

**Report Issued:**

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**Progress Report:**

December 2013

**KEY FINDINGS**

- 1) Despite increased funding, fewer people have received services and outcomes still fall short of performance targets.
- 2) With the expansion of New Mexico’s Medicaid program, the need for state-funded behavioral services may decrease.
- 3) Recent issues of potential Medicaid fraud demonstrate a need for a stronger, better coordinated system to monitor program integrity.
- 4) The Collaborative has not maintained an ongoing assessment of system capacity.
- 5) Evidenced-based practices provide a high probability that outcomes for consumers will improve and use of public monies will be more efficient.

***Human Services Department Costs and Outcomes of Selected Behavioral Health Grants and Spending***

The evaluation examined spending and outcomes of the spending related to the safety net system for behavioral health service consumers and analyzed the adequacy of resources, the potential impact of federal healthcare reform, and outcomes being achieved by consumers.

**Background.** New Mexico’s behavioral health system has gone through several changes during the past decade. The most significant of which occurred in 2004 when legislation was enacted creating the Interagency Behavioral Health Purchasing Collaborative to administer, develop, and coordinate a single statewide behavioral health care system. However, effective January 2014, Human Services Department (HSD) will implement changes in the Medicaid system that will reintegrate physical and behavioral health. This change will break up behavioral health funding among multiple managed care organizations and agencies.

The need for a well-functioning behavioral health system in New Mexico that is responsive to consumer needs and protects public funding is evidenced by the health status of the population. The state leads the nation in alcohol-induced and drug-induced deaths. Suicide is the second leading cause of death among New Mexico youth and 30 percent of adults served in the mental health system have co-occurring mental health and substance abuse disorders. According to the Department of Health, the economic cost of alcohol abuse alone was more than \$2.5 billion in 2006, or \$1,250 per person.

The continuing cycle of change and the state’s epidemiological data present sound reasoning for continual monitoring of the system. LFC program evaluations of the behavioral health system were completed four times during these transformative years. Similar findings were cited in each of the evaluations: utilization of services did not result in more consumers being served or outcomes improving; financial oversight of the statewide entities was lax; and payment and business practices of the statewide entities and providers were cause for concern. All of this occurred in a system which has received increased funding and served fewer clients who have needed more inpatient hospitalizations and more psychiatric emergency visits, but were provided fewer crisis interventions.

**Key Recommendations.**

- The Legislature should require HSD to complete a Medicaid eligibility projection and a behavioral health needs and gaps analysis to justify existing funding levels and consider repurposing at least 50 percent of current state funding levels to Medicaid in FY16, if substantiated by the gaps and needs study. The evaluation projected 17 thousand consumers in state-funded services would migrate to Medicaid.
- HSD should report the results of the behavioral health provider audits to the LFC, clarify the role of the HSD Inspector General in the auditing process, strengthen oversight of OptumHealth’s monitoring of program integrity, establish performance measures in contracts to aid in monitoring the level of provider oversight for



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## **FY15 BHSD Fund Repurposing Proposal:**

- \$1.6 for compliance audit function.
- \$3.0 million for technical assistance for providers.
- \$3.5 million for value-added services.
- \$1.5 million to increase to non-Medicaid funding.
- \$2.5 million for supportive housing, veterans' services, and peer support workforce development.

## **The June 2013 MCO and OptumHealth contract amendments:**

- Clarifies the process for identification of overpayments and the provider's self-reporting responsibilities.
- Stipulates the contractor's role in recovery of overpayments.
- Mandates suspension of Medicaid and non-Medicaid payments when credible allegations of fraud have been verified.
- Directs how recovery of funds will be dispersed.

program integrity by OptumHealth and managed care organizations (MCO), require the statewide entity to detail analysis of changes in service costs and utilization and take appropriate action and evaluate services and programs for duplication to ensure funding is spent in the best interest of consumers.

- HSD should require the statewide entity to provide more detailed analysis of financial, service utilization, and provider access information for monitoring of the behavioral health system performance and to target resources appropriately.
- HSD should develop a minimum provider outcome data set to present to the Legislature, to display on websites, or to provide to the public on request, and prioritize service funding to evidenced-based practices.
- HSD should investigate how evidenced-based practices, such as Screening, Brief Intervention, Recovery and Treatment (SBIRT) and problem-solving courts, can be financially supported in the state.

