Report
to
The LEGISLATIVE FINANCE COMMITTEE

Human Services Department and Office of the Attorney General
Medicaid Fraud, Waste, and Abuse Controls
July 14, 2011

Report #11-07

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David Abbey
Director

July 14, 2011

Ms. Sidonie Squire, Secretary
Human Services Department
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Hon. Gary King, Attorney General
Office of the Attorney General
408 Galisteo St. – Villagra Bldg.
Santa Fe, New Mexico 87501

Dear Secretary Squire and Attorney General King:

On behalf of the Legislative Finance Committee (Committee), I am pleased to transmit the *Medicaid Fraud, Waste, and Abuse Controls Program Evaluation.* The evaluation team assessed program costs, performance, and oversight of efforts by the Human Services Department and the Office of the Attorney General to combat fraud, waste, and abuse in Medicaid programs. An exit conference was conducted with the Human Services Department and the Office of the Attorney General to discuss the contents of the report. The Committee would like a plan to address the recommendations within 30 days.

I believe this report addresses issues the Committee asked us to review and hope both participating entities will benefit from our efforts. We very much appreciate the cooperation and assistance we received from the staff of each agency.

Sincerely,

David Abbey

David Abbey, Director

DA:MG/svb

Cc: Senator John Arthur Smith, Chairman, LFC
Representative Luciano "Lucky" Varela, Vice-Chairman, LFC

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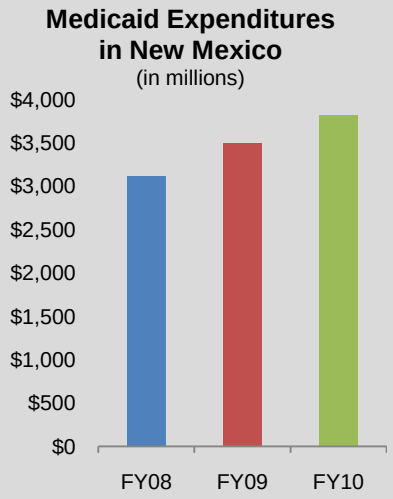
EXECUTIVE SUMMARY

In New Mexico, fraud, waste, and abuse controls for Medicaid exist in the Human Services Department (HSD) including contracted managed care organizations (MCOs) and within the Medicaid Fraud and Elder Abuse Division (MFEAD) of the Office of the Attorney General .



Source: LFC Volume II

Over 75 percent of Medicaid claims are accounted for by New Mexico's seven MCOs.

Medicaid enrollment and expenditures are at their highest point in state history. In FY10, New Mexico's Medicaid program served over 460,000 New Mexicans at a cost of $3.8 billion. However, the amount of Medicaid funds lost to fraud, waste, and abuse is poorly understood. The National Healthcare Anti-Fraud Association predicted in FY10 that fraud alone would account for 3 percent of all healthcare expenditures nationwide, totaling $60 billion. In New Mexico, fraud, waste, and abuse controls for Medicaid exist in the Human Services Department (HSD), including contracted managed care organizations (MCOs), and within the Medicaid Fraud and Elder Abuse Division (MFEAD) of the Office of the Attorney General.

The HSD is designated the single state agency by the Centers for Medicare and Medicaid Services (CMS). The HSD is responsible for administering claims payments for the fee-for-service program, and remitting capitation payments to MCOs. Over 75 percent of Medicaid claims are accounted for by New Mexico's seven MCOs, which serve as the representatives of the state in administrating Medicaid services and also serve as the first line of defense in detecting fraud, waste, and abuse. Within the HSD, the Quality Assurance Bureau (QAB) oversees surveillance for the fee-for-service program, and the Office of the Inspector General (OIG) is responsible for recipient fraud concerns.

The entity responsible for investigating and prosecuting provider fraud and resident abuse and exploitation is the Medicaid Fraud and Elder Abuse Division (MFEAD) within the Attorney General's office. Created as the state of New Mexico's Medicaid Fraud Control Unit under the federal Medicaid Anti-Fraud and Abuse Amendments of 1977, the MFEAD is funded by a mixture of federal and state funds.

The entities responsible for Medicaid fraud, waste, and abuse controls in New Mexico have potential for preventing, reducing, and recovering the monies lost to such activities. However, as a whole, they do not pay for themselves, suffer from fragmented program integrity oversight, and foster a pattern of wasteful spending. Significant opportunities exist to improve upon these controls and improve performance among the HSD, the MFEAD, and the MCOs.

Structural, functional, and oversight issues need to be addressed in order to ensure effective use of state and federal resources supporting Medicaid fraud, waste, and abuse controls. A refocusing of some personnel, the implementation and use of meaningful performance

The MFEAD ranks 49th in the nation both in ROI and total dollars recovered for FFY10.

Even though most of the HSD expenditures are from Medicaid, the OIG focuses the majority of their efforts on non-Medicaid programs such as SNAP and TANF.

Combined, the seven MCO program integrity units have 10.69 FTEs overseeing $1.8 billion in Medicaid funds.

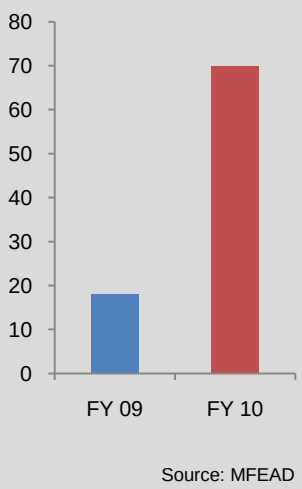
measures across all entities including improved oversight of MCOs, and more effective communications among entities will ensure improved outcomes.

New Mexico has a poor return on its investment in reducing Medicaid fraud, waste, and abuse. New Mexico spends an estimated $7.8 million across the HSD and the MFEAD to root out fraud, waste, and abuse. In FY10, recoveries by these entities were approximately $5.3 million. As a whole, New Mexico's efforts do not pay for themselves, do not have adequate internal performance measures such as return on investment (ROI), and lack adequate oversight and performance measures on program integrity for MCOs.

The MFEAD ranks next to last nationally on ROI despite having adequate resources. The MFEAD is one of only three Medicaid Fraud Control Units that recover less money from Medicaid fraud and abuse than is expended from its grants. The MFEAD ranks 49th in the nation both in ROI and total dollars recovered for FFY10. New Mexico's ROI is $0.53 for every $1 spent, far behind peer states such as West Virginia ($17.72) and South Carolina ($22.44). For the last four years, the MFEAD's expenses exceeded recoveries. When compared with similar states on staffing measures such as expenditures per staff member and staff per investigation, the MFEAD ranks near the middle, showing that many states are doing more with less.

The HSD's Office of the Inspector General primarily focuses on other programs despite Medicaid expenditures accounting for the vast majority of the HSD's spending. The majority of the HSD's expenditures are dedicated to Medicaid and many of these expenditures are in high risk areas. However the HSD's OIG recipient fraud recoveries account for only 2 percent of all of the OIG's recoveries. Even though most of the HSD's expenditures are from Medicaid, THE OIG focuses the majority of their efforts on non-Medicaid programs such as SNAP and TANF. The OIG has not had a positive return on investment for the last two fiscal years and lacks data to calculate ROI activities associated with the Medicaid program within the OIG.

The HSD lacks adequate oversight over MCO fraud, waste, and abuse functions. MCO contracts do not provide clear guidance or adequate benchmarks to measure success of their efforts in combating fraud, waste, and abuse. As a result, none of the MCOs provide concrete evidence of the effectiveness of their programs. Additionally, the HSD does not provide guidance on MCO program integrity unit staffing. Combined, the seven MCO program integrity units have 10.69 FTEs overseeing $1.8 billion in Medicaid funds.



Existing collaboration between the MFEAD and the OIG may be in violation of federal law.

The HSD, as the single state Medicaid agency, is responsible for claims payments for the DD waiver, however the QAB does not track fraud referrals specific to DD waiver contractors.

Unlike other states, the OIG does not report to the HSD secretary directly, potentially impeding independence and objectivity.

Fragmented Medicaid program integrity oversight fosters jurisdictional confusion, duplication of effort, and ineffectiveness.

Among the entities responsible for combating fraud, waste, and abuse for Medicaid, there exist gaps in communication among agencies, inefficient uses of resources, and a lack of effective practices. All of these issues contribute to problems in tracking, discovering, and investigating fraud, waste, and abuse.

Communication problems between the MFEAD and the HSD adversely affect fraud, waste, and abuse efforts. The MFEAD cites many examples of interference, filtering, and sterilization regarding information provided to the MFEAD from the HSD. Additionally, existing collaboration between the MFEAD and the OIG may be in violation of federal law. Changes in communication also led to a 290 percent increase in fraud referrals from the HSD between FY09 and FY10, contributing to the MFEAD's increased percentage of open referrals. Guidelines for referral-building to the HSD from the MFEAD could increase viability of referrals.

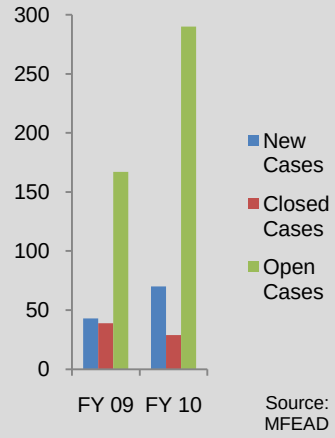
Neither the QAB nor the MFEAD track PCO or DD waiver home and community-based services for program integrity issues. In FY10, PCO accounted for $334 million, or 46 percent, of total program spending, making it one of the fastest growing service categories in the CoLTS program. PCO fraud risk is demonstrated through the MFEAD's 21 open home health investigations related to agencies or providers, or 29 percent of total open investigations. PCO timesheet fraud is also a major work driver for the MFEAD.

In FY08, DD waiver expenditures were $267 million. The HSD, as the single state Medicaid agency, is responsible for claims payments for the DD waiver, however the QAB does not track fraud referrals specific to DD waiver contractors. While DD waiver is a smaller portion of overall Medicaid expenditures, services related to day habilitation, respite and substitute care, and therapies can leave gray areas for improper payments as is the case with PCO in CoLTS.

Potential conflicts of interest and inefficiencies in the OIG could be resolved through reporting and personnel changes in the HSD. The OIG does not report to the HSD secretary directly, potentially impeding independence and objectivity. Also, other states leverage a model of their OIG reporting to the cabinet secretary along with placing the entire state program integrity function into their OIG. In Arizona, all referrals go to one point of contact and all preliminary investigations are housed under one functional division reporting to the cabinet secretary.

There is currently no designated timeline for completion of an initial investigation in the MFEAD and no guidelines exist for prioritizing referrals.

MFEAD New, Closed, and Open Fraud Cases Per FY



Source: MFEAD

New Mexico falls short in implementing GAO strategies to help reduce fraud, waste, and abuse.

Optum Health has been unable to provide meaningful encounter data to the HSD leaving the capitated rate to be set based on estimates rather than actual claims data.

The MFEAD processes are slowed by a lack of referral prioritization and an imbalance in the allocation of human resources. When a referral is received at the MFEAD, it is forwarded to the director, who reviews the referral and assigns a team which includes an attorney and various investigators. There is currently no designated timeline for completion of an initial investigation and no guidelines exist for prioritizing referrals. This has contributed to a high rate of outstanding referrals and a backlog of open cases. Home and community-based services, including PCO, and inaccurate reporting of service hours are the main workload drivers in fraud referrals. These types of cases usually do not have a clinical component and do not require the assistance of a RN investigator, so RNs are sometimes reallocated to perform other administrative tasks such as court filings. In contrast, there are too few special agents. Two agents assist on cases across the state without a geographic division of labor, performing a variety of functions, including interviewing witnesses and executing search warrants.

Significant opportunities exist to strengthen Medicaid fraud, waste, and abuse controls. Problems in provider credentialing, limitations in payment review, and a lack of meaningful measurement of MCO activities all contribute to a need to streamline procedures and improve oversight of MCO. Central to controlling Medicaid fraud, waste, and abuse are strategies to improve provider enrollment requirements, enhance pre- and post-payment review, improve contractor oversight, and develop processes to address identified vulnerabilities. These strategies are outlined by the U.S. Government Accountability Office (GAO). However, New Mexico falls short in implementing GAO strategies to help reduce fraud, waste, and abuse.

The HSD's role in managing fee-for-service and managed care creates fragmented and confusing requirements and practices for providers and MCOs. Provider application procedures differ between fee-for-service and MCOs, such as a lack of a credentialing questionnaire for fee-for-service. Also, while state law requires the HSD to ensure credentialing processes are coordinated among MCOs, each MCO has a separate credentialing function. Other application discrepancies include the requirement that providers disclose potential conflicts of interest in their applications, found for only one MCO. Discrepancies also exist in data methodology as MCOs and the QAB utilize different techniques for overpayment recoveries with varying success rates. Additionally, a lack of adequate encounter data reporting requirements results in high margins of error and an inability for some MCOs to meaningfully report this data. As a result, the HSD estimates the capitated rate for Optum Health, rather than using actual claims data.

In its current state the QAB referral database is unlikely to have the capability to support the Patient Protection and Affordable Care Act.

The QAB uses a database to track referral data that does not allow for meaningful analysis and leaves New Mexico's Medicaid program vulnerable to repeat offenders. Data integrity issues and insufficient database design limit the HSD's ability to identify repeat offenders, track length of time from initial referral to referral closure, calculate dollars under investigation, and identify potential performance metrics. In its current state, the QAB referral database is unlikely to have the capability to support the Patient Protection and Affordable Care Act. Extracting meaningful analysis from a referral database would assist the QAB in identifying high risk providers who have repeat referrals and understanding the current state of program integrity efforts, MCO performance, and fiscal impact.

Key Recommendations.

The Human Services Department

The HSD should implement ROI measures internally and across all MCOs to track success of program activities and program effectiveness.

The HSD should amend MCO contracts to include performance measures related to fraud, waste, and abuse prevention activities.

The HSD should streamline and prioritize Medicaid program integrity functions through the following.

- Move the OIG to report directly to the HSD secretary.
- Consolidate selected staff from the QAB, Internal Audit and the Investigations Bureaus into a new Medicaid Program Integrity Bureau within the OIG.
- Designate the Medicaid Program Integrity Bureau to be the single point of contact for receiving, detecting, investigating allegations of fraud and abuse; coordinate to prepare referrals to the Office of Attorney General; oversee, with Medicaid's Contract Management Bureau, external quality review organization contract audits of MCOs and performance and compliance of MCO program integrity functions.

