compromise an ongoing investigation) continues to be under investigation. See 42 CFR § 455.23(d)(3)(ii).

B. Responsibilities of the HSD

1. Conduct a preliminary investigation of suspected fraud, abuse or other questionable practices to determine if there is sufficient basis to warrant a full investigation. If the findings of a preliminary investigation give the agency reason to believe that an incident of fraud or abuse has occurred in the Medicaid program, the agency must refer the case to the MFCU. See 42 CFR § 455.14 and § 455.14. This does not preclude CONTRACTOR from also making a direct report to MFEAD as provided in 42 C.F.R §§ 438.608, 455.17, and 1007.9.

4. Comply with guidelines, developed pursuant to 42 CFR
§ 455.23, outlining the procedure for addressing allegations of fraud and/or abuse by Medicaid providers, including the determination of credible allegations, the referral of credible allegations to MFCU the suspension of payments or consideration of good cause exceptions, and the resolution of suspensions. This does not preclude CONTRACTOR from also making a direct report to MFEAD as provided in 42 C.F.R §§ 438.608, 455.17, and 1007.9.

5. Should HSD determine that it has received a credible allegation of fraud pursuant to 42 CFR § 455.23, it must comply with CMS Performance Standard for Referrals of Suspected Fraud from a Single State Agency to a Medicaid Fraud Control Unit, attached hereto as Exhibit A and any other applicable state and federal laws and regulations. If conflicts arise between laws and regulations, Federal and/or State law will take precedence. This does not preclude CONTRACTOR from also making a direct report to MFEAD as provided in 42 C.F.R §§ 438.608, 455.17, and 1007.9.

H. Special Provisions. HSD and the MFCU agree upon the following special provisions:

2. Nothing in this MOU shall in any way affect the HSD's authority to administer and supervise the Medicaid Program. This section does not preclude CONTRACTOR from also making a direct report to MFEAD as provided in 42 C.F.R §§ 438.608, 455.17, and 1007.9.

Appendix C: NMAG proposed changes to MCO contracts

4.17.2 Reporting and Investigating Suspected Fraud, Waste, and Abuse

4.17.2.3 The CONTRACTOR shall report all confirmed, credible or suspected Fraud, Waste and Abuse to HSD, but does not preclude an additional direct report by CONTRACTOR to MFEAD as provided in 42 C.F.R §§ 438.608, 455.17, and 1007.9 for confirmed, credible or suspected Fraud, Waste and Abuse as follows within the time frames required by HSD:

4.17.2.3.1 Suspected Fraud, Waste and Abuse in the administration of Centennial Care shall be reported to HSD, but does not preclude an additional direct report by CONTRACTOR to MFEAD as provided in 42 C.F.R §§ 438.608, 455.17, and 1007.9. It shall be HSD's responsibility to report all verified cases to MFEAD.

4.17.2.3.2 All confirmed, credible or suspected provider Fraud, Waste and Abuse shall be immediately reported to HSD, but does not preclude an additional direct report by CONTRACTOR to MFEAD as provided in 42 C.F.R §§ 438.608, 455.17, and 1007.9. Both referrals shall include the information provided in 42 C.F.R § 455.17, as applicable. It shall be HSD's responsibility to report verified cases to MFEAD.

4.17.2.3.3 All confirmed or suspected Member Fraud, Waste and Abuse shall be reported to HSD.

4.17.2.4 The CONTRACTOR shall promptly (within five (5) Business Days) make an initial report to HSD of all suspicious activities and begin conducting a preliminary investigation of all incidents of suspected and/or confirmed Fraud, Waste and/or Abuse. CONTRACTOR is not precluded from also making a direct report to MFEAD as provided in 42 C.F.R §§ 438.608, 455.17, and 1007.9. The CONTRACTOR shall have up to twelve (12) months from the date of the initial report of suspicious activity to complete its preliminary investigation and shall provide HSD with monthly updates. HSD may, in its sole discretion, require that the CONTRACTOR complete its preliminary investigation in a shorter time frame. In addition, unless prior written approval is obtained from the agency to who the incident was reported or its designed, after reporting Fraud, Waste and/or suspected Fraud, Waste and/or Abuse, the CONTRACTOR shall not take any of the following actions as they specifically relate to Centennial Care:

4.17.2.4.1 Contact the subject of the investigation about any matters related to the investigation;

4.17.2.4.2 Enter into or attempt to negotiate any settlement or agreement regarding the incident; or

4.17.2.4.3 Accept any monetary or other type of consideration offered by the subject of the investigation in connection with the incident.