## **Agency-reported Progress to Date.**

- Based on savings from Medicaid migration, HSD's FY15 budget proposes to redirect \$12.1 million to enhance quality and compliance initiatives, refinance value-added services that will no longer be funded by OptumHealth, and to increase funding for state-funded, non-Medicaid services. In the 2015 budget request, HSD predicts a migration of 15 thousand consumers to Medicaid.
- The contracts integrating Medicaid behavioral health services with MCOs have been completed for a January 2014 start date. A subsequent amendment to those contracts was issued to comply with new federal laws and regulations relating to program integrity.
- A June 2013 amendment to the Centennial Care contract requires MCOs to give behavioral health data to HSD for a state data warehouse, giving HSD more control over data analysis.
- The Collaborative is developing data points to measure outcomes throughout the behavioral health system and a matrix of community-based services to ensure an understanding of existing services to promote complementary use of services and prevent duplication.
- HSD received a \$10 million grant from SAMHSA in September 2013 for SBIRT implementation. This is an intervention for alcohol and substance abuse clients and is recognized as an evidenced-based practice.

## **Outstanding Issues.**

- HSD has not finalized decisions regarding the continuing role of OptumHealth with the implementation of Centennial Care and issuance of a request for proposal for administration of non-Medicaid managed care. HSD intends to extend the OptumHealth contract through December 2014. This will be done through the healthcare exemption in the procurement code, not via sole source or emergency purchase. Concerned over HSD's assertion contracts with previous statewide entity was exempt from the procurement code, legislation was enacted to clarify Collaborative contracts are not exempt. The 2014 contract will be for administrative services: paying claims, assisting with reporting of grant dollars, and quality



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monitoring, the full scope yet to be determined. Services would be paid on an administrative basis and not a capitated rate. During the year a request for information will be issued to solicit ideas for other models for consideration of the formal request for proposal. With all the changes in the behavioral health provider network, the development of a request for proposals and the implementation of Centennial Care, HSD is concerned that a July 2014 statewide entity contract start is not feasible. With the integration of physical and behavioral health, the responsibilities of a statewide entity would be considerably fewer than cited in the existing contract.

- The LFC has not received a copy of the contracted audit of 15 providers. HSD and the Attorney General have impounded the report to prevent compromising the investigation. However, all claims data and consumer records from the affected providers have been retrieved and secured by those agencies, so it is unclear why the embargo continues for those portions of the findings.
- HSD is questioning the role of the Collaborative. Although the responsibilities of the Collaborative are defined in New Mexico law, the recent years' history of the entity appears to demonstrate waning interest on behalf of statutorily identified members and at least two members have chosen to assume management of funds previously dispersed through the Collaborative.
- An HSD analysis of workforce needs in the behavioral health system has not been performed since the 2002 Behavioral Health Needs and Gaps report. A 2013 LFC program evaluation reported New Mexico is experiencing a pronounced shortage of behavioral health professionals. The situation will be exacerbated with more consumers seeking services through Medicaid expansion.

**Behavioral Health System Update.** In October 2012, HSD was notified that a program evaluation on the department's management of behavioral costs and services was scheduled and slated for presentation to the LFC in May 2013. At this meeting, HSD was made aware a request for access to claims data and site visits to review clinical documentation would be made. HSD was assured confidential consumer information would not be recorded, removed from the site, or used in the report, in compliance with federal law and regulation. The intent of the requests was to validate clinical documentation met service standards and was accompanied with appropriate billing practices. Before a formal request could be made, the LFC received a denial from the HSD Inspector General Office. LFC persisted and the claims data was finally approved, but late in the evaluation process. Site visits were not approved. The requested information for both the program evaluation and the progress report were not timely or complete, limiting the quality and scope of both reports. The recent delays impacted the ability to assess whether disruptions in care delivery were occurring and analyze expenditures for services pre- and post-transition.

In March 2013, HSD informed LFC of the contract with the Public Consulting Group (PCG) for the purpose of auditing 15 New Mexico providers. HSD indicated the audit was prompted by suspicious provider billing practices identified as a result of OptumHealth data system upgrades. According to HSD, the provider agencies were selected because they accounted for 85 percent of behavioral health spending and provided care for 30 thousand of the most vulnerable consumers. In June, 2013, HSD released a limited summary of audit results, stating the violations appear to have

***The PCG audit was funded with \$1.9 million from the HSD contractual services category.***



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## Consumer Safety Audit Findings:

- Egregious lack of treatment resulting in suicide.
- Disregard for follow up after a suicide attempt.
- Lack of communication between providers relating to medication management.
- Failure to safeguard hospitalized consumers with suicidal tendencies.