The HSD should consider modifying its rate development and amounts available for administration and profit for MCOs, including increasing its pay-for-performance set-aside to 5 percent of total premium, administratively setting base capitation rates for all MCOs, sharing medical savings with MCOs that meet all of their performance targets, and using a competitive bid process for awarding administrative/ profit amounts.

The Medicaid Fraud and Elder Abuse Division

The MFEAD should implement ROI measures to track success of program activities.

The MFEAD should reallocate at least one RN investigator FTE to a special agent, or alternately consider completing the required process for investigators to also serve as special agents.

The MFEAD should formalize referral guidelines from the MFEAD including data required for a fraud referral from the QAB.

Legislature

The Legislature should revise state statute to bring the state false claims act into compliance with DHHS OIG requirements to increase the share of civil settlements recovered by New Mexico.

BACKGROUND INFORMATION

Medicaid overview. The Medicaid program was created by Title XIX of the Social Security Act (42 USC 1396 et seq.) in 1965 to provide health insurance grants to states for low income individuals and families. The Medicaid program is a federal and state funded program with provisions required to be met by states to receive funding. Federally, Medicaid is managed by the Centers for Medicare and Medicaid Services (CMS). In 1973, the New Mexico Legislature passed the "Public Assistance Act" (27-2 NMSA 1978) which codifies the state's enactment of the federal Medicaid program. In 1997, the legislature enacted the Medicaid Fraud Act (30-44 NMSA 1978) which defines Medicaid fraud and associated penalties. The Medicaid fraud statute coincided with the move to managed care organizations in 1997. The growth of managed care organizations in the Medicaid program is significant as the traditional model of reimbursing doctors for services delivered ("fee-for-service") is replaced with payments to managed care organizations on a per enrollee basis known as capitated payments. These managed care organizations in turn reimburse doctors on the basis of services and have an incentive to decrease service costs to maximize profits. New Mexico has seen a growth in managed care organizations from four organizations in FY09 to seven in FY11.

Fraud, waste, and abuse in Medicaid. By 2018, CMS predicts that healthcare spending will reach $4.4 trillion and account for 20 percent of the gross domestic product. The Medicare and Medicaid programs together spent $720 billion nationally in 2009. In FY10, New Mexico's Medicaid program served over 460,000 people and had expenditures of $3.8 billion for all programs. The amount of Medicaid funds lost to fraud is poorly understood. During the same time period that the state enacted its Medicaid Fraud Act and was increasingly moving to managed care, the US Department of Health and Human Services, Office of the Inspector General (DHHS OIG) released a report that identified an overpayment rate of 14 percent or $23 billion in 1997. The National Healthcare Anti-Fraud Association predicted in FY10 that fraud accounts for 3 percent of all healthcare expenditures, or $60 billion. A recent overview in the 2010 American Criminal Law Review predicts the portion of this cost of healthcare fraud to taxpayers to be about $36 billion a year nationally.

The U.S. Government Accountability Office (GAO) recommends five strategies to help reduce waste, fraud, and abuse in Medicare and Medicaid:

- Strengthen provider enrollment standards and procedures;
- Improve pre-payment review of claims;
- Focus post-payment claims review on most vulnerable areas;
- Improve oversight of contractors; and
- Develop a robust process for addressing identified vulnerabilities.

Most of these strategies are aligned with provisions of the federal Patient Protection and Affordable Care Act (PPACA), which requires increased review of potentially high risk provider applications, greater oversight of contractors (home healthcare providers, prescription benefit managers, and others), and the addition of pre-payment controls to minimize release of improper payments. GAO also emphasized the role that states play in the design of their individual state Medicaid, and as such they are vital in addressing control weaknesses that contribute to improper payments. In New Mexico, fraud, waste, and abuse controls for Medicaid exist in the Human Services Department (HSD), including contracted managed care organizations (MCOs), and within the Medicaid Fraud and Elder Abuse Division of the Office of the Attorney General (MFEAD).

Human Services Department (HSD). The Medical Assistance Division within the HSD is responsible for administering claims payments for the fee-for-service program and remitting capitation payments to the managed care organizations supervising the Salud!, CoLTS, and behavioral health programs as the designated single state agency by the Centers for Medicare and Medicaid Services (CMS).

Quality Assurance Bureau (QAB). The primary objective of the QAB is to ensure quality through oversight of all aspects of care quality, fraud and abuse detection, and performance measurement. CMS requires states to have a specific program integrity unit within the single state agency to review issues related to fraud, waste, and abuse in Medicaid. The QAB performs this function.

Office of the Inspector General (OIG). The Office of the Inspector General has responsibilities to prevent and detect fraud, waste, and abuse in programs administered by the HSD, including Medicaid. The OIG conducts investigations, audits, and financial recovery operations using 39 FTEs divided into the Investigations Bureau, Internal Audit Bureau, Restitution and Administrative Services Bureau, and Fair Hearings Bureau. Specific to Medicaid, the Investigations Bureau assesses violations of law and misconduct related to Medicaid recipients, including program eligibility. Additionally, the Internal Audit Bureau creates an annual audit and project plan, which includes Medicaid issues that require further scrutiny. For FY 2010, this audit plan included projects on durable medical equipment providers and Medicaid exclusions.

Managed care organizations. The state of New Mexico contracts with seven managed care organizations (MCOs) which are responsible for over 75 percent of Medicaid claims, which include four MCOs for the Salud! program, two for the CoLTS program, and one for behavioral health services. These MCOs serve as the representatives of the state in administrating Medicaid services by contracting providers and maintaining a network, and also serve as the first line of defense in detecting fraud, waste, and abuse. The MCO contracts refer to fraud, waste, and abuse detection functions as Program Integrity (PI). Contracts require that MCOs have a written policy of how they address program integrity issues; a structure that includes a compliance officer and committee; provide enterprise-wide training on issues related to fraud, waste, and abuse; and report any reasonable suspicions of fraud to the QAB after conducting a preliminary investigation. The HSD assesses compliance with these provisions through periodic comprehensive compliance audits of MCO operations by the New Mexico Medical Review Association, through monthly and quarterly reporting, as well as through annual fraud plan approvals for each of the MCOs.

Medicaid Fraud and Elder Abuse Division- Office of the Attorney General. In 1977, Congress passed the Medicare-Medicaid Anti-Fraud and Abuse Amendments, which created Medicaid Fraud Control Units. These units are funded with a combination of federal and state funds, with the objective of investigating and prosecuting provider fraud and resident abuse. Each state has a Medicaid Fraud Control Unit, and in New Mexico it is the Medicaid Fraud and Elder Abuse Division (MFEAD) within the Office of the Attorney General. The MFEAD is approved to staff 21 FTEs, but has 16 FTEs and five vacancies as of May 2011. The MFEAD investigates and pursues judicial action through the criminal or civil courts relating to provider fraud, elder abuse, or elder financial exploitation. The MFEAD receives case referrals from various outlets including a required public fraud hotline, nursing home facilities and other institutions, state agencies, law enforcement, and state licensing boards. The MFEAD also represents New Mexico in multi-state lawsuits against entities such as pharmaceutical companies, durable medical equipments firms, and nursing home operators and also handles qui tam (whistleblower) cases under the False Claims Act.

PROJECT INFORMATION

Evaluation Objectives

- Review the cost, responsibility and coordination of State agencies and other entities for detection and correction of Medicaid fraud and abuse.
- Assess the performance outcomes from efforts to combat fraud and abuse and how they compare to benchmarks and other states.
- Identify coordination efforts between the Office of the Attorney General, the Human Services Department, federal entities and other stakeholders to combat healthcare fraud and abuse.

Scope and Methodology

- Reviewed:
  - Applicable laws and regulations;
  - LFC file documents, including all available project documents;
  - Relevant benchmarks, policy, and procedures from other states;
  - Information from outside sources including DHHS THE OIG and CMS;
  - Literature and best practice documents regarding Medicaid fraud;
- Interviewed state agency staff, staff in other state agencies, and staff from federal entities;

Authority for Evaluation. The LFC has the statutory authority under Section 2-5-3 NMSA 1978 to examine laws governing the finances and operations of departments, agencies and institutions of New Mexico and all of its political subdivisions, the effects of laws on the proper functioning of these governmental units and the policies and costs. The LFC is also authorized to make recommendations for change to the Legislature. In furtherance of its statutory responsibility, the LFC may conduct inquiries into specific transactions affecting the operating policies and cost of governmental units and their compliance with state law.

Evaluation Team.
Charles Sallee, Deputy Director for Program Evaluation
Maria D. Griego, Program Evaluator
Jon Courtney, Program Evaluator
Steve Morgan, Consultant

Exit Conference. The contents of this report were discussed with Ms. Sidonie Squier, Secretary, Human Services Department, Mr. Albert Lama, Deputy Attorney General, and senior staff from each department on July 5, 2011.

Report Distribution. This report is intended for the information of the Office of the Governor, the Human Services Department, the Office of the Attorney General, the Office of the State Auditor, and the Legislative Finance Committee. This restriction is not intended to limit distribution of this report, which is a matter of public record.

Charles Sallee
Deputy Director for Program Evaluation

NEW MEXICO HAS A POOR RETURN ON ITS INVESTMENT IN REDUCING MEDICAID FRAUD, WASTE, AND ABUSE Error! Bookmark not defined.

New Mexico spends an estimated $7.8 million across the HSD and the MFEAD to root out fraud, waste, and abuse in the state's $3.8 billion Medicaid program. Using a conservative 3 percent estimate from the National Healthcare Anti-Fraud Association, New Mexico's Medicaid system annually contains an estimated minimum of $75 million of fraud.

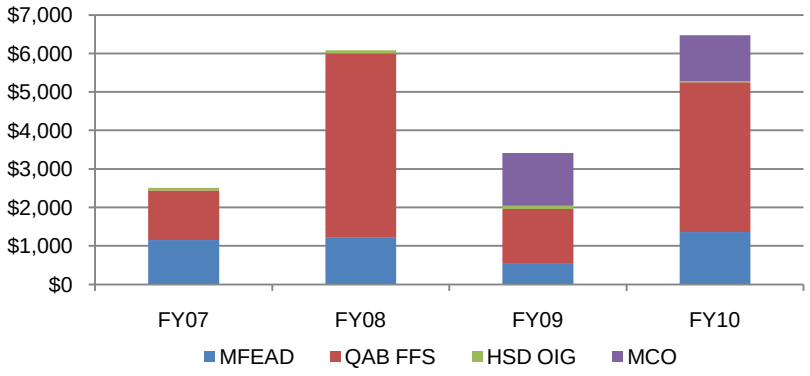
In FY10, the HSD had 56 full-time equivalent (FTE) staff across its Quality Assurance Bureau (QAB) and Office of Inspector General (OIG) at a cost of about $5.9 million. An estimated 11 FTE were employed by Medicaid at the state's seven managed care organizations in program integrity functions. However, not all of these FTEs are dedicated full-time to Medicaid program integrity and may perform other program functions for Medicaid not directly tied to fraud, waste, and abuse. In FY10, these entities reported recovering over $6 million in overpayments or criminal/civil judgements as a result of fraud or abusive billing either from providers or recipients. The state must revert the federal portion of most recoveries at the approved federal matching rate. However, states may receive an additional 10 percent of recoveries if they have enacted a false claims statute that complies with federal guidelines.

Table 1. Expenses
(in thousands)

Entity	FTEs	Expense
HSD - QAB	17	$3,850
HSD - OIG	39	$2,037 *
HSD – MCO**	11	Unknown
MFEAD	21	$1,915
Total	**88**	**$7,801**

Source: MFEAD, HSD, MCOs. * OIG also oversees other programs so not all expenses can necessarily be attributed solely to Medicaid.**Actual expenses are not reported and FTE are estimated from a survey.

Graph 1. Total Medicaid Recoupments by Entity FY07-FY10
(in thousands)



Note: MCO data only available for FY09 & FY10.

Source: MFEAD, HSD

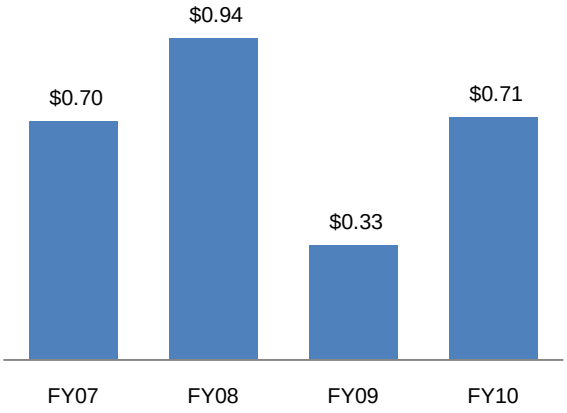
In FY10, the Medicaid Fraud and Elder Abuse Division of the Office of the Attorney General ranked 49th nationally in return on investment; for every dollar spent the state recoups 53 cents. Provider fraud represents 80 percent of all healthcare fraud, therefore the MFEAD's ability to successfully prosecute provider fraud cases is a core component in recovering taxpayer dollars and deterring fraud in the Medicaid system. However, the MFEAD does not generate enough revenue into Medicaid from civil or criminal recoveries to pay for itself completely. Only three states' Medicaid Fraud Control Units, which are New Mexico, Alaska and Delaware, do not pay for themselves. The FY10 national return on investment for state Medicaid Fraud Control Units was almost $9 per every $1 spent, with West Virginia recouping $17.72 and South Carolina $22.44. In addition, CMS reports its federal Medicare Integrity Program medical review activities has a return on investment of $21 per $1 spent.

In federal FY10, the MFEAD recoveries from civil judgements were small compared to other states and as a percentage of total Medicaid expenditures. According to DHHS, New Mexico's civil judgements averaged $50 thousand, ranking the state 48th. Civil judgements totaled $956 thousand, or about 0.03 percent of Medicaid expenditures, placing the state 49th nationally.

Many of the MFEAD's larger recoveries are related to Qui Tam (whistleblower) cases or multi-state settlements. Other judgments are smaller and may not even pay for the resources expended to prosecute. For example, a 2011 case where a respite care provider submitted falsified timesheets resulted in a total judgment of $6 thousand. As timesheet fraud is a major work driver for the MFEAD, the result may continue to be smaller civil judgments. In contrast, the MFEAD prosecuted a PCO agency for not completing criminal background checks, falsifying provider medical test results, and failing to comply with monthly supervisor visits. The total judgment in the case was $622 thousand. These examples demonstrate the wide range of potential returns on the MFEAD cases and further bolster the need to track resources used in cases and their results.

