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F I S C A L I M P A C T R E P O R T

SPONSOR Begaye **ORIGINAL DATE** 01/30/12 **LAST UPDATED** **HB** 66

SHORT TITLE Medicaid Fraud Prevention and Detection **SB**

ANALYST Chabot

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY12	FY13	FY14	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		>$4,000.0	>$500.0	>$4,500.0	$500.0 Recurring	General Fund/Federal Funds

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION
LFC Files

Responses Received From
Attorney General Office (AGO) [Extensive Analysis]
Human Services Department Medical Assistance Division (HSD/MAD)

SUMMARY

Synopsis of Bill

House Bill 66 (HB 66) would require the Human Services Department (HSD) to implement a "Medicaid fraud prevention and loss recovery program" supported by a new information technology "IT" system.

HSD states this system would interface with the current claims processing system to identify and prevent errors in real time using automated protocols from the American Medical Association and the Center for Medicare and Medicaid Services (CMS). The bill would require HSD to initiate procurement for this system by June 1, 2012 "notwithstanding any existing contract to update the human services department's information technology system for Medicaid claims processing and payment" (i.e., the MMIS fiscal agent contract).

The bill would require additional prepayment review for claims that are considered at a higher risk for fraud, based on analysis of utilization patterns. The bill also requires that HSD conduct regular post-payment reviews. The bill requires additional reporting to the Legislative Finance and Health and Human Services committees.

The bill also would require HSD to establish a new claims database with "unadulterated data, exactly the way the claims data that Medicaid providers submit to the Medicaid program or to

managed care organizations before any data manipulation of claims processing has occurred or any data are lost."

The bill would require HSD to "conduct regular audits of Medicaid claims after payment of the claims to ensure that the diagnoses are accurate and valid based on the supporting Medicaid provider documentation within the recipient's medical record."

The bill would allow but does not require HSD to enter into shared savings contracts and specifies maximum percentages and total payment amounts that may be made under such contracts.

The AGO did an extensive analysis of this bill which are attached. See AGO attached comments.

FISCAL IMPLICATIONS

There is no appropriation in the bill; however, HSD estimates creating a new database that interfaces with the Medicaid payment system would cost $4 to $10 million with an additional $500.0 thousand to $1 million annually to operate and maintain.

See AGO analysis for extensive comments (attached).

SIGNIFICANT ISSUES

HSD states "This bill is duplicative of current activities and initiatives already in place within HSD/MAD. The current MMIS is a continually maintained database of Medicaid claims, managed care encounters, and Medicaid providers. The system has several incorporated components that analyze medical codes, claims data, and medical claims to evaluate utilization patterns and other claim edits on a prepayment basis. These prepayment reviews, including the CMS-required National Correct Coding Initiative (NCCI), automatically screen claims for errors, duplication, and potential fraud.

"HSD/MAD recently purchased and implemented an update to the fraud and abuse detection system. The Fraud and Abuse Detection System (IFADS), incorporates all of the methodologies described in this bill to uncover fraud, waste and abuse as well as providing the MAD Program Integrity Unit staff with the components to aid investigations, research and validation of suspicious behaviors. Some of the components include peer group profiles, comprehensive algorithm strategies and technologies, activity spike detection, and tools to analyze historical data to develop profiles of health care delivery and service utilization patterns.

"HSD/MAD uses these technologies and tools to identify and target fraudulent or abusive practices and conduct post payment medical record reviews and audits. The HSD Office of Inspector General established a Recipient Medicaid Fraud Team that assists the HSD/MAD Program Integrity Unit in the investigation and review/audit of suspicious activity.

Finally, the Patient Protection and Affordable Care Act (PPACA) of 2010 mandated several provisions related to program integrity, fraud, waste, and abuse. HSD/MAD implemented many safeguards to comply with those requirements, including updated provider participation agreements, an updated provider screening and enrollment process, and the implementation of the Recovery Audit Contract (RAC) program.

"The RAC program is a CMS-mandated program that already includes the provisions set forth in the "Vendor Contract; Shared Savings/Limits" section of this bill. The RAC program required that that Medicaid program solicit a vendor/contractor and enter into a shared savings program with such contractor. HSD/MAD awarded the RAC contract to a vendor in 2010 and has developed a work plan to meet all provisions of the fraud detection, prevention and loss recovery of the PPACA. This program has provided New Mexico and other states with the mechanism and methodology to contract with vendors with the information technology services or infrastructure and expertise to identify improper payments. These activities are contractually funded through a state "suspense fund" that closely resembles the methodology described within this bill."

See AGO attached Significant Legal Issues

PERFORMANCE IMPLICATIONS

See AGO attached Performance Implications with Enacting This Bill

ADMINISTRATIVE IMPLICATIONS

See AGO attached Administrative Implications with Enacting This Bill

TECHNICAL ISSUES

Page 8, Lines 5 through 9, requires HSD to report to the Legislative Health and Human Services and Legislative Finance Committees. Governors have often vetoed reporting requirements to legislative agencies. Since this is not an appropriation bill, inclusion of the reporting requirement may lead to a veto of the entire bill.

HSD assesses "the requirement to develop a new claims database with "unadulterated data, exactly the way the claims data that Medicaid providers submit to the Medicaid program or to managed care organizations" is duplicative of data in the current HSD Data Warehouse and would essentially require maintenance of the Source 837 electronic health claims and National Council for Prescription Drug Programs electronic transactions, plus creation of a file layout for data captured from paper claims before claims processing adds data to the claim record from various MMIS master files (e.g., client, provider and reference data)."

See AGO attached Technical Issues or Drafting Error

OTHER SUBSTANTIVE ISSUES

See AGO attached Other Substantive Legal Issues and Amendments Needed to Improve This Bill.

Attachment:
AGO Analysis

GAC/lj:amm

LFC Requester:	Greg Geisler

AGENCY BILL ANALYSIS
2011 REGULAR SESSION

WITHIN 24 HOURS OF BILL POSTING, EMAIL ANALYSIS TO:

LFC@NMLEGIS.GOV

And

DFA@STATE.NM.US

{Include the bill no. in the email subject line, e.g., HB2, and only attach one bill analysis and related documentation per email message}

SECTION I: GENERAL INFORMATION

{Indicate if analysis is on an original bill, amendment, substitute or a correction of a previous bill}

Check all that apply:

Original X **Committee / Floor Amendment** ___

Correction ___ **Committee Substitute** ___

Date 1-19-2012

Bill No: HB 66

Sponsor: Ray Begaye

Short Title: Medicaid Fraud Prevention & Detection

Reviewing