## NM Provider Pay Holds as of 11-16-13

PIW	\$351,527
El Mirador	\$370,751
Southwest Counseling	\$704,417
PMS	\$3,377,771
Hogares	\$1,812,888
Counseling Center	\$309,825
Border Area MH	\$670,283
YDI	\$235,263
Counseling Associates	\$565,339
Families and Youth	\$578,839
Valencia Counseling	\$543,016
SOY	\$1,697
SNMHD	\$156,671
Pathways	\$243,427
Teambuilders	\$3,637,547
<b>TOTAL:</b>	<b>\$13,559,261</b>

Source: HSD

persisted for several years. According to the PCG report, each of the agencies failed to meet compliance standards, with over \$36 million in overpayments projected by the audit contractor. After removing claims with errors that could be attributed to human documentation error, the audit found that more than 25 percent of the claims should not have been billed or paid. Although provider-specific audit information was not shared with the LFC, HSD did reveal non-compliance issues relating to consumer safety and fund mismanagement. In the course of the audit, other issues of concern were assessed: unusual compensation/benefits for key stakeholders and enterprise structures allowing financial gain for provider leadership.

As stated in the 2013 program evaluation, the HSD Inspector General had not been involved in any fraud and abuse monitoring, a responsibility of that office. Again, during this audit process, it does not appear as if the Inspector General took any action to verify OptumHealth's suspicious billing allegations or to validate the Public Consulting Group audit results prior to referral to the Attorney General.

Given the scope of the May 2013 program evaluation dealing with program integrity, this progress report includes an update on the system through the completion of the audit, the resulting HSD actions of the 15 audited providers, the transition to new providers, and OptumHealth's role in management of the behavioral health system over time.

**Fraud referral status.** After the completion of the audit, HSD made the decision that credible allegations of fraud could be made against 15 New Mexico providers. During the week of June 21, 2013, the 15 providers were made aware that violations were found, but not given information specific to their programs. On June 24, 2013, all 15 providers' funding was halted through "pay holds". The only action available to providers was to file for a "good cause exception," impossible to defend without access to the suspected violations. HSD accepted good cause exceptions in whole or part from Presbyterian Medical Services (PMS) for non-behavioral health services, Easter Seals El Mirador for non-behavioral health services, and Service Organization for Youth in full. The same requests from all other providers were denied by HSD.

Neither New Mexico statute nor HSD regulations afford due process to providers subject to credible allegations of fraud resulting in pay holds. The contracts with the Arizona providers mandates HSD share findings and proposed sanctions of any HSD or federal audits with the provider and allows the provider to respond prior to the imposition of sanctions. This language did not exist in OptumHealth contracts with the displaced New Mexico providers.

In May 2013, HSD issued an amendment to the OptumHealth contract as a result of directives in the federal Affordable Care Act (ACA). The ACA effectively alters the standard that state agencies use to withhold Medicaid payments to a provider from "reliable evidence of fraud" to "credible allegation of fraud." Under the replaced "reliable evidence" standard, the burden was on the state to provide actual evidence to suspend payments. Under the new standard, no actual evidence is required and only an allegation is necessary to temporarily or permanently suspend payments.



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## Settlement Agreement with PMS and YDI:

- Precludes the Medicaid Fraud Control Unit from completing any investigation and potentially alleging criminal charges against PMS or YDI for conduct relating to the submission of claims for payment of behavioral health services during the settlement period.
- Does not allow the payments by PMS and YDI to serve as an admission of any liability or fault.

States have the flexibility to determine what constitutes a “credible allegation of fraud” according to that state’s law and procedures. New Mexico, as most states, does not have a codified procedure for determining when there is a credible allegation of fraud, when funds should be suspended, and how to afford the providers due process.

Texas appears to have the most specific laws on this subject: When the responsible agency receives an allegation of Medicaid fraud, the Office of Inspector General must conduct a preliminary investigation to determine whether there is a sufficient basis to warrant a full investigation. Due process for providers is included in the Texas statute and regulations. Provider must be given notice of a withholding of payment within:

- (i) Five days of taking such action unless requested in writing by a law enforcement agency to temporarily withhold such notice.
- (ii) Thirty days if requested by law enforcement in writing to delay sending such notice, which request for delay may be renewed in writing up to twice and in no event may exceed 90 days.

The provider must be given : (A) specific basis for the hold, including identification of the claims supporting the allegation at that point in the investigation and a representative sample of any documents that form the basis for the hold and (B) a description of administrative and judicial due process remedies, including the provider's right to seek informal resolution, a formal administrative appeal hearing, or both. A provider may appeal directly to the State Office of Administrative Hearing or engage in an informal resolution process first.