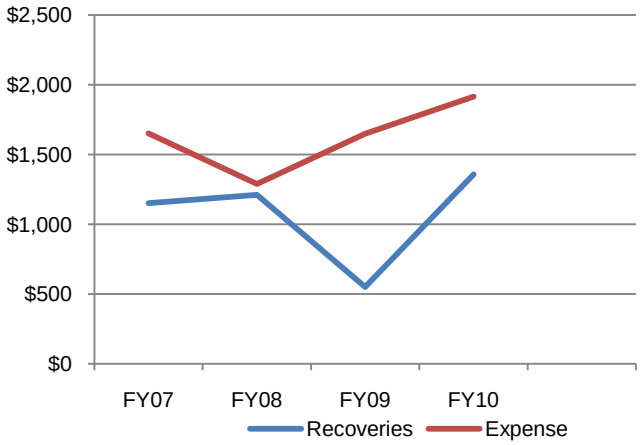
The MFEAD has historically struggled to pay for itself. The MFEAD averaged $1.1 million in identified Medicaid criminal and civil recoveries between state FY07 and FY10, with average expenses of $1.6 million. Over this time period, expenses continued to increase, while in FY09, recoveries took a sharp decline. In FY10, expenses continued to outpace recoveries, indicating that the MFEAD is only recuperating the state match funds of approximately 25 cents on the dollar.

Graph 2. MFEAD Medicaid Recoveries per Dollar of Expense FY07-FY10



Source: MFEAD

Graph 3. MFEAD Recoveries and Expenditures, FY07-FY11
(in thousands)



Source: MFEAD and LFC Volume II

Many states' Medicaid Fraud Control Units are doing more with less. New Mexico ranks 28th in number of staff per total investigations for FY10 and ranks 25th in Medicaid expenditures per MFEAD staff member. New Mexico also ranks near the middle for these two staff resource measures nationally and among peer states. Looking at five states with higher spending levels and five with lower spending levels, New Mexico has the 7th lowest amount of Medicaid expenditures per staff and the 6th highest level of staff per investigation. Considering additional rankings on measures such as ROI, Medicaid total recoveries, and convictions, the MFEAD is underperforming given its adequate fiscal and human resources.

Table 2. Expenditure per Medicaid Fraud Control Unit staff member as Compared to States with Similar Medicaid Expenditures FFY10
(in thousands)

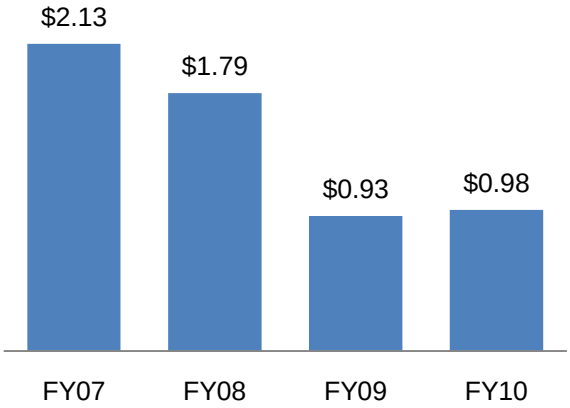
	Total FFY10 Medicaid expenditure	Medicaid expenditure per Fraud Unit staff member	Staff Per Investigations
Alabama	$3,421,115	$488,731	4.7
Maine	$2,405,287	$343,612	9.0
Oregon	$4,269,153	$341,532	5.9
Colorado	$4,193,565	$299,540	7.1
Iowa	$3,153,215	$286,656	17.5
Oklahoma	$4,088,939	$240,526	9.0
New Mexico	**$3,581,365**	**$223,835**	**7.7**
Arkansas	$4,071,189	$185,054	4.7
Kansas	$2,538,386	$169,226	10.7
West Virginia	$2,650,115	$165,632	4.0
Mississippi	$4,216,556	$150,591	20.2

Source: LFC Analysis of US DHHS THE OIG dataset

The current state false claims act has not been approved by DHHS OIG, limiting New Mexico's share of civil settlements. Approval of a state false claims act from DHHS OIG qualifies a state for a 10 percent increase in their share of civil settlements. New Mexico has enacted a state false claims act but has not received DHHS OIG approval for the act. New Mexico's false claims act was reviewed by DHHS OIG in

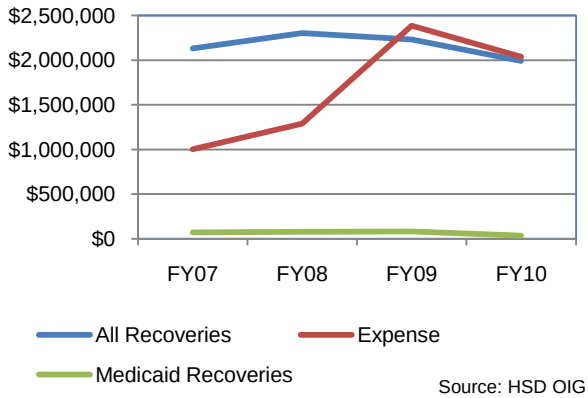
2008 and was found to be out of compliance with state false claims act requirements. Since this review, additional changes have been made in the federal false claims act, further affecting compliance for New Mexico's false claims act. Revising the state statute to comply would result in additional revenues.

Graph 4. HSD - OIG Return on Investment All Programs FY07-FY10



Source: LFC Analysis

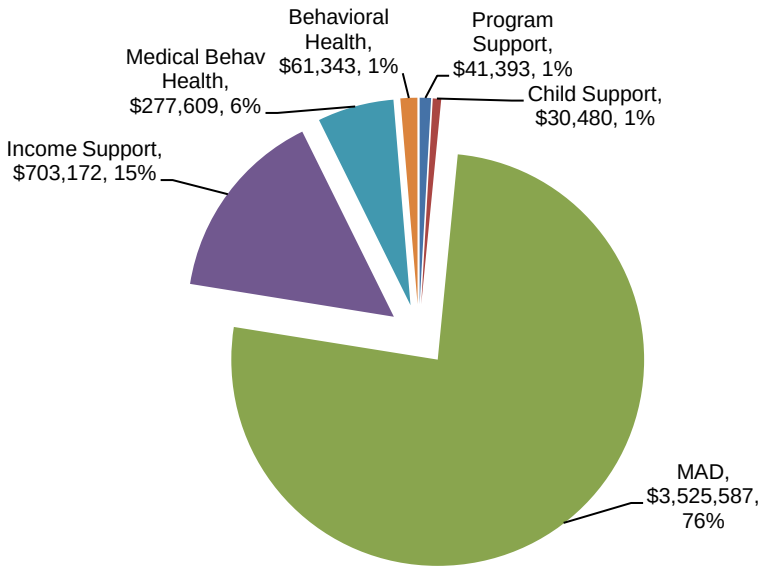
Graph 5. HSD OIG's Recoveries and Expenses FY07-FY10



Source: HSD OIG

The HSD's Office of the Inspector General (OIG) primarily focuses on other programs and only recovered a total of $265 thousand for the Medicaid program between FY07 and FY10. Medicaid recoveries constituted only 2 percent of all OIG recoveries in FY10. The OIG historically has only focused on recipient fraud, primarily for non-Medicaid programs such as the Supplemental Nutrition Assistance Program (formerly food stamps) and the Temporary Assistance for Needy Families (TANF) program. However, Medicaid accounts for the vast majority of the HSD's spending, totaling $3.8 billion in FY10 and involves high-risk spending areas. The OIG has not generated sufficient recoveries to provide a positive return on this investment, particularly as expenses increased in FY09 and FY10. Sufficient information was not available to isolate ROI for activities associated with the Medicaid program within the OIG. Collecting and monitoring this type of data will be increasingly important as the OIG adjusts its staff focus to Medicaid.

Graph 6. SFY 2010 HSD Expenditures
(in thousands)



Source: January 2011 Volume II

In FY10, the Quality Assurance Bureau recovered over $2 million or about 53 cents on every dollar spent pursuing these overpayments due to abusive billing practices. The QAB, among all entities pursuing recoveries in Medicaid, is responsible for the majority of recoupments. However, the QAB focuses its oversight efforts on an increasingly small portion of Medicaid costs under the fee-for-service portion of the program. Although the QAB targets overpayment recuperation efforts to only the 25 percent of Medicaid that falls under fee-for-service, they are responsible for 60 percent of total recoupments in FY10. The QAB relies on Medicaid managed care organizations (MCOs) to conduct surveillance and the program integrity function for the remaining portion of Medicaid.

Through the Accountability in Government Act, the Legislature could use performance measures to monitor the return on investment in Medicaid program integrity functions at the HSD and the Medicaid Fraud and Elder Abuse Division in the Office of the Attorney General. Both agencies routinely report amounts recovered or collected from civil and criminal judgments to LFC.

The HSD has outsourced fraud, waste, and abuse detection functions to Medicaid MCOs with insufficient performance expectations and oversight. The HSD does not provide clear guidance or adequate benchmarks to measure success of MCO efforts in combating fraud, waste, and abuse. As a result, none of the MCOs provide concrete evidence of their effectiveness. All MCOs respond to referrals received from recipients and providers, investigate individual instances, and per the contract, notify the QAB with their resolution or request to escalate the issue for further scrutiny. The HSD does not require MCOs to report potential financial impact of cases they are investigating, although MCOs often disclose this information. Not having a consistently required method to measure results across all MCOs does not give the HSD adequate information to determine an MCO's ability to identify high-risk claims activity or recuperate funds that were inappropriately paid to providers. The HSD needs sufficient data to hold MCOs accountable in their role of prudently managing Medicaid funds.

MCOs leverage data mining, either internally or through a third party vendor, to review claims using standard edits looking for unusual claims behavior. These edits include looking for claims submitted by deceased providers or for deceased recipients, billing for services outside of a provider's declared specialty, or frequency of narcotic prescriptions issued. Finally, program integrity officers at the MCOs request medical records and/or contact the recipient to verify appropriate services were rendered. Some MCOs routinely select a random sample of recipients and ask them to contact the MCO if the services billed were not actually rendered. While all of these activities are useful surveillance tools for strengthening program integrity, insufficient guidance exists on how extensive these activities should be and whether they are sufficient to be considered a thorough fraud, waste, and abuse prevention program.

No contract performance measures relate to designing effective fraud, waste, and abuse programs. Within the MCO contracts, there are various measures that the HSD uses to rate performance and award performance pay, but only two of the ten measures relate to an MCO's ability to successfully guard Medicaid funds, and none are specific to program integrity. The HSD lacks sufficient MCO reporting requirements to monitor the effectiveness of program integrity activities. There are two reporting requirements related to program integrity and more than 15 reporting requirements related to financial, clinical, and customer service standards. This imbalance in reporting creates a side effect where seeking out potential issues of fraud, waste, and abuse may take on a secondary role to other compliance requirements. Not having a performance measure or performance reporting related to fraud, waste, and abuse detection minimizes the importance of having adequate controls and fails to motivate MCOs to find ways to improve their surveillance functions.

The HSD does not require Medicaid MCOs to report program integrity expenses and recoveries of overpayments, limiting effective oversight. The HSD does not require quantitative performance reporting of MCO efforts related to program integrity. Without this information, the HSD cannot conduct return on investment analysis. In addition, MCOs did not provide expenses associated with generating recoveries to LFC evaluators, making a complete return on investment (ROI) impossible to calculate. Study findings suggest that ROI analysis, while not a perfect measurement, is an easily implemented, straightforward baseline to begin measuring program integrity efforts. As an alternative measurement, MCOs recovered $1.2 million in overpayments in FY10, 0.067 percent of total claims paid.

The HSD does not require, nor monitor, the size of a program integrity unit within a MCO, resulting in 10.69 total FTE overseeing $1.8 billion in Medicaid funds in FY11. This results in an average of $167 million per FTE across all MCOs. In some cases, one compliance officer was tasked with managing both Medicaid program integrity activities alongside monitoring the MCO's commercial book of business.

Opportunities exist for MCOs to provide meaningful outcome measurements of program integrity activities. One MCO, Amerigroup, tracks what they refer to as "soft dollar" recoveries, where they identify the savings captured by mitigating the abusive behavior. They reported soft dollar recoveries for the last two fiscal years of $1.3 million. Both hard and soft dollar recoveries, as well as ROI calculations, have potential to quantify the long-term effects of program integrity activities. Without measurement parameters, the HSD will not be able to appropriately allocate resources.

RECOMMENDATIONS

The HSD and the MFEAD should implement return on investment measures to track success of program activities and request the addition of these measures to those reported under the Accountability in Government Act. Both agencies should work to set reasonable targets, benchmark performance with other states, and set long-term goals for improvement.

The Legislature should revise state statute to bring the state false claims act into compliance with DHHS OIG requirements to increase the share of civil settlements recovered by New Mexico.