7.27. Cooperation Regarding Fraud

7.27.1 The CONTRACTOR shall make an initial report to HSD and the Collaborative to the extent the activities relate to Behavioral Health, within five (5) Business Days when, in the CONTRACTOR's profession judgement, suspicious activities may have occurred. CONTRACTOR is not precluded from also making a direct report to MFEAD as provided in 42 C.F.R §§ 438.608, 455.17, and 1007.9. The CONTRACTOR shall then take steps to establish whether or not, in its professional judgment, potential Fraud has occurred. The CONTRACTOR will then make a report to HSD, and MFEAD if applicable, and submit any applicable evidence in support of its findings. If HSD decides to refer the matter to the MFEAD, or another State or federal investigative agency, and the CONTRACTOR has not made a previous referral to MFEAD, HSD will notify the CONTRACTOR within ten (10) Business Days of making the referral. The CONTRACTOR shall cooperate fully with any and all requests from MFEAD or other State of federal investigative agency for additional documentation or other types of collaboration in accordance with applicable law.

7.27.2-10 No change

7.27.11 Referrals For Credible Allegation of Fraud

7.27.11.1 The CONTRACTOR shall report to HSD suspected cases of Fraud whenever there are credible allegations of Fraud. CONTRACTOR is not precluded from also making a direct report to MFEAD as provided in 42 C.F.R §§ 438.608, 455.17, and 1007.9. The CONTRACTOR shall follow HSD's direction in identifying and reporting cases of credible allegations of Fraud. Absent a prior report by CONTRACTOR to MFEAD, HSD shall make the final determination of whether to refer such cases to MFEAD and other law enforcement agencies, for further investigation. HSD's directions to the CONTRACTOR may include but are not limited to:

7.27.11.1.1 - 7.27.11.4 No change

Appendix D: The Joint Protocol for Coordination of Referrals of Fraud by Medicaid Providers

Article I. The role of the Medicaid Fraud Control Unit

B. The MFCU will also:

1) Share information as to the existence and nature of ongoing cases and referrals with HSD-OIG except where such information sharing could reasonably be deemed to compromise an ongoing investigation.

2) Request assistance and cooperation from Participants in those investigations where necessary, including cooperation by referring Participants.

3) Consistent with applicable state and federal law that governs NMDOH confidentiality, and subject to the confidentiality requirements enumerated In Article VIII of this MOU, provide documentation upon request in support of any case being investigated by MFCU, except where such information sharing could reasonably be deemed to compromise an ongoing investigation.

4-5 no change

6) Where necessary, request assistance from the referring Participants and apprise HSD-OIG of all findings that substantiate credible allegations of fraud referred from any source; except where such information sharing could reasonably be deemed to compromise an ongoing investigation.

7) No change

8) Notify HSD-OIG of any fraud referrals received from DOH, ALTSD, CYFD, MCOs, and any other source, except where such information sharing could reasonably be deemed to compromise an ongoing investigation.

Article 2: Roles and Responsibilities

A-D. No change

E. To the extent allowed by law, DOH, HSD, ALTSD, and CYFD shall notify the MFCU of information they receive regarding potential abuse, neglect, exploitation or misappropriation of resident's property in long term care health facilities. This shall not prevent any of the MCOs from making referrals directly to MFCU.

Article 3: Process and Procedure

A. DOH will report to the MFCU any incidents reported to it pursuant to Section 11508 of the Social Security Act (the Act), as established by Section 6703(B)(a)-(b) of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act); see also 42 U.S.C.A. §1320b-25. These sections, included in 42 U.S.C.A. § 1397j termed the "Elder Justice Act," requires that all long term care facilities report to the licensing agency and at least one law enforcement agency, any reasonable suspicion of crimes committed against a resident of the facility. This shall not prevent any of the MCOs from making referrals directly to MFCU. See CMS memorandum regarding Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility (LTC); Section 1150B of the Social Security Act, attached as Exhibit A to this Joint Protocol and Memorandum of Understanding. DOH also agrees to report all substantiated incidents of abuse, neglect and exploitation (as defined in NMAC 7.1.13.7 (A), (J), and (T)) in all health facilities. This shall not prevent any of the MCOs from making referrals directly to MFCU.

B. HSD will report as per the separate MOU of 2005. HSD will also report to the MFCU any incidents of abuse, neglect and exploitation of which it is aware through the HSD Office of Inspector General. This shall not prevent any of the MCOs from making referrals directly to MFCU.