Ohio’s definition of credible allegations of fraud mirrors the federal regulations but Ohio has codified the appeals process for affected providers. The due process procedure is significant because it allows the provider an opportunity to immediately prove that they were not in violation or if they were in violation that the entity as a whole was not responsible, but that an agent or employee of the provider committed fraud.

On June 21, 2013, the audit report was referred by HSD to the Attorney General, U.S. Attorney, and FBI. At that time both the Attorney General and HSD refused to reveal any more audit information, stating to do so would compromise the Attorney General’s investigations. In late July, the State Auditor filed a lawsuit to subpoena and received a copy of the audit report, contingent upon maintaining the confidentiality of the report.

On October 17, PMS and Youth Development Inc. (YDI) reached a settlement with HSD. The agreements fully and finally resolve all civil and administrative matters at issue between the parties relating to billing and reimbursement for Medicaid and non-Medicaid behavioral health services. The state waived, discharged, released, indemnified, and held harmless PMS and YDI from all liability of any kind which arises and provides the same protection for HSD from PMS and YDI. The agreements included payment to HSD of four million dollars from PMS and \$240 thousand from YDI. However, the Attorney General stated the protection for PMS and YDI, Inc. does not extend to any criminal findings, and all 15 agencies in the referral will be investigated by his office.



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## Legal Actions

### Completed:

Motion for temporary restraining order to restore Medicaid funding denied.

State Auditor Hector Balderas receives a copy of the PCG audit from HSD by court order.

Two separate District Court Judges rule that the PCG audit should remain sealed.

HSD ordered to afford hearing for provider whose Medicaid payments were suspended in 2012 and make available information and documentation relating to the allegations of credible fraud.

### Pending:

A whistleblower lawsuit is filed by former HSD employee who alleges she was fired for her communications to OSA and AG concerning OptumHealth and HSD.

State Auditor Hector Balderas goes back to court to obtain the original PCG audit results after discovering that the first copy had been altered by HSD.

Notice has been given to GSD that several former providers and patients may bring lawsuits against the State.

It is unclear whether OptumHealth will receive a percentage of the money recouped from the two providers. Amendment 15 to the OptumHealth contract provides a payment schedule for recouped funds allowing OptumHealth to keep a percentage of the non-federal share of the recoupment. OptumHealth is not entitled to recovery if the Collaborative or HSD independently identified and pursued the false and/or fraudulent claims.

**Status of Attorney General investigations and State Auditor activities.** The Attorney General's office is still in the investigative phase of the referral received from HSD on aberrant billing practices of 15 behavioral health providers. Significant resources have been dedicated to this investigation. Results will be released as individual provider investigations are completed, with the first of those reports possible by the end of 2013, according to that office.

Given HSD's significant expenditure of federal funds, independent auditors are federally required by federal law to test and report whether HSD has adequate procedures in place to identify fraud and safeguard federal funds. For example, federal guidelines require that HSD have methods or criteria for identifying suspected fraud cases, methods for investigating those cases, and procedures for referring suspected fraud cases to law enforcement officials. New Mexico law requires HSD to submit an annual fiscal year financial audit, which is conducted by an independent auditor, to the Office of the State Auditor (OSA). The OSA has issued the independent auditor a formal and confidential referral which directs the auditor to include certain items in its normal test work related to HSD's oversight and expenditure of Medicaid funds and compliance with its own internal policies and procedures for investigating, verifying and referring credible allegations of fraud. The referral also notifies the independent auditor that the OSA has received complaints and allegations relating to the provider audits, including the procurement process followed by HSD. The report is due to the OSA no later than December 16, 2013.

Throughout this entire process, several lawsuits have been filed. Many could be unresolved for years, based upon the time needed for the investigation to be completed. If successful, it is not known who would be the liable entity or what resulting costs may be.

**Provider pay hold status.** Pay holds were continued for the 14 remaining providers until lack of funds prevented 12 agencies from continuing operations. The funds accumulated through the holds are being held by OptumHealth. Funding holds were active for all behavioral health funding streams.

**Selection of new providers.** Between June 2013 and August 2013, HSD entered into contracts with five Arizona behavioral health providers. First contacts and contract dates vary by agency.



### Selection criteria for replacement providers:

- Standing in the Arizona Regional Provider Network-had to be in good standing.
- Transparency in reporting data and record of good outcomes for consumers
- Analysis of IRS filed 990's.
- Experience in assisting a struggling BH entity
- Experience in serving a similar demographics
- Good billing record (less than a 5% error rate on average).
- Controls in place for quality and compliance monitoring across multiple sites.
- Willingness to assist a neighboring state, with uncertainty of what may be found onsite.