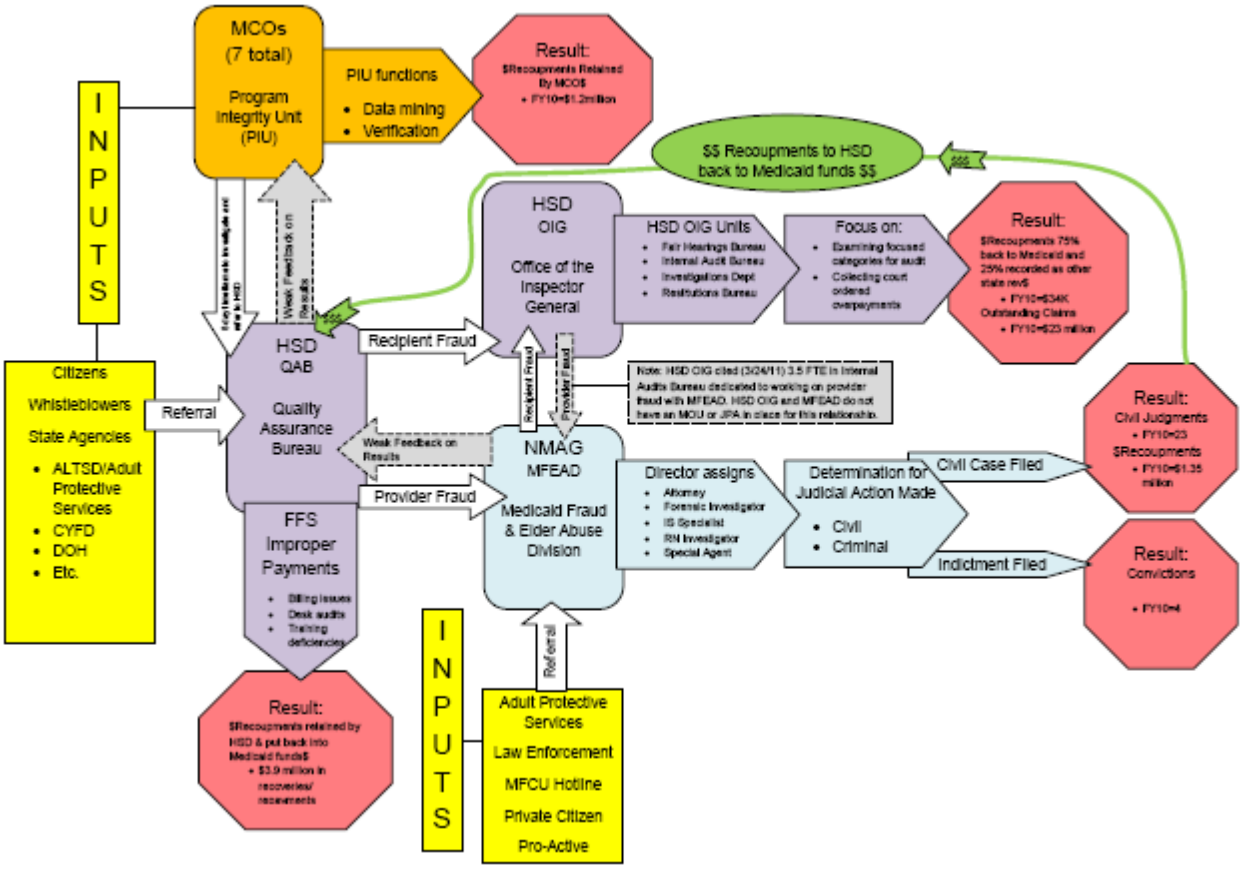
The HSD should implement both hard and soft dollar recoveries and ROI calculations across all MCOs with guidelines on how to measure and report this data to the HSD to demonstrate program effectiveness.

The HSD should amend MCO contracts to include performance measures related to fraud, waste, and abuse prevention activities. MCOs should be incentivized to improve their efforts to seek out irregular behaviors from providers and recipients and quantify how their efforts are preventing a loss to the state.

FRAGMENTED MEDICAID PROGRAM INTEGRITY OVERSIGHT FOSTERS JURISDICTIONAL CONFUSION, DUPLICATION OF EFFORT, AND INEFFECTIVENESS

Lack of coordination between entities results in inconsistent practices, oversight gaps, and duplication of efforts. Figure 1 shows how referrals for fraud make their way from the identifying entity to the MFEAD for prosecution.

Figure 1. Fraud Referral Process Map



In the case of recipient fraud, referrals are made to the Office of the Inspector General (OIG) at the HSD by MCOs, providers, state agencies such as the DOH or the ALTSD, or the public. Any recoveries made by the OIG are referred back to Medicaid funds administered by the HSD.

The Quality Assurance Bureau (QAB) requires MCOs to report suspicious activity within five business days of identifying a concern. All MCOs are contractually required to perform a preliminary investigation on all referrals, which can lead to resolution and closure of some referrals.

The QAB flags overpayments for recoupment for what they deem to be abusive billing practices and not fraud. The QAB staff use the best practices promulgated by CMS for fraud referrals to the MFEAD, but also use their professional judgment for referrals to the program integrity unit of the QAB for recoupment versus the MFEAD as fraud. In Tennessee, the program integrity unit sends a letter to MCOs notifying them when issues have been escalated or closed. This provides formal notice to MCOs as to whether they

should continue to pursue overpayment recovery themselves or whether they need to defer all action to their state's Medicaid Fraud Control Unit. The QAB, in contrast, does not notify MCOs of the status of outstanding referrals and whether they have been escalated to the MFEAD or closed. Moreover, provider or recipient referrals for violations of the Medical Practice Act are forwarded to the Medical Board, violations of the Nurse Practice Act go to the Board of Nursing and violations of the Pharmacy Act go to the Board of Pharmacy.

Communication problems between the MFEAD and the HSD adversely affect fraud, waste, and abuse efforts. According to annual reports, the MFEAD has cited examples of interference in the division's requests for information by the HSD in the past, including that the HSD inhibits prosecutions by inappropriately filtering and sterilizing information provided to the MFEAD. Furthermore, the current MOU between the HSD and the MFEAD places responsibility on the MFEAD to make and monitor program recommendations to the HSD.

The MFEAD has not communicated guidelines for referral-building to the HSD, resulting in increased referral investigation of information-poor referrals and increased time to turn referrals into cases. The MFEAD has identified issues with referrals received from the HSD not containing sufficient data to expedite the decision process on whether a referral is viable to become a case. CMS has published best practice guidelines for referrals to state Medicaid Fraud Control Units which include:

- basic information (name, address, Medicaid Provider ID, etc.);
- source of complaint;
- date issue reported to state; and
- description of suspected misconduct (including specific statutes, rules or regulations violated; claims payment data for three years or over the duration of the suspected act, whichever is greater; all communications between the state agency and the provider related to this issue; and exposed dollar amount, when available).

Additionally, the MFEAD could reduce the amount of time and resources expended on validating referrals by partnering with the HSD to review referrals and provide guidance on what constitutes an appropriate fraud referral. The MFEAD experienced an almost 290 percent increase in referrals from the HSD's surveillance and utilization review section (SUR/S), however many of these referrals were not viable to convert into a civil or criminal case. In FY10, 38 referrals to the MFEAD were not viable for various reasons, including no evidence of fraud, incomplete data, or lack of jurisdiction. This contributed to a case conversion rate of 19 percent.

Some the HSD and the MFEAD's collaboration may conflict with federal law. The OIG's Internal Audit Bureau within the HSD started work on provider fraud to supplement the MFEAD's efforts to investigate provider fraud, but without a formal memorandum of understanding (MOU) or joint powers agreement (JPA). The agencies have not formalized this relationship or process to ensure it does not run counter to federal law or requirements for investigating Medicaid fraud. As the entity responsible for provider fraud, the MFEAD must be separate and distinct from the single state agency (HSD) that administers or supervises the administration of the state plan.

The MFEAD is required to do an independent review of possible provider fraud in the Medicaid program and "no official of the Medicaid agency will have authority to review the activities of the unit." The MFEAD may refer a case to another prosecuting authority, provided they maintain oversight responsibility. The current MOU for the HSD and the MFEAD only recognizes the Medical Assistance

Division of the HSD as the entity that can work with the MFEAD. Memoranda of understanding would need to be updated to reflect new functional relationships with the OIG.

Neither the QAB nor the MFEAD track PCO and DD waiver home and community-based services for program integrity issues. Personal Care Option services (PCO), as administered by the CoLTS program, has become a major cost-driver and risk area within Medicaid. In FY10, PCO accounted for $334 million, or 46 percent of total program spending, making it one of the fastest growing service categories in the CoLTS program. PCO fraud risk is demonstrated through the MFEAD's 21 open home health investigations related to either agencies or providers, which is 29 percent of total open investigations. PCO timesheet fraud is a major work driver for the MFEAD.

The QAB also does not track PCO-related referrals, so it is impossible to ascertain the volume of referrals specific to this service category. For example, Ambercare is a home health care agency operating under 11 provider ID numbers in both fee-for-service and managed care. Between FY07 and FY10, Ambercare claims payments totaled $109 million. As an agency, they have been referred to the QAB seven times in the last three years and there have been three civil judgments through the MFEAD totaling $85 thousand.

In FY10, Developmental Disabilities Waiver (DD waiver) expenditures were approximately $300 million. The HSD, as the single state Medicaid agency, is responsible for claims payments for the DD waiver, however the QAB does not track fraud referrals specific to DD waiver contractors, nor has it performed surveillance of claims associated with this large program. While DD waiver is a smaller portion of overall Medicaid expenditures when compared to Salud! or CoLTS, services related to day habilitation, respite and substitute care, and therapies can leave gray areas for improper payments as is the case with PCO services in CoLTS.

The OIG does not report to the HSD secretary directly, inconsistent with other states impeding independence and objectivity. The OIG reports to one of two deputy secretaries within the HSD, placing the OIG investigators in a position where they could review their own division. The Arizona OIG, in contrast, reports directly to the cabinet level secretary, and as designated in statute, the office independently creates its audit work plan without influence from the agency or the executive branch. This management structure allows the office to have autonomy to organize work priorities and maintain the flexibility required to address high risk issues as they arise.

The OIG could bolster program integrity functions through supplementing MCO data-mining activities. While there are certainly statutory concerns around the OIG taking on case investigation on behalf of the MFEAD, there are other opportunities to leverage their investigative expertise to build efficiencies in the referral process. The HSD currently mines data for fee-for-service through the SUR/S division. However, the state has zero visibility to MCO data-mining activities for the other 75 percent of Medicaid claims. While MCOs in Arizona mine data, Arizona's OIG also reviews all MCO claims data to root out potential irregular claims patterns. Performing greater data analysis within a single state agency would increase the HSD's visibility in program integrity for the entire Medicaid system.

The OIG could increase program integrity efficiency through streamlining procedures between the QAB, the OIG, and the MFEAD. Other states leverage a model of placing the entire state program integrity function into their Office of the Inspector General. In Arizona, all referrals go to one point of contact, all preliminary investigations are housed under one functional division, and all provider fraud referrals go through one channel to the Medicaid Fraud Control Unit. CMS does not recommend any

specific model for program integrity within the single state agency, but under the HSD's current organizational structure, the QAB is the designated single point of contact for fraud, waste, and abuse investigation.

The QAB does not conduct on-site audits, despite evidence of their effectiveness. GAO recommends on-site inspections for high risk providers, but the QAB has not performed on-site inspections for two years due to a department moratorium on travel. As an alternative, they have instituted a desk audit process that targets services experiencing unusual changes in claims activity.

Information sharing between MCOs is limited by confidentiality and competition. Information sharing can be an extremely useful tool in assessing patterns of abuse, but the naturally competitive relationship amongst the various MCOs may not create an environment where candid sharing of issues can occur. The HSD coordinates a monthly meeting where all MCOs can broach topics, but this meeting focuses on operational issues, and fraud and abuse are not consistently discussed. There is no opportunity for the individual MCOs to meet one-on-one with the the QAB, despite at least one MCO requesting such meetings. In Tennessee, MCOs meet regularly with the state Medicaid agency to discuss specific cases, concerns over potential repeat offenders, and patterns of abuse in the system. It is then the state agency's responsibility to analyze information from these meetings and communicate with other MCOs to address potential system-wide issues. This level of detailed information sharing would bolster the HSD's ability to analyze recurring issues and devise more appropriate guidance for MCOs in how to address risk.

The Medicaid Fraud and Elder Abuse Division struggles to successfully resolve cases due to lack of case prioritization and human resource allocation. Although the MFEAD FTEs and budget are adequate, attrition, delays in filling key positions, and the allocation of staff among various functions have contributed to inefficiencies in referral investigation. The MFEAD staff includes attorneys, information system (IS) specialists, CPA forensic auditors, registered nurse (RN) investigators, and special agents. The division is authorized for 21 positions, but due to a statewide hiring freeze and attrition, it has a vacancy rate of 24 percent as of February 2011.

Table 3. Positions and Vacancies in THE MFEAD, Feb 2011

Position	Number of Positions	Vacancies
Director	1	0
Assistant Attorney General	4	1
CPA Forensic Auditor	2	0
IS System Engineer	1	1
IS Specialist-Investigator	2	0
RN Investigator	3	0
Special Agent	3	0
Certified Paralegal	2	1
Grant Administrator	1	1
Administrative Assistant	2	1
Total	**21**	**5**

Source: THE MFEAD

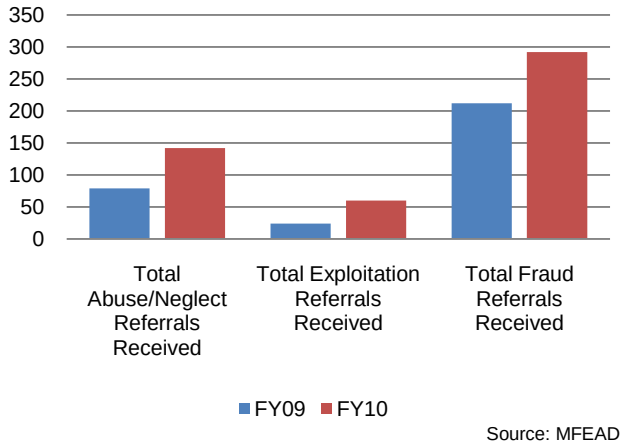
Investigations are slowed by imbalanced allocation of human resources at the MFEAD, with some functional areas overburdened, while other areas are not being utilized effectively. Particular areas of concern in staffing include the RN investigators and specials agents. Three RN investigators support investigations through offering medical expertise relating to appropriateness of services provided as they relate to diagnoses. This is an important function in researching referrals involving provider up-coding to increase claims payout. However, the main workload driver in fraud referrals currently is related to home and community-based services, including PCO and fraudulent reporting of service hours. These types of cases usually do not have a clinical component and do not require the assistance of a RN investigator, so these investigators are sometimes reallocated to perform other administrative tasks such as court filings.

In contrast, there are too few special agents. Currently, two agents assist on cases statewide, performing a variety of functions including interviewing witnesses and executing search warrants. Special agents travel extensively and often cannot work on various cases simultaneously. For example, the average turnaround time to execute a search warrant is seven days, during which time the agent cannot address any other assigned referrals or cases. Additionally, lack of specific geographic division of labors between the two special agents leads to extensive amounts of time lost to travel.

Nevada's Medicaid Fraud Control Unit retains a staff of 17, with one RN investigator and all other investigators who are sworn officers and able to execute the same functions as special agents at the MFEAD. Also, Nevada has two offices to cover the entire state: one which focuses on the southern part of the state, and another office that covers the northern part. Similar to New Mexico, Nevada has a significant amount of rural territory, and having two offices has allowed their unit to better manage time spent on travel.

Organizational structure, procedural, and statutory issues are impeding the MFEAD from garnering more positive outcomes. In FY 2010, the MFEAD received 292 fraud referrals, executed 12 criminal indictments, and was awarded $1.3 million from civil actions. According to the U.S. Department of Health and Human Services (US DHHS), the MFEAD ranks 17th nationally in percentage of fraud indictments to investigations and 29th in fraud convictions to investigations (see **Appendix A**). Fraud referrals increased between FY09 and FY10 as shown below, but the MFEAD is responsible for other referrals related to abuse/ neglect and exploitation, as well.