**Table 1. HSD Contacts with Arizona Companies**

Provider Agency	First Contact with NM	Contract Date
Agave Health, Inc.	Early January 2013	July 10, 2013
La Frontera Center, Inc.	May 2013	June 18, 2013
Turquoise Health and Wellness, Inc.	June 2013	July 5, 2013
Open Skies Healthcare, Inc.	Late June-Early July	August 01, 2013
Valle Del Sol of New Mexico	Late June 2013	July 5, 2013

Source: Arizona Companies

HSD indicated the federal Substance Abuse and Mental Health Services Administration (SAMHSA) personnel had recommended the audit firm and the Arizona providers to HSD. SAMHSA indicated the New Mexico personnel had informed SAMHSA of their intent to contract with specific Arizona providers and SAMHSA did not make recommendations regarding those providers. The agency also denied recommending a specific firm or MCO to conduct the audit.

Although selection criteria was shared with the LFC, it is unclear how the criteria was measured, other than reviews of quality dashboards posted by Arizona's state behavioral health administration.

**Contracts with Arizona providers.** The HSD contracts with Arizona providers place both parties and behavioral health consumers at risk for service disruptions and stability of the provider network. The contracts primarily focus on reimbursement for services and the mandated General Services Department boilerplate language. The scope of the work section states, "Undertake and provide all services that were previously provided by the behavioral health entity identified by HSD. The contractor can rely on pre-existing work for the purposes of providing ongoing clinical services to consumers, including but not limited to assessments, treatment plans, and progress notes." However, with consumer records impounded, there was limited pre-existing work to guide, and not disrupt, consumer treatment plans. Providing all services of the prior agencies means some of the selected providers will deliver services not in their Arizona service array, including comprehensive community support services and treatment foster care.

All five contracts allow either party may terminate, for convenience or cause, with 30 days notice to the other party. This clause exposes New Mexico to the possibility that providers could cease operations in the state with minimal notice, leaving consumers without access to treatment. The program integrity portions of the contract focuses only on findings and sanctions, and does not prescribe an acceptable fraud and abuse monitoring program. Further, the new companies do not meet capitalization requirements for cash reserves.

The providers were expeditiously awarded emergency certifications, licensures, and designations by DOH, CYFD, a national multisystemic therapy accreditation agency, and the Board of Pharmacy. Both DOH and CYFD require that documentation justifying longer term approvals would be submitted at a later date. However, treatment foster care, not a service delivered by all of the new providers in their Arizona programs and comprehensive community support services, a design unique to New Mexico, were



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also approved. It does not appear OptumHealth has been involved in providing technical assistance or training to ensure the new providers meet the New Mexico standards.

**Funding status of new providers.** Payment to these providers is subject to the availability of funds, an issue which HSD is presently facing. Funding for each provider was identified in their respective contracts. The contracts are slated to expire December 31, 2013, when MCO's replace HSD as the contracting bodies. The Arizona providers are in negotiations or have completed contracts with the MCOs. It is not known if OptumHealth has interacted with these providers for contracts in the upcoming year.

**Table 2. Contractual Funding for Arizona Providers**  
(in thousands)

Agency	Contractual Amount	Expended as of 11/21/2013
Agave Health, Inc.	\$7,100	\$7,100
La Frontera Center, Inc.	\$4,750	\$4,750
Turquoise Health and Wellness, Inc.	\$2,000	\$2,000
Open Skies Healthcare, Inc.	\$2,000	\$1,921
Valle del Sol of New Mexico	\$2,000	\$2,000
<b>Total</b>	<b>\$17,850</b>	<b>\$17,771</b>

Source: HSD

## LFC Reasons for BAR Objection

- Essential use of the funds was not described.
- The request was premature.
- Detailed descriptions of the transgressions by New Mexico providers were not given to the LFC.
- Per hourly contract rates were excessive.
- HSD had not provided detail on how initial funds were spent.
- The replacement of providers appeared to be creating disruptions in services for needy individuals.

The initial funding for these providers was accessed through a budget adjustment request (BAR) to transfer \$7.5 million from HSD's other contracted services category. A second budget adjustment request for an additional \$10.3 million was made by HSD and approved by DFA. For multiple reasons, the LFC objected to the adjustment request.

In addition to former employee payroll expenditures, reimbursements were made to treatment foster care parents and shelter care services. The Arizona providers, for most sites, assumed physical facilities and rental obligations in buildings which had housed the New Mexico providers. In most situations, the lease payments are made to the former provider, a foundation of the provider, or an investment group which includes the former provider. Valle del Sol has chosen to consolidate services and administration in Los Lunas, but not in the Henry Perea Building, a state-owned facility. The May 2013 program evaluation expressed concern the lease arrangements with former providers violated the state's anti-donation statute.

The contract does allow reimbursement for costs associated with the agreement, but does not specify which costs are allowable. The contract also states tangible personal property purchased with funds from this agreement shall become the property of HSD unless specifically authorized by HSD or if the contractor continues to do business in New Mexico.

The contracts require providers to submit detailed invoices to either the Collaborative or the HSD Inspector General before reimbursement is made. A review of the available invoices demonstrates many have been approved without expenditures being detailed. At least one situation exists where erroneous payments were made. Although the contracts do not stipulate a responsibility for former provider payrolls, the Arizona



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providers were obligated to fund the closing payrolls for the transitioned providers. It is not known if this was accomplished through an HSD letter of direction to OptumHealth or a verbal agreement between the providers and HSD. One new provider billed worked hours of the former employees at the enhanced rate for contractor employees. The remittance was directed to HSD inspector general staff. LFC could not identify the approving party, but did verify through the SHARE system significant overpayment was made.

**Table 3. Transitional Provider Spending**

Agency	Payroll, Foster Parents, BH Shelter Staff	Professional Services	Leasing	Operating Cost	Total Expenditures
Agave	\$5,042,815	\$2,057,184			\$7,100,000
La Frontera	\$1,422,156	\$2,040,812	\$183,800	\$1,103,230	\$4,749,999
Open Skies	\$736,046	\$850,738	\$333,840		\$1,920,626
Turquoise	\$652,280	\$786,162	\$90,608	\$470,948	\$2,000,000
Valle del Sol	\$880,776	\$539,884	\$67,463	\$511,876	\$2,000,000
<b>Totals</b>	<b>\$8,734,076</b>	<b>\$6,274,782</b>	<b>\$675,712</b>	<b>\$2,086,054</b>	<b>\$17,770,626</b>

Source: HSD

Financial independence, through service billings, for the Arizona providers has been delayed by the need to adjust processing systems and to train staff transitioned from the New Mexico providers. Clinical documentation was found to not meet the requirements for legitimate billing. As of October 2013 only Valle del Sol and Agave have paid claims in the OptumHealth system. Allowing invoice billing for professional services and other expenses, as opposed to funding through claims submission, has eliminated the opportunity for HSD to determine if the volume and services for consumers are appropriate and prevents HSD from ensuring actuarially sound rates for MCOs and providers.

Unanticipated delays in claim reimbursements are financially stressing each of the new providers. Each provider had exhausted available funding as of November 22, 2013. HSD has directed OptumHealth to continue appropriate payments to the new providers using the settlement collections from PMS and YDI.

**Service disruptions.** Transition of providers created difficulties for consumers and the new providers. However, disruptions in service were difficult to assess. Consumer medical records were impounded by HSD, leaving new providers without clinical information. The number of consumers being served by pre- and post- transitioned agencies and the number and qualifications of personnel delivering the services were also not available.

Enrollment data from OptumHealth includes contact and service information for all consumers so those receiving services could be identified and notified of provider terminations and availability of new providers. The contracts between OptumHealth and New Mexico providers clearly give OptumHealth the authority to notify consumers of provider terminations. The claims data could have been used to retrieve active services by consumers to prevent disruption in care.



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Claims data was requested for FY12 through FY14. LFC intended to analyze utilization patterns and also determine if disruptions in care had occurred. The data was received one week prior to the completion of the progress report, but was not usable until a password was obtained and missing data was received. The validity of the data came into question when vast differences between FY12 and the FY13 and FY14 claims were found and, except for two, the Arizona providers had not yet been completely successful in claims submissions.

An analysis of the New Mexico Crisis and Access line shows the average monthly number of routine and urgent calls for July and August increased 72 percent compared to the previous five months.

OptumHealth compiled a Secret Shopper survey at the request of LFC. The survey showed significant variation for access to care pre- and post- transition. The survey specific to new providers was done nearly four months after operations began. Surveys completed prior to the transition showed most providers, with few exceptions, could accommodate requests within HSD access standards or could make appropriate referrals if services were not available at the surveyed facility.