Graph 7. Number of Referrals Received Per Fiscal Year



Source: MFEAD

The MFEAD has a high number of open referrals that go without completion for extended periods of time due to lack of prioritization. As of April 2011, the MFEAD had 448 open referrals, with 180 open for more than a year, or 40 percent of all open referrals. The MFEAD's referral intake and assignment process does not include any workload prioritization or process completion guidelines. When a referral is received, it is forwarded to the director, who reviews the referral and assigns a team which includes an attorney and various investigators. There is currently no designated timeline for completion of this initial investigation and no guidelines for prioritizing referrals. This has contributed to the high rate of outstanding referrals.

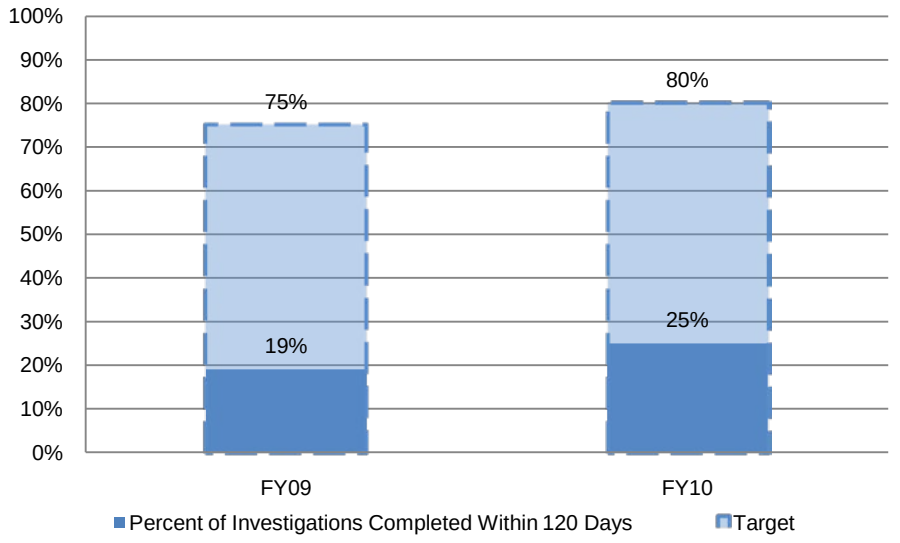
Table 4. Age of Open Referrals, April 2011

Aging Category	Cases	Percentage
0-30 days	29	6.5%
31-60 days	19	4.2%
61-90 days	13	2.9%
91-120 days	26	5.8%
121-180 days	73	16.3%
181-1 year	108	24.1%
1-2 yrs	135	30.1%
2-5 yrs	45	10.0%
Greater than 5	0	0.0%
Total	**448**	**100.0%**

Source: THE MFEAD

The MFEAD reported that for FY10, 25 percent of investigations were completed within 120 days, well below the target of 80 percent. The MFEAD's performance on its timeliness measure during the last two fiscal years is well below the targets set for each year, and the performance on this measure likely contributes to the current backlog in open cases.

Graph 8. Percent of Investigations Completed in 120 Days



Source: MFEAD

In Nevada, the state Medicaid Fraud Control Unit has instituted procedures for how referrals should be prioritized, as well as how much time investigators have to make a recommendation on whether a case should be pursued. Similar to the MFEAD, referrals go through the director for initial review and assignment. Investigators have 90 days to thoroughly research a referral and provide a recommendation on whether to proceed with a case. While there are exceptions to this 90-day rule, placing a timeline on the initial vetting process allows the agency to focus their efforts and move on to building cases, which is where the return on investment occurs through convictions and civil recoveries.

RECOMMENDATIONS

The HSD and the MFEAD should meet regularly per the terms of the MOU currently in place and in coordination with best practices.

The MFEAD should formalize referral guidelines, including data required for a fraud referral from the QAB.

The OIG and the MFEAD should formalize MOUs or JPAs to investigate provider fraud aligned with federal law and regulations.

The HSD and the MFEAD should begin tracking referrals and investigations specific to PCO and DD waiver services to assess true risk associated with these service categories, as well as total costs associated with investigation and prosecution of these cases.

The HSD should streamline and prioritize Medicaid program integrity functions through the following:

- Move the OIG to report directly to the HSD secretary, and the Legislature should consider formalizing the OIG's autonomy of mission in statute;
- Consolidate selected staff from the QAB and the OIG Internal Audit and Investigations Bureaus into a new Medicaid Program Integrity Bureau within the OIG. Remaining QAB staff should be merged into the Contracts Bureau and focus on performance and quality management oversight of MCO contracts; and
- The Medicaid Program Integrity Bureau would be the single point of contact for receiving, detecting, investigating allegations of fraud and abuse; coordinate and prepare referrals for the MFEAD; oversee, in coordination with the HSD's Contract Management Bureau, external quality review organization contract audits of MCOs and performance and compliance of MCO program integrity functions.

The HSD should consider supplementing MCO data-mining processes within the OIG to increase the HSD's visibility in program integrity for the entire Medicaid system while also serving as an audit of MCO data-mining process effectiveness.

The HSD should reinstitute an on-site audit plan that includes periodic planned audits, as well as spontaneous site visits by the HSD staff or a contracted audit firm.

The HSD should institute a regular schedule of one-on-one meetings with MCOs to discuss specific cases, concerns over potential repeat offenders, and patterns of abuse in the system. Data collected in these meetings should be utilized to analyze system-wide trends and communicate findings back to all MCOs.

The HSD should consider instituting best practices by retaining MCO program integrity procedures, upgrading required referral information, meeting more frequently with MCO staff to ensure training and processes are up to date, and validate program integrity procedures are uniform across all MCOs.

The MFEAD should reallocate at least one RN investigator FTE to a special agent, or alternately consider completing the required process for investigators to also serve as special agents.

The MFEAD should consider dividing cases assigned to special agents by geographic area to reduce transit time and costs and leverage geographic proximity to more efficiently process workload.

The MFEAD should institute an official guideline clearly defining a referral investigation deadline to match the current GAA performance measure. Such a guideline could include a prioritization system for referrals.

SIGNIFICANT OPPORTUNITIES EXIST TO STRENGTHEN MEDICAID FRAUD, WASTE, AND ABUSE CONTROLS

The HSD's role in managing fee-for-service and managed care creates fragmented and confusing requirements for providers and MCOs. The HSD and the MCOs use different processes for managing Medicaid plans. Many of these processes impact the ability to prevent and control fraud, waste and abuse. Additionally, New Mexico falls short in implementing recommendations by the U.S. Government Accountability Office (GAO). The five strategies GAO recommends are strengthening provider enrollment standards and procedures, improving pre-payment review of claims, focusing post-payment claims review on most vulnerable areas, improving oversight of contractors, and developing a robust process for addressing identified vulnerabilities.

The HSD's requirements for credentialing providers differ between fee-for-service and MCOs. The HSD plays no role in vetting providers before they are contracted into managed care. Several states, including Arizona, Texas, and Tennessee, require the single state agency to screen providers and assign a Medicaid provider identification number before they can begin the application process with one of their MCOs. These states also will not pay any provider if they contracted with the MCO before completing the state vetting process. New Mexico does not require a MCO-contracted provider to obtain a Medicaid provider ID, but does maintain this requirement for fee-for-service providers. While overlap is possible, the state should establish and manage one uniform methodology for approving providers to operate within the Medicaid program.

For fee-for-service, the HSD manages the provider application and credentialing process. There is an absence of a credentialing questionnaire, which would normally include questions regarding work and criminal history, certifications, hospital privileges, and whether licenses have been suspended or revoked. Most of the state's contracted MCOs use a form provided by the Council of Affordable Quality Healthcare or by the Health Service Corporation. While the HSD does not require that MCOs use these forms, they are a largely accepted format, requiring more thorough information from potential providers. This disparity presents a significant information gap in what the HSD reviews when vetting potential Medicaid fee-for-service providers versus what MCOs review in their process. A unified application and credentialing process for all Medicaid programs would ensure a thorough vetting process and increased visibility for the HSD regarding the approved provider pool.

The HSD is looking at options to build efficiencies in the provider credentialing process and also comply with new requirements under the Patient Protection and Affordable Care Act (PPACA). While there are options that will make the process fully electronic and systematic among all Medicaid programs, the current goal is for MCOs to contract directly with a credentialing vendor. Again, this does not address the issue of having one mandatory and uniform process across the state for Medicaid providers.

Only one MCO requires providers to disclose any potential conflicts of interest on their application. Conflicts of interest are of particular concern in home and community based services (HCBS) and PCO, as costs and utilization continue to increase in these service categories. The Centers for Medicare and Medicaid Services (CMS) in a March 2009 Medicaid integrity program review noted the HSD was out of compliance in requiring disclosure of ownership interests and business transactions that could constitute conflicts of interest. They recommended the HSD update fee-for-service provider applications and also

require MCOs to update their application requiring providers to disclose these issues. As of the date of this report, the HSD has not implemented this recommendation for MCO applications.

MCOs and the QAB utilize different methods for overpayment recoveries with varying success rates. In the fee-for-service program, the QAB recovers identified overpayments by taking a credit against future outgoing claims payments, providing quick resolution. The QAB directs ACS, as the Medicaid fiscal agent, to either void or adjust payment on the next payment cycle, which occurs weekly. This has led to their high success rate in obtaining recoveries. However, MCOs note that they often request overpayment recoveries be paid directly to them and use payment plan arrangements to facilitate this process. This can reduce effectiveness in obtaining recoveries, as the provider drives when repayment occurs. One MCO noted that when they have attempted to take recoveries against future claims payments, providers have pursued legal action for withholding payment for services rendered.

The HSD does not have a protocol in place for addressing providers that have been terminated by MCOs. Since MCOs are responsible for contracting with providers, they can terminate the provider for cause without the HSD's approval. However, while approval from the state is not necessary, failing to notify the HSD of the cause of termination reduces the HSD's visibility to potential waste, fraud, and abuse issues. A provider termination should trigger a process of further scrutiny of provider claims in other MCOs, the fee-for-service program, or other state plans. This should also be the case for providers who have had a civil judgment levied against them by the MFEAD who are still able to participate in Medicaid programs. In reviewing the MFEAD's and the QAB's referral data, there have been instances of repeat offenders who continue to operate in the Medicaid system, even after various referrals and cases were brought against them.

Encounter data reporting requirements focus solely on data completeness and not data accuracy. The primary area of concern in the managed care capitation arrangement is the accuracy of reported encounter data. Per the MCO contract, the HSD requires that encounter data submitted have a maximum 1 percent error rate, and encounters that error out are to be corrected and resubmitted. However, this requirement relates to formatting and not the overall correctness of encounter data. There is no requirement for MCOs to show that they have reconciled encounter data to financial reporting or any other benchmark to justify that the data is correct and appropriate, and the HSD does not perform any type of reconciliation control. It is extremely important to ensure that encounter data is accurate going into the capitation rate setting process, as inaccurate data could result in incorrect capitation rates being paid to MCOs. While the majority of MCOs advised that they perform a financial reconciliation of encounter data prior to submission, the HSD has stated that requiring MCOs to do this would be burdensome and result in extensive IT costs. The HSD has also expressed the desire to perform an encounter data validation process and has designed a project around this, but has been unable to proceed further.

For the purpose of this evaluation, LFC evaluators tested reasonability of encounter data to quarterly financial reporting provided by MCOs. This proved a difficult process, as encounter data and financial data are reported using different parameters. For the Salud! program alone, there was a variance between encounter data and financial claims data of 12.7 percent for FY10, or $110.3 million. In the case of CoLTS, the HSD was unable to provide a complete encounter data set by MCO, which resulted in the exclusion of 52 percent of CoLTS expenditures comprised of PCO, home and community-based services, and home healthcare.

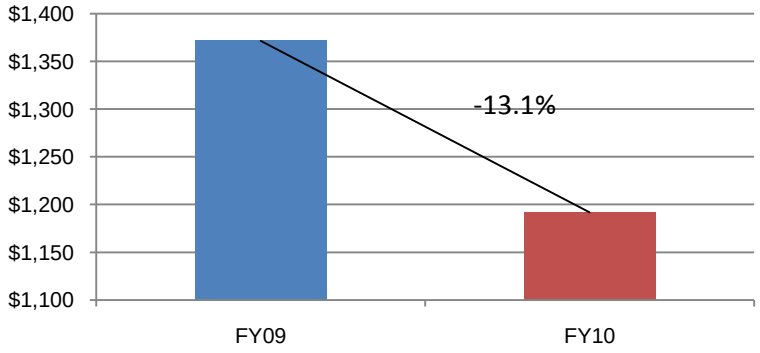
Two MCOS have failed to comply with current performance measures, leading to corrective action and sanctions. Regarding performance on these measures, in FY09 Evercare was sanctioned over $2.9 million by the HSD for encounter data reporting problems. Additionally, due to technical issues, Optum Health has been unable to provide meaningful encounter data to the HSD leaving the capitated rate to be set based on estimates rather than actual claims data. In FY10, Optum Health was paid $243 million in capitation payments based on this alternate formula.

The HSD does not utilize prepayment review to reduce improper payments. Medicaid follows the common methodology of "pay and chase," which places the burden of all program integrity functions on recuperation of overpayments. Experts advise greater success in preventing improper payments through prepayment review. Neither providers who have been successfully prosecuted by the MFEAD, or have been identified by the QAB as having made improper claims are flagged for prepayment review. In addition to reducing inappropriate payments, prepayment review creates a sentinel effect of advising providers that claims have a greater chance of being reviewed on a consistent basis, deterring suspicious claims activity.

MCOs utilize prepayment review, but reserve this for providers that fall into high risk categories or have had issues with inappropriate claims behavior. In 2010, Optum Health instituted a large prepayment review initiative, halting payment on $1.6 million dollars of behavioral health claims, citing concerns over the veracity of these claims. This created concerns for both the HSD and the Behavioral Health Collaborative, as well as for providers. In the 90 days since initiating this process, the HSD has requested Optum clear $1 million dollars of the held claims as appropriate. Optum's lack of clear procedure and communication with the state hindered their ability to effectively leverage prepayment review. Clearly defining a process for both fee-for-service and the MCOs would better position the state to effectively carry out a prepayment review process.

There is a financial disincentive for MCOs to recoup waste, fraud, and abuse. Successful waste, fraud, and abuse detection will result in recoupments, which in turn will reduce claim dollar volume that MCOs are reporting to the state through encounter data. MCOs are experiencing some success in recuperating overpayments from providers. These amounts are less than generally accepted ranges of suspected overpayments in healthcare systems: MCOs recovered $1.2 million in FY10, 0.067 percent of total claim dollars paid. This amount represents a 13 percent drop from FY09 to FY10.

Graph 9. MCO Total Reported Hard Dollar Recoveries FY09-FY10
(in thousands)



Source: MCO survey conducted by LFC

If MCO recoupments better matched current estimates of outstanding fraud, it would negatively impact capitation rates by reducing claim volumes used in the rate-setting process. This creates a disincentive for MCOs to aggressively root out waste, fraud, and abuse. While there is no direct evidence that MCOs are minimizing their program integrity efforts to maximize capitation payments, the nature of the capitation arrangement could promote this type of activity.

The QAB uses a database to track referral data that does not allow for meaningful analysis and leaves New Mexico's Medicaid program vulnerable to repeat offenders. Medicaid fraud, waste, and abuse referrals are reported to the HSD's Quality Assurance Bureau (QAB). The QAB maintains a database to log the referral data, maintain any supporting documentation received with the referral, and track referral status. However, the current design of this database inhibits effective qualitative analysis, limiting its purpose to serving only as a referral log. LFC evaluators queried the database to identify repeat offenders, track length of time from initial referral to referral closure, and identify potential performance metrics. However, data integrity issues and insufficient database design methodology made these tasks difficult or impossible to complete. Having the ability to extract meaningful analysis from a referral database would assist the QAB in not only to identify high risk providers who have repeat referrals, but also understand the current state of program integrity efforts, MCO performance, and fiscal impact. Based on the current data available, the QAB would be hard-pressed to do any system-wide analysis on how many dollars are currently under investigation and which providers are driving those investigations.

The MFEAD operates a similar intake database to track referrals and cases as they move through the judicial process. This database is built to give analytical reporting in addition to tracking cases, and was able to manage ad hoc reporting requests from LFC evaluators related to performance metrics, indicating flexibility to grow into new functionalities.

Looking at a wider range of provider claims activity may provide a better picture of risk issues. Given the high number of small, infrequent incidents, what appears as a simple billing error at one MCO might turn out to be a pattern of aberrant behavior across various MCOs and plans. West Virginia, a similarly largely rural state with a limited provider pool, makes it a routine practice to share information with private insurers and other risk pools to identify abuse that may not be readily apparent through Medicaid-specific investigations. A redesign of the referral database would allow for this type of system-wide analysis; additionally, sharing information with GSD, NMPSIA, NMRHCA, and APS should provide more substantive data to the HSD to focus their program integrity efforts and minimize risk. Both the HSD and the MFEAD would benefit from identifying repeat offenders of this nature, placing them under increased scrutiny, and terminating their Medicaid eligibility or revoking their medical license.

New Mexico's rural nature makes it difficult to maintain an adequate network of providers. Limited provider access in rural areas sometimes competes with intentions of rooting out fraud, waste, and abuse. This concern can be addressed through sanctions, increased claims scrutiny, or a prolonged termination. In West Virginia, the single state agency pursues punitive sanctions or phases out terminations to allow other providers to establish themselves, minimizing service disruption.

The referral database is unlikely to have the capability to support recently passed federal legislation. Provisions of the Patient Protection and Affordable Care Act (PPACA) stipulate that states will have to terminate Medicaid providers that have been terminated from either Medicare or another state's Medicaid

program. This requirement sets the stage for a system-wide program integrity function at the national level. The QAB will have a greater responsibility to identify and terminate providers who act inappropriately and will then be tasked with notifying other states of their actions. Having an efficient referral database will streamline this process, allowing the QAB to more quickly identify patterns of behavior that warrant termination. Additionally, the database can provide background information for other states if needed in their termination process.

Since 2006, Legislative Finance Committee evaluations of Medicaid have identified over $300 million in excessive and wasteful Medicaid spending, some of which has been addressed by the HSD. LFC has issued five reports since 2004 on Medicaid that have identified overpayments, poor financial practices, and problematic payment practices that resulted in spending more on Medicaid than was necessary (see **Appendix B)**.

RECOMMENDATIONS

The HSD should consider modifying its rate development and amounts available for administration and profit for MCOs, including increasing its pay-for-performance set aside to five percent of total premium, administratively setting base capitation rates for all MCOs, sharing medical savings with MCOs that meet all of their performance targets, and using a competitive bid process for awarding administrative/profit amounts.

The HSD should amend MCO contracts to address the financial disincentive that exists for MCOs to make recoupments for fraud, waste, and abuse through performance measures or some other incentive program.

The HSD should ensure that all Medicaid providers are consistently and thoroughly vetted at the state agency level. Such a solution could include the hiring of a credentialing vendor.

The HSD should comply with the requirement for providers to disclose ownership interests and business transactions that could constitute conflicts of interests as recommended by CMS.

The HSD should stipulate a uniform methodology for provider repayment recovery for all Medicaid services and MCOs should note this same process in their provider contracts.

The HSD should develop guidelines or performance measures to ensure accuracy of MCO encounter data.

The HSD should review whether to adjust contract requirements, and possibly administrative rules, to specify how MCOs may use targeted prepayment claims review and a reporting mechanism to oversee its use by the state. Any changes should balance the need to ensure prompt payment to providers with risk reduction from improper payments and for providers with a history of abusive billing practices.

The QAB should partner with the MFEAD to rebuild their referral database and design a data entry protocol that would foster stronger analytical capabilities, increase the efficiency in identifying repeat offenders, and promote compliance with PPACA.

The HSD should pursue punitive sanctions or phase out terminations of providers guilty of fraud, waste, and abuse to allow other providers to come in and establish themselves, minimizing service disruption.

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Susana Martinez, Governor
Sidonie Squier, Secretary

July 12, 2011

Mr. David Abbey, Director
Legislative Finance Committee
325 Don Gaspar, Suite 101
Santa Fe, New Mexico 87501

RE: HSD Response to LFC Medicaid Fraud Controls Program Evaluation Report

Dear Mr. Abbey:

Thank you for accepting the following document as the Human Services Department's (HSD) response to the Legislative Finance Committee's (LFC) draft "Medicaid Fraud Controls" evaluation report. The review conducted by the LFC's program evaluation team provided a valuable learning opportunity for HSD and we agree with a number of the recommendations in the draft report and will work to implement them as resources allow. The response is intended to clearly describe HSD's position on the LFC's report.

HSD is committed to reducing waste, fraud and abuse within the Medicaid system. In recent years, the HSD's Medical Assistance Division (MAD) and Office of Inspector General have been required to operate their programs with fewer staff and more limited resources. Although challenging, the department has been able to set priorities for its programs and find more efficient ways of doing business. Even with these challenges, HSD has achieved some impressive results. But more can be done, and the department will continue to seek the most efficient operational structure to maintain and improve this high-priority function.

An example of HSD's success is the recently completed Federal Fiscal Year (FFY) 2009 "Review for Medicaid Fee-for-Service, Managed Care and Eligibility Data Analysis from Payment Error Rate Measurement (PERM)" by the U.S. Department of Health and Human Services (HHS). The review's overall finding is that New Mexico's Medicaid estimated payment error rate is 1.87% for the fee-for-

service program and managed care program combined. This is the third lowest error rate of the 17 states reviewed in the PERM Cycle One, FFY2009 – a clear indication that we are stopping bad payments before they go out.

In an effort to expand Departmental efforts to identify fraudulent and abusive billing in the Medicaid program, HSD's Office of the Inspector General (OIG) staff persons have recently begun using data-mining techniques to identify potential areas of fraudulent and abusive Medicaid billing. In addition, when the new Medicaid Management Information System/Fiscal Agent contract is awarded, the contract will include a state-of-the-art fraud and abuse detection system (FADS) to replace the current FADS product, as well as other enhancements that will improve HSD's ability to identify potentially fraudulent and abusive billing practices.

HSD thanks the LFC evaluation team members for their readiness to support us in our efforts to identify fraud and abuse within the Medicaid program. HSD is committed to continuing and improving efforts to ensure that our scarce Medicaid dollars are not wasted on fraudulent and abusive billing practices.

Sincerely,

Sidonie Squier
Cabinet Secretary

RECOMMENDATIONS

HSD and the OAG should implement return on investment measures to track success of program activities and request the addition of these measures to those reported under the Accountability in Government Act. Both agencies should work to set reasonable targets, benchmark performance with other states and set long-term goals for improvement.

HSD agrees with this recommendation as another way to measure the effectiveness of our work. MAD will develop a return-on-investment (ROI) methodology that meaningfully measures our efforts in recovering payments made on fraudulent and abusive billing, and on the prevention of fraud and abuse within the Medicaid program. In addition, HSD will collaborate with MFEAD to identify and set appropriate measures, goals and targets for our respective directed activities.

HSD should implement both hard and soft dollar recoveries and ROI calculations across all MCOs with guidelines on how to measure and report this data to HSD to demonstrate program effectiveness.

HSD agrees with this recommendation and will work to implement mandatory reporting of hard and soft dollar recoveries across all MCOs. HSD will also investigate and consider the feasibility of implementing ROI calculations across the MCOs as another method to meaningfully measure program effectiveness. It is important to note that the managed care organizations are tasked with the same CMS activities and responsibilities required of MAD's Quality Assurance Bureau (QAB). MCO program integrity units must also meet all federal requirements defined in 42 CFR §438.602 and§438.608. HSD will continue to collaborate with the MCOs to identify data that will demonstrate program effectiveness and reflect required activities.

HSD should amend MCO contracts to include performance measures related to fraud, waste and abuse prevention activities. MCOs should be incentivized to improve their efforts to seek out aberrant behaviors from providers and recipients and quantify how their efforts are preventing a loss to the state.

HSD agrees with this recommendation and will consider how best to add contractual performance measures related to MCO program integrity activities including: measures related to the detection, preliminary investigation and referral of all allegations of Medicaid fraud to the QAB/MFEAD and the identification, investigation and recovery of improper Medicaid payments and/or Medicaid billing.

HSD should institute a regular schedule of one-on-one meetings with MCOs to discuss specific cases, concerns over potential repeat offenders, as well as patterns of abuse in the system. Data collected in these meetings should be utilized to analyze system-wide trends and communicate findings back to all MCOs.

HSD agrees with this recommendation and has already instituted this approach to fraud and abuse information gathering. For the past several years, MAD's QAB Program Integrity Unit has hosted Program Integrity bi-monthly meetings with the MCOs. The HSD Office of Inspector General and MFEAD are invitees to these regularly scheduled meetings. Open

cases, areas of concern, patterns of abuse, concerns about specific providers and MCO best practices are all topics of discussion. While all referrals from the MCOs are discussed at the scheduled meetings, the MCO referrals to HSD/OIG or the MFEAD that result in an investigation are not discussed in great detail or referenced in meeting notes in order to safeguard ongoing cases and not compromise investigations and/or prosecution. MCOs frequently work collaboratively to jointly audit and sanction providers and they report these activities during these established meetings. HSD uses information discussed during these meetings to focus audits of other MCOs or FFS activities.

In addition, the QAB Program Integrity Unit and all MCOs participate on the NM League of Health Care Justice Task Force, which comprises representatives from government agencies (FBI, MAD, OIG, Insurance Fraud, IRS, Medical Examiners, Attorney General, Medicare, Pharmacy Board, Postal Inspection Service, Tax and Revenue, and Worker's Compensation Administration) and private commercial health care programs. This task force meets bi-monthly to share information and coordinate efforts in investigating provider fraud, waste, and abuse. Data sharing in these forums has been successful in identifying patterns of abuse and directing collaboration between the MCOs and other agencies as evidenced in the successful investigation and prosecution of several providers. An example of such collaboration includes the identification and MCO joint investigation of a provider billing inappropriately for sleep studies. The case was ultimately investigated and prosecuted by the MFEAD and FBI; resulting in the provider being excluded from the Medicaid provider network and leaving the state.

HSD and MFEAD should meet regularly per the terms of the MOU currently in place and in coordination with best practices.

HSD agrees with this recommendation and already has held, for the past several years, regularly scheduled bi-monthly meetings with MFEAD. While vacancies in the MFEAD have prevented regular attendance at the scheduled meetings, MFEAD has indicated that the recent recruitment of a Medicaid Fraud Control Unit Director will enable future attendance.

HSD should streamline and prioritize Medicaid program integrity functions through the following.

- ***Move OIG to report directly to the HSD secretary, and the Legislature should consider formalizing OIG's autonomy of mission in statute.***

- ***Consolidate selected staff from QAB, Internal Audit and the Investigations Bureaus into a new Medicaid Program Integrity Bureau within OIG. Remaining QAB staff should be merged into Contracts Bureau and focus on performance and quality management oversight of MCO contracts.***

- ***The Medicaid Program Integrity Bureau would be the single point of contact for receiving, detecting, investigating allegations of fraud and abuse; coordinate with prepare referrals to the Office of Attorney General; oversee, in coordination with Medicaid's Contract Management Bureau, external quality review organization contract audits of MCOs and performance and compliance of MCO program integrity functions.***

HSD does not agree with these recommendations, at this time. Any potential advantages to this reorganization are outweighed by the apparent disadvantages. The Inspector General currently reports to a Deputy Secretary, primarily for more routine management functions and oversight. Ultimate departmental authority resides with the Secretary, and all OIG matters are brought to the Secretary's attention.

With regard to splitting up the Quality Assurance Bureau, it is important to note that all MAD program staff members are committed to identifying and reducing fraud, waste and abuse. The program integrity staff within MAD's QAB must work across all MAD bureaus as part of their work to identify and recover fraud, waste, and abuse. Operating within the same division allows the Program Integrity and Contract Administration Bureaus to work more effectively than if divided across the department. HSD is also concerned that dividing the functions would erode programmatic expertise of the program integrity staff, making fraud and abuse detection more difficult, not easier. While HSD finds that this recommendation unnecessarily creates an artificial barrier to working across all the MAD bureaus, it also finds it to be a "fix" for something that isn't broken. The QAB program integrity unit is the most successful of the three entities reviewed by the LFC evaluators in terms of identifying and recovering fraud, waste, and abuse. The LFC analysis identified QAB as the entity responsible for the majority of recoupments and/or recoveries. The Program Integrity Unit staff of eight (8) persons is responsible for 60 percent of total recoupments/recoveries in FY10 alone.