**Table 4. Secret Shopper Results**  
11/13/13 and 11/14/13

<b>Agave Health</b>	Call not completed as dialed-called number three times (Routine Call)	If therapist available, available for existing crisis patients only (Urgent Call)	Answering machine instructed caller to dial 911 (Crisis Call)	Therapist available (Crisis Call)
<b>La Frontera</b>	First appointment weeks away (Routine Call)	Voice mailbox is full (Urgent Call)	Someone available to process now-therapist available in 10 days (Routine Call)	Therapist available (2X Crisis Call)
<b>Open Skies Healthcare</b>	Call went to voicemail, instructions to call 911 or leave message (Routine Call)	Therapist Available (Urgent, Crisis and Routine Call)		
<b>Turquoise Health and Wellness</b>	No therapist on call for crisis referred to ER (Crisis Call)	No therapist available. Could provide names of therapists in community (Routine Call)	No answer, no option to leave voicemail (Urgent Call)	Therapist Available (Crisis Call)
<b>Valle del Sol of New Mexico</b>	Answering machine recording-call 911, crisis line number, leave message (Crisis Call)	Spoke to intake person and made her aware that the Santa Fe office number went to voicemail (Routine Call)	Wait list-will call (Routine)	Therapist Available (2X Crisis Call, Urgent Call, Routine Call)

Source: OptumHealth

*The survey is conducted by assuming consumer or family member status and requesting a routine, urgent, or crisis appointment.*



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According to the Memorial Medical Center psychiatric unit medical director, admissions to the psychiatric unit had significantly increased in October and November 2013. Beds remain full, with patients presenting to the emergency room having 12 to 24 hour waits for an inpatient bed. Lack of inpatient beds has also caused an increase in requests to transfer patients to the New Mexico Behavioral Health Institute. Dona Ana county 2013 admissions to the Institute showed an average of 38 patients was admitted every four months. From July through November, 2013, 60 patients were admitted. The medical director indicated the presenting complaints from consumers were: no access to medications and the decreased frequency, cancellation, or delay of outpatient appointments, including consumers in high-intensity and frequent contact programs such as intensive outpatient and assertive community treatment.

Comparing July and August 2012 data with the same months in 2013, emergency room use by Salud recipients with a behavioral health diagnoses, show no change from year to year. Encounters to the UNM Psychiatric Emergency Room also do not demonstrate an increasing trend since the transition. This facility would be representative of both state and Medicaid-funded consumers.

Personnel in the new agencies contacted LFC staff with concerns specific to their position or practice: physicians' only access to information regarding consumer drug therapy is to call local pharmacies, lack of clinical documentation which exposes consumers to a restart in the assessment and treatment process, the discontinuation a prescription program providing free medications which impacted drug therapy and exacerbated illnesses, and the lack of adherence to fidelity to program standards, specifically the Assertive Community Treatment program. Information was received also expressing concern that payee funds are being co-mingled with agency funds, in violation of federal Internal Revenue statute. The complaint continues by stating payee access to their funds was delayed resulting in the inability of consumers to purchase food or pay rent. Also medication changes are being made without consent of the guardian, which is prohibited by federal and state law or regulation.

These issues and concerns were forwarded to HSD for review, the proper authority for follow-up.

HSD claims many of the audited agencies withheld information from the new providers, took medical files, shredded records, and did not accurately report staffing patterns. As a result, HSD had to develop a method of gaining access to medical records while maintaining the confidentiality of the records. HSD also reported efforts made by OptumHealth to contact consumers to explain the transition. The outreach could not be validated by LFC.

***OptumHealth oversight of providers.*** A review of OptumHealth anti-fraud reports from FY11 through FY12 demonstrates knowledge of suspicious billing activity by behavioral health providers. For OptumHealth's first quarter FY11 fraud and abuse reports to HSD, claims data for eight agencies was mined to identify if more than eight hours for one service was billed for a single consumer. Services reviewed were skills training and development, comprehensive community support services, psycho-social



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rehabilitation, and multi-systemic therapy. The review found expenditures for services above five hours in a day, for single consumers, were nearly \$10 million. Of the eight providers only four were chosen for field audits: El Mirador, Families and Youth, Inc, Valencia Counseling, and Carlsbad Mental Health. Teambuilders, one of the eight and a high volume provider, was not selected. The initial conclusion by OptumHealth indicated eight hours appears to be the community norm. Subsequent reports do not address this specific issue, although issues, in addition to overutilization, were found.

**Table 5. FY 11 OptumHealth Summary Fraud Monitoring Report**

Agency	Initial Allegation Code
Border Area Mental Health	Altering medical records
Counseling Associates	Billing for services not rendered
Pathways	False coding and overutilization
PMS	Billing for unnecessary services, altering medical records, fraudulent employee behavior
Southwest Counseling	Billing for unnecessary services
Valencia Counseling	Overutilization
The Counseling Center	Overutilization

Source: OptumHealth CI-16 Anti-Fraud Report 10/31/2012

OptumHealth has the contractual duty to have in place a comprehensive internal program to prevent, detect, investigate and report potential and actual violations, and to help recover funds misspent due to fraudulent actions by the provider. In the first quarter of FY11, OptumHealth indicates the agency was taking steps to significantly increase its fraud and abuse prevention and detection activities by upgrading an analyst position to a fraud and abuse investigator and creating a new position for data analysis. Results of those actions are not cited in the subsequent reports. In the second quarter of FY11, OptumHealth began a review process of the fraud and abuse functions and activities of the company, but reports indicate they were still in the experimental stages of the program, reviewing lessons learned and opportunities for improvement.