This does not mean, however, there is no room for improvement of the unit's performance. HSD is committed to identifying and implementing all possible program efficiencies in order to ensure the Medicaid program reduces fraud, waste and abuse everywhere possible. Many of the recommendations made here will be helpful in that effort.

HSD should consider instituting best practices by retaining MCO program integrity procedures, upgrading required referral information, meeting more frequently with MCO staff to ensure training and process are up to date, and validate program integrity procedures are uniform across all MCOs.

HSD has a long-standing best practices model that directs MCOs in their integrity procedures, referrals, and associated processes. HSD will continue to review its practices regarding MCO program integrity activities.

MAD's QAB is responsible for the day-to-day management of the FFS and managed care program integrity activities, as well as the oversight compliance of program integrity standards defined by CMS and mandated by state regulations, managed care contracts or joint powers agreements (JPA) requirements. In compliance with 42 CFR §438.602 and §438.608, QAB has procedures for reviewing MCO program integrity program requirements, which include, but are not limited to, reporting of complaints that warrant preliminary investigation, analyses of utilization and referral patterns to detect fraud or abuse in the managed care program, and specific requirements for procedures and a compliance plan designed to guard against fraud or abuse. The contracts and Request for Proposals (RFP), which are incorporated in contracts by reference, between the New Mexico Human Services Department (HSD) and the MCOs describe activities that must be performed in the identification, detection, investigation of allegations of fraud and recovery of improper payments.

HSD/QAB assesses compliance with these provisions and requirements through monthly and quarterly reporting, as well as approval of policies, procedures and annual Fraud and Abuse Compliance plans. In addition, the External Quality Review Organization (EQRO) performs annual comprehensive compliance audits of MCO operations including federally mandated program integrity requirements. While EQRO reviews have not identified any deficiencies in meeting program integrity

standards or requirements, HSD/QAB has an established process in place to mandate corrective action plans and/or monetary sanctions if such deficiencies are identified in future reviews.

OIG and MFEAD should formalize MOUs or JPAs to investigate provider fraud aligned with federal law and regulations.

We agree that this relationship should be formalized, if possible. However, this recommendation may not be in accordance with federal requirements. It is likely that any formalized working relationship between HSD/OIG and MFEAD to investigate Medicaid provider fraud must also include QAB. HSD will need to examine and evaluate any efforts by the HSD/OIG to investigate provider fraud so that all HSD/OIG investigations are within federal regulations. CMS has been very clear in directing state Medicaid programs in their role to detect and investigate all allegations of fraud; and mandating that full investigations are the sole responsibility of the Medicaid Fraud Control Units. Since the recommendation to investigate provider fraud is in conflict with federal law and regulations, this issue will require legal guidance, agreements between the two departments and ultimately HHS/OIG and CMS approval.

HSD should consider supplementing MCO data mining processes within OIG, in order to increase HSD's visibility in program integrity for the entire Medicaid system while also serving as an audit of MCO data mining process effectiveness.

HSD does not agree with this recommendation.

Not only does HSD QAB perform data mining using the Surveillance Utilization Review System (SURS), but the HSD OIG already has full access to Medicaid claims and encounter data through the Medicaid Management Information System (MMIS) data warehouse and has begun data mining activities. Prior to OIG starting its data-mining activities, staff persons from MAD's Program Information Bureau trained OIG staff about the structure and contents of the MMIS data warehouse and how to use it so the OIG staff would get reliable and useful results.

The HSD has designated and CMS has approved the Medical Assistance Division as the entity responsible for the SURS. CMS Medicaid Integrity Group (MIG) recently performed an on-site review of HSD compliance with all requirements set forth in 42 CFR §456 – Utilization Control. A vital part of the federal requirement of the state Medicaid program is its efforts to protect federal funds through the performance of SURS activities. The SURS has two primary purposes: 1) to process information on medical and health care services to guide Medicaid program managers and 2) to identify the providers (and recipients) most likely to have committed fraud against the Medicaid program. The expertise and knowledge of the Medicaid program require staff members located within the MAD Quality Assurance Bureau and MAD Benefits Services Bureau to jointly manage all utilization review activities.

The current SURS was implemented in November of 2006 and complies with all Centers for Medicare & Medicaid Services (CMS) requirements and standards for MMIS-certified (Medicaid Management Information Systems) SURS systems. As such, it is able to generate all federally required statistical reports that support the ranking of suspicious providers and clients, including, but not limited to, management summary reports (total and by peer group); exception

provider reporting; provider treatment analysis by peer group; profile reports; annual ranking by dollars for utilization for clients and providers; and quarterly identification of the medical services for which over-utilization is most prevalent.

The Department has identified the challenge of performing SURS requirements using managed care encounter data and is currently reviewing proposals for replacement of the existing SURS with a solution or enhancement that will use a collection of comprehensive algorithm strategies that employ advanced technologies to detect suspicious fee for service (FFS) and encounter claims. The system enhancement will allow experienced QAB staff members to build customized comprehensive algorithms that employ advanced technologies to detect suspicious medical claims, non-compliance, and complex health care fraud, abuse, and waste in managed care organizations.

HSD should reinstitute an on-site audit plan that includes both periodic planned audits, as well as spontaneous site visits by HSD staff or a contracted audit firm.

While HSD does not disagree with this recommendation, budget constraints have required all state agencies to examine goals, duties and activities to identify process efficiencies and cost saving practices. Due to limited staff, MAD/QAB identified some audits and reviews scheduled on their audit work plan that could be more efficiently performed as desk audits rather than on-site audits. This practice has increased the number of audits performed by the eight (8) designated Program Integrity staff persons and increased the amount of recoveries collected through the audit process. While HSD values the focus on desk audits, we understand the need for on-site audits as well. MAD/QAB has utilized the role of federal audit contractors to meet that need and requirement. QAB directs and coordinates all federal audit contractors to focus on areas of concern and ensure that efforts are not duplicated by the numerous ongoing audits within the state. Some of the federal audit programs currently working on focused reviews and audits with the MAD include: the CMS Medicaid Integrity Program (MIP) and Medicaid Integrity Contractors (MICs), created through the Deficit Reduction Act (DRA) of 2005; the Payment Error Rate Measurement (PERM) reviewers; the Health & Human Services, Office of Inspector General (HHS/OIG); and the Medicaid Recovery Audit Contractor (RAC) Program, mandated by Section 6411 of the Affordable Care Act.

The RAC Program mandates that MAD contract, on a contingency payment basis, with a RAC to implement a CMS approved recovery program. CMS has approved the state plan amendment for the implementation of the RAC program and this contractor is managed through the QAB. In June, HSD contracted with Health Management Solutions (HMS) to serve as the state's RAC. QAB directs the RAC scope of work related to all audits and reviews and ensures that any providers and/or services that warrant a targeted or focused review are included on the RAC work plan.

HSD and MFEAD should begin tracking referrals and investigations specific to PCO and DD waiver services to assess true risk associated with these service categories, as well as total costs associated with investigation and prosecution of these cases.

HSD agrees with this recommendation and the current database used by MAD/QAB does track all referrals received by the Medical Assistance Division as well as all referrals made to MFEAD, HSD/OIG or any other licensing agency. While the database does have the ability to track referrals, it is not able to report referrals by program or issue. All tracking and trending by issue, service, or provider are performed manually. While the manual process is resource intense, it has been successful in identifying areas and services of concern as demonstrated by the increase in referrals to MFEAD for providers

and services related to PCO and DD waiver services. The new FAD system will have an improved tracking and reporting product that will reduce the manual work required now.

HSD should consider modifying its rate development and amounts available for administration and profit for MCOs, including increasing its pay-for-performance set aside to five percent of total premium, administratively setting base capitation rates for all MCOs, sharing medical savings with MCOs that meet all of their performance targets, and using a competitive bid process for awarding administrative/profit amounts.

HSD is already considering this recommendation as it works on modernizing the Medicaid program.

HSD should develop guidelines or performance measures to ensure accuracy of MCO encounter data.

HSD has a set of guidelines and performance measures in place for MCO encounter submissions and data validity. Encounter data and submission guidelines can be found in the MCO/CSP manual and encounter submission performance requirements are in each MCO's contract. These documents are posted on MAD's website on the SALUD program page. HSD often rejects encounter submissions because they do not meet data validity or formatting requirements. MCOs have been financially sanctioned for not meeting encounter submission performance measures. Part of our actuaries' scope of work is to validate the actual accuracy of the MCO encounter data against other MCO submitted data.

HSD should amend the contract to address the financial disincentive that exists for MCOs to make recoupments for fraud, waste and abuse through performance measures or some other incentive program.

In relation to fraudulent and abusive provider activity, the oversight is contractually delegated to the MCOs. The contract does not provide prescriptive language in how extensive these activities should be. This allows the MCOs' flexibility in developing and/or performing effective processes for their managed care model, which differs by organization. The MCOs are required to report their recoveries and these recoveries are included in the data reported and utilized in capitation rate development. HSD agrees that specific reporting would be beneficial in monitoring effectiveness in each MCO's review processes and benchmarking their results against other MCO's and the expectations of HSD.

HSD does not agree that there are pure financial disincentives for MCOs to find and recoup payments for fraudulent, wasteful and abusive billing. In recent years, capitation rates have stayed the same or decreased, dependent on the program, as HSD introduced cost containment and increased expectations of efficiency into the rate calculations. These rate changes motivate MCOs to increase their activities to root out fraud, waste and abuse so they can be sure their dollars are spent on valid services. For example, within the capitation rate development for SFY12, HSD analyzed the managed care programs for waste and utilization management through efficiency studies that included the following:

- Inefficiency or unnecessary utilization of prescriptions
- pharmacy generic pricing

- inappropriate use of emergency room services and
- potentially preventable inpatient admission (PPA)

HSD will consider implementing performance measures and specific reporting to track the fraud, waste and abuse.

HSD should stipulate a uniform methodology for provider repayment recovery for all Medicaid services and MCOs should note this same process in their provider contracts.

HSD will consider providing guidance to the managed care organizations for provider repayment recovery in future contracts. We will work with the managed care organizations to develop common methodologies and processes.

HSD should review whether to adjust contract requirements, and possibly administrative rules, to specify how MCOs may use targeted prepayment claims review and a reporting mechanism to oversee its use by the state.

HSD agrees with this recommendation and continues to take actions to move away from the old-fashioned methodology of "pay and chase". Over the years MAD has implemented numerous claims edits, most recently adding National Correct Coding edits, which validate claims before they are paid in order to reduce the need to recover inappropriate payments. If claims don't pass the edits, they are not paid. The MCOs have all implemented similar pre-payment edits.

Any changes should balance the need to ensure prompt payment to providers with risk reduction from improper payments and for providers with a history of abusive billing practices.

HSD agrees with this recommendation and practices it on an on-going basis. Both HSD and its MCOs have the systematic ability to suspend and review claims of billers who have a history of abusive billing practices. In addition, both HSD and the MCOs can flag claims for certain services for manual reviews prior to payment.

HSD should take action to ensure that all Medicaid providers are consistently and thoroughly vetted at the state agency level. Such a solution could include the hiring of a credentialing vendor.

HSD agrees with the recommendation that all Medicaid providers, current and new ones, be consistently vetted at the agency level. This idea is among the changes HSD is considering as it modernizes the Medicaid program. This change in approach to provider credentialing is significant in its size and scope, can be costly, and can be administratively burdensome for the providers when the process is first initiated, therefore, careful planning must precede this kind of change.

HSD should comply with the requirement for providers to disclose ownership interests and business transactions that could constitute conflicts of interests as recommended by CMS.

HSD agrees with this recommendation and is implementing the requirement for fee for service providers. HSD will work with its MCOs to be sure they comply with this requirement as well.

QAB should partner with MFEAD to rebuild their referral database and design a data entry protocol that would foster stronger analytical capabilities, increase the efficiency in identifying repeat offenders, and promote compliance with PPACA.

HSD does not agree with this recommendation. While QAB and MFEAD work together to identify, track and investigate fraud, our roles, responsibilities and reporting requirements differ considerably. Our agencies have collaborated on the development and implementation of referral forms and processes in compliance with "Best Practices For Medicaid Program Integrity Units' Interactions With Medicaid Fraud Control Units" developed jointly by the National Association of Medicaid Fraud Control Units and the National Association for Medicaid Program Integrity. QAB and MFEAD will continue to partner with MFEAD when needed.

In order to comply with many of the provisions of the Patient Protection and Affordable Care Act (PPACA), HSD/MAD is evaluating a SURS enhancement that meets or exceeds all requirements. The case tracking component of the SURS enhancement will provide QAB with a robust tool to track, document, and support investigation and recovery activities for providers and clients. QAB will have the ability to collect information, manage investigations, monitor progress, record events, create and track documentation, and maintain supporting result sets and spreadsheets.

HSD should pursue punitive sanctions or phase out terminations of providers guilty of fraud, waste, and abuse to allow other providers to come in and establish themselves, minimizing service disruption.

HSD agrees with this recommendation and currently complies with federal regulation that prohibits the state from contracting with providers who are guilty of fraud, waste, and abuse. Our fiscal agent has implemented a report for comparison of actively enrolled provider files against the HHS-OIG List of Excluded Individuals/Entities (LEIE) and any provider guilty of fraud is excluded from participating in any Medicaid program.

The agency also notifies the HHS Inspector General of any action it takes on the provider's application for participation in the program, including any action it takes to limit the ability of an individual or entity to participate in its program, regardless of what such an action is called. This includes, but is not limited to, suspension actions, settlement agreements and situations where an individual or entity voluntarily withdraws from the program to avoid a formal sanction.

The MCOs help transition their members to new providers when their current provider leaves the program or closes the practice. HSD/MAD will ensure that the MCOs also help members make the transition to new providers when

their provider is terminated for fraud. These actions minimize disruption and lead to appropriate access for our members.

The Legislature should revise state statute to bring the state false claims act into compliance with DHHS OIG requirements to increase the share of civil settlements recovered by New Mexico.

HSD supports this recommendation.

Attorney General of New Mexico

GARY K. KING
Attorney General

ALBERT J. LAMA
Chief Deputy Attorney General

July 12, 2011

David Abbey, Director
Legislative Finance Committee
State Capitol Bldg., Suite 101
Santa Fe, NM 87501

Re: Response of the New Mexico Attorney General's Office to the Legislative Finance Committee Program Evaluation Team's Report on the State's Medicaid Fraud Programs

Dear Mr. Abbey:

The New Mexico Attorney General's Office appreciates the opportunity to respond to the Legislative Finance Committee Program Evaluation Team's report evaluating state programs addressing fraud, waste and abuse in Medicaid. The report focuses on programs administered by the Human Services Department ("HSD") and the Medicaid Fraud and Elder Abuse Division ("MFEAD") within the Attorney General's Office. This response addresses the findings and recommendations directed to the MFEAD.

Return on Investment

According to the report, MFEAD recouped only 53 cents for every dollar spent to prosecute provider fraud cases in federal FY10 and ranked 49th nationally in return on investment. For several reasons, the Attorney General's Office believes that return on investment may not accurately reflect the effectiveness of MFEAD's Medicaid fraud and abuse prosecutions or the activities of the Division as a whole.

First, for purposes of measuring MFEAD's performance, statistics on MFEAD's return on investment present only one side of the equation. While the report focuses almost exclusively on MFEAD's activities in recovery of Medicaid funds improperly paid to providers, MFEAD has many other responsibilities, including investigation and prosecution of abuse, neglect, and exploitation of patients in health care facilities receiving payments under the state Medicaid program. This is an obligation imposed by the Code of Federal Regulations[1] and is a condition of MFEAD's receipt of federal funding.

[1] 42 C.F.R. 1007.11(b).

While a critical component in the protection of Medicaid recipients, these cases do not typically produce a financial recovery for the Program,[2] but the federal government considers them a priority. The Patient Protection & Affordable Care Act of 2010 ("PPACA") includes provisions for additional reporting requirements of abuse, neglect, and exploitation of residents in federally funded long term care facilities (generally, nursing homes and intermediate care facilities for the mentally retarded),[3] and the Center for Medicare & Medicaid Services ("CMS") has recently issued new directives to state agencies regarding implementation of regulations to enforce these reporting obligations.[4]

MFEAD takes its obligation to investigate and criminally prosecute these cases seriously. For example, 9 criminal cases were filed and 8 criminal convictions were obtained in FY11, which include:

1. Felony Abuse/ Neglect of a Resident (Resulting in Death) against a nursing home company and its out-of-state management company;

2. Felony Abuse/ Neglect of a Resident (Substantial Pain or Incapacitation) against a nurse employed by a nursing home; and

3. Felony Criminal Sexual Penetration charges in a case in which the victim was developmentally disabled.

These and similar cases are of great importance and require a significant commitment of staff time and skill sets to prosecute effectively. However, none of these cases are expected to produce a financial return to the state. Accordingly, the report's emphasis on return on investment does not present a true picture of MFEAD's overall efficiency and performance.

The report's reference to two cases brought in 2011 is misleading because it focuses solely on the amounts recovered. MFEAD did obtain a civil settlement from a PCO agency in an amount exceeding $622,000; the other case referenced was a criminal conviction for felony Medicaid fraud with restitution of over $6,000 paid. These two cases are cited to show the need for MFEAD to track resources devoted to its cases and the results they produce. In this instance, the report reaches this conclusion without considering the significant differences between civil and criminal cases, the amount of time required for each and the distinct benefit that may result from both.

Regarding the criminal case, as a result of the conviction, the defendant will be barred from future employment in any facility receiving funds from a federally-funded health care program. While the referenced criminal case produced a smaller financial recovery, the case garnered enduring protection of the Medicaid Program and those served by the Program. As highlighted by this example and numerous other cases prosecuted by the MFEAD, criminal prosecution and Program exclusion represent significant deterrents in addressing fraud, waste and abuse in Medicaid.

Even in terms of dollars and cents, this outcome is of significant future benefit to the Medicaid Program. In general, a civil fraud proceeding against a provider may not necessarily be the most beneficial to the

[2] Most criminal prosecutions do not result in a monetary recovery for the State. By analogy, criminal prosecutions for child abuse or neglect do not result in return of funds to the State, but no one would suggest such cases should not be investigated and prosecuted because they do not generate money.

[3] See 42 U.S.C. 1320b-25, effective March 23, 2010.

[4] See CMS Ref: S&C: 11-30-NH (June 17, 2011).

public. As noted above, a provider who is convicted in a criminal proceeding is permanently barred from receiving reimbursements or payments under Medicaid. In contrast, even when MFEAD successfully prosecutes a provider in a civil proceeding, the provider often does not have sufficient assets to permit meaningful restitution. Despite this fact, during FY11 MFEAD reported total collections of $3,201,977.18, of which $817,637.67 were state funds. These collections covered both the state share and the federal share of the Division's budget.

Second, a significant percentage of the MFCU civil recoveries identified in the OIG dataset are the result Qui Tam actions. Due in large part to New Mexico's payment mechanism for managed care providers, New Mexico generally recovers less than other states in Qui Tam actions against providers. Based upon the LFC Program Evaluation Team's Report, only 25 percent of Medicaid falls under fee-for-service in New Mexico Medicaid whereas most states rely on much higher percentages. Furthermore, contractual obligations under managed care provide incentive for Managed Care Organizations ("MCO's") to limit fraud referrals that could ultimately result in an MFEAD Civil or Criminal prosecution. Thus, side-by-side comparisons with other States based solely on an analysis of amounts recovered does not accurately reflect whether resources are being utilized effectively in New Mexico.

Third, the report's figures for MFEAD's staff resources may be inaccurate. To support its contention that MFEAD is underperforming, the report shows that MFEAD allocates an average of 7.7 staff members per investigation. This is misleading. While the chart indicates "Staff per Investigations", the calculation performed actually indicates the number of "Investigations per Staff". Even if defined in this manner, the chart does not account for staff fluctuations or differences in each State's classification of a case. During FY09 and FY10, the MFEAD encountered a significant annual vacancy rate as well as a significant increase in referrals; however, the MFEAD was able to maintain a significant closure ratio thereby utilizing less staff resources per investigation than is described in the US DHHS OIG Data Set upon which this chart is based.

Need for Effective Communication and Allocation of Human Resources

We agree that better communication between HSD and MFEAD will facilitate the effectiveness of New Mexico's Medicaid fraud, waste and abuse efforts. As noted in the report, MFEAD experienced a 290% increase in referrals from HSD, which required a substantial diversion of staff resources to review and screen the referrals to the detriment of MFEAD operations. MFEAD will work to implement and communicate to HSD procedures for screening and identifying viable cases.

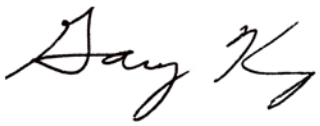
MFEAD agrees that it needs to conduct an internal review of how it prioritizes cases and allocates human resources, as discussed in the report. The issues may be resolved, in part, once the problems with referrals are addressed. As noted, the huge increase in referrals and need to review and assess them resulted in a diversion of MFEAD staff from their usual responsibilities. MFEAD believes that the need to use staff for purposes of screening and assessing referrals will lessen once HSD is clear on the criteria for proper referrals.

With one exception, MFEAD generally concurs with the recommendations directed to MFEAD for addressing issues related to communication, prioritizing referrals and human resource allocation. MFEAD does not agree with the recommendation for dividing cases assigned to special agents by geographic area to the extent that such designation is inconsistent with the need of any particular case. For purposes of implementing the recommendations, we believe it is particularly important that a single point

of contact be identified within HSD. This will facilitate MFEAD's efforts to communicate effectively with HSD and better manage referrals from HSD to MFEAD.

The Attorney General's Office is committed to working with the Legislature to address issues related to Medicaid fraud, waste and abuse. In particular, we will continue our efforts to improve communications between MFEAD and HSD, human resource allocation within MFEAD and procedures for prioritizing cases.

Sincerely,



Gary King
Attorney General of New Mexico

Albert J. Lama,
Chief Deputy Attorney General
Acting Medicaid Fraud Division Director

APPENDIX A: ROI for the 50 Medicaid Fraud Control Units in the United States

State MFCU Abuse and Fraud Return on Investment (ROI) FFY10

States	ROI	Ranking
MISSOURI	$31.12	1
KENTUCKY	$23.95	2
SOUTH CAROLINA	$22.44	3
TENNESSEE	$20.88	4
UTAH	$20.55	5
MAINE	$19.61	6
KANSAS	$19.05	7
MINNESOTA	$18.76	8
WEST VIRGINIA	$17.72	9
NORTH CAROLINA	$17.53	10
IOWA	$16.43	11
WISCONSIN	$15.89	12
CONNECTICUT	$15.69	13
OHIO	$15.39	14
NEBRASKA	$13.99	15
MASSACHUSETTS	$13.92	16
LOUISIANA	$12.48	17
OKLAHOMA	$11.77	18
WASHINGTON	$11.22	19
FLORIDA	$11.20	20
MICHIGAN	$10.87	21
NEW JERSEY	$10.80	22
MARYLAND	$10.65	23
TEXAS	$10.61	24
GEORGIA	$9.08	25
MFCU AVERAGE ROI	**$8.98**	**N/A**
PENNSYLVANIA	$8.68	26
NEW HAMPSHIRE	$8.24	27
INDIANA	$7.84	28
NEW YORK	$6.88	29
ALABAMA	$5.88	30
CALIFORNIA	$5.87	31
OREGON	$5.80	32
VERMONT	$5.66	33
SOUTH DAKOTA	$5.03	34
WYOMING	$4.28	35
ILLINOIS	$4.08	36
COLORADO	$4.05	37
ARKANSAS	$4.03	38
MISSISSIPPI	$2.63	39
NEVADA	$2.40	40
RHODE ISLAND	$2.26	41
VIRGINIA	$2.08	42
MONTANA	$2.05	43
HAWAII	$1.70	44
D.C.	$1.53	45
IDAHO	$1.52	46
ARIZONA	$1.16	47
DELAWARE	$0.99	48
NEW MEXICO (49th)	**$0.53**	**49**
ALASKA	$0.02	50

Note: ROI calculations follow methodology used by US DHHS OIG

Source: US DHHS OIG

APPENDIX B: Summary Finding from Previous LFC Evaluations of Medicaid

Personal Care Option (2004). The report identified $1.2 million in possible overpayments for services while clients were at the same time hospitalized. HSD requested the project to help identify abusive and possibly fraudulent billing practices and methodology for future monitoring.

Behavioral Health Collaborative (2006 & 2008). The collaborative provided the single entity MCO with a year-end FY06 Medicaid managed care funding increase of $11 million, which was unrelated to its performance or the provision of additional services under the contract. The report identified another $2.5 million in overpayments for non-Medicaid services as a result of pre-payment arrangements, which violated the procurement code. A follow-up report found the collaborative had expanded this wasteful practice by advancing $6 million from the general fund for the Medicaid fee-for-service program. Finally, administrative fees paid for Medicaid fee-for-service were double (10 percent) the amounts paid for similar administrative services for public employee benefit plans and exceeded industry standards.

Physical Health Managed Care (2009). Medicaid MCOs capitation payments exceeded service and administrative costs by $107 million between FY06 and FY08 that should have been recovered by HSD. Contracts required MCOs to spend 85 percent of premiums on services but they only spent 81 percent. The report recommended reducing future rates to recapture the excessive payments. While HSD disagreed with the report's finding, it has since reduced MCO rates and saved an estimated $42 million in FY10. The report found that the default payment methodology used by HSD and MCOs for some outpatient services resulted in spending far more for services than they cost, and modernizing this payment practice would save millions. HSD has since moved to rectify this excess and save an estimated $140 million. The report also identified $3.7 million in unspent provider fee increases that should have reverted to the state, but HSD allow MCOs to retain and spend unnecessarily. The managed care rate development process already accounts for trends in medical prices that potentially make additional fee increase appropriations unnecessary. Finally, the report found that HSD allowed MCOs to keep and spend penalty amounts for not meeting performance on initiatives MCOs were already contracted or have the flexibility to perform. According to HSD this practice ceased in FY10.

Coordination of Long-Term Services Program (2011). The report identified the PCO program within CoLTS as a major cost-driver with weak regulations that may result in excessive utilization. HSD has since tightened some of its regulations that will save an estimated $30 million.

Additional administrative and other management efficiencies could help streamline Medicaid and make it more affordable with better outcomes. The 2009 LFC report on Medicaid offered a number of options to improve care and lower costs.

The method to develop MCO rates grows potential administrative/profit funding at the same rate as projected medical costs, which discourages administrative efficiencies. The methodology of developing actuarially sound rate ranges involves projecting future costs based on historical spending, plus administrative costs. State policies requiring plans to spend 85 percent of revenue on medical costs may unintentionally encourage unnecessary spending on medical care. HSD has not implemented a contractual provision to encourage the appropriate reduction of medical spending in a way that does not penalize MCOs.

Using a 15 percent cap on administration does not take into account administrative scale efficiencies achieved by larger plans or the use of out-of-state parent companies for administrative services. Plans with bigger premium income are rewarded with larger administrative allocation and potential profit simply because they are larger, not because they are better value or have better performance. For example, Presbyterian's Salud! line of business is twice that of its competitors and operates multiple product lines. As a result, the plan should be able to achieve a different level of administrative efficiency. A similar situation exists for Molina, which relies on its out-of-state parent company to provide claims processing and other services. This outsourcing lowers administrative costs, yet it is unclear how New Mexico Medicaid benefits from these administrative efficiencies in the rates it pays. HSD appears to have recognized this problem and put a 5 percent cap on profit margin for the current contract in FY09.

New Mexico has been a national leader in using pay-for performance Medicaid managed care contracts but puts little funding at-risk for poor performance. Historically only 0.5 percent of premiums were subject to this innovation. In FY09, MCOs could earn a maximum of $7 million through this performance program. By comparison, the contracts allowed MCOs to earn a profit total upwards of $70 million. Options should be explored to reorient the contracts to ensure MCOs' profit is earned through proper containment of medical spending while producing the health outcomes the state needs.

All MCOs that submitted bids during the Salud! competitive bidding process were awarded contracts. Three MCOs were originally awarded contracts under Salud!, with a fourth MCO joining the program in FY09. Contracting all MCOs creates a disincentive for the MCOs to be cost competitive. As of the end of FY10, there were 328 thousand enrollees in the Salud! program across four MCOs, for an average of 82 thousand enrollees per MCO. In contrast, under Tennessee's Medicaid physical health program, Tenncare, there were approximately 1.2 million enrollees across three MCOs, an average of 400 thousand enrollees per MCO. Retaining only three MCOs under the Salud! program would result in an average of 109 thousand enrollees each.