In the last quarter of FY13, OptumHealth had 89 cases open, pending further review, and 29 cases pending preliminary review and referral, if appropriate. In the final FY13 full year summary, only eight of the fifteen providers, later implicated in suspicious activities, are mentioned.

**HSD oversight of OptumHealth.** OptumHealth has received over \$135 million capitated and administrative fees over the past three years, but has not been able to fulfill contractual obligations.

In response to the RFP, OptumHealth replied in the affirmative to possession of a claims system which had specific controls for prevention and detection of claims edits and post-processing review of claims, which has proven problematic. Also, the original HSD contract with OptumHealth directs the entity to have and implement a functioning claims processing system and policies and procedures to address prevention, detection, preliminary investigation and reporting of potential and actual provider fraud and abuse. However, from the beginning of its contract until present, OptumHealth has been under eight corrective action, directed corrective action, or process improvement plans. The directed corrective action plan resulted in the placement of a contracted overseer at a

**OptumHealth Fees  
FY11-FY13**

FY 11	\$48,547,842
FY12	\$42,339,155
FY13	\$43,720,810

Source: Collaborative



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## DHI Findings 2010-2013

- Lack of care coordination,
- Treatment records were not maintained in a manner that is current, comprehensive, detailed, organized and legible, Master treatment plans, assessments and reassessments were not completed.
- Documentation did not exist describing participation by all team members in consumer care meetings, Consumer consents for care were lacking.

cost of nearly \$200 thousand to OptumHealth. The primary violations identified in the directed corrective action plan were the inability to process claims accurately and timely and a cumbersome service registration process, which impacted claims submissions. Most significant was a spike in denials issued by OptumHealth, which expanded the corrective action plan. To alleviate the financial pressures on providers, OptumHealth relaxed system edits and implemented expedited claims payments which later resulted in the need to recoup over \$22 million in overpayments. By June 2011, \$18 million had been recouped.

As of 2013, the contracted overseer recommended the directed action plan be transferred to the Collaborative to continue work on open issues. OptumHealth's operations from FY09 through FY12 produced many opportunities for errors in payments to providers and reporting to the Collaborative. It is unclear if any of the chaos within the OptumHealth contributes to the findings of the audit completed in 2013.

Data was available to OptumHealth demonstrating a need for action much earlier than FY13. As an example, OptumHealth should have been alerted of a need for deeper data analysis when the number of consumers being served decreased and costs increased. There is no documentation that this data was analyzed, but may have demonstrated inappropriate billing or overutilization. Also, no evidence is available to show that OptumHealth interceded when the Department of Health surveys of core service providers found major deficiencies which were duplicated across agencies. Because the OptumHealth claims processing system was not adequate for nearly three years, these reports would have provided information that further investigation on their part was necessary to ensure services were provided, compliance with standards were maintained, and only legitimate reimbursement was requested and paid. If OptumHealth would have intervened earlier in response to the DOH findings, it is possible the drastic actions resulting from the PCG audit could have been prevented.

**Impact of Medicaid expansion.** The May 2013 program evaluation projected that 17 thousand existing consumers would migrate to Medicaid. HSD's FY 15 budget request proposes an increase of \$5.4 million to the Behavioral Health Services Division and a savings of \$15.3 million with the migration of consumers to the Medicaid program. A needs and gaps analysis has not been completed. Without more information is not clear why or if an increase in non-Medicaid funding is necessary with Medicaid expansion or why additional dollars are needed for program integrity functions and technical assistance for providers if HSD intends to continue contracting with a statewide entity.

**Conclusion.** With the proposed changes in the statewide entity contract and the implementation of Centennial Care, the recommendations made in the 2013 program evaluation are even more relevant: complete a gaps and needs analysis, repurpose unspent state general fund dollars to programs and services which are needed and are evidence-based, and ensure functioning systems are in place to: monitor the judicious use of public funding. The responsibility for closer monitoring is also increased by the addition of new providers, the lack of clarity in the roles for both the Collaborative and OptumHealth, and the reintegration of physical and behavioral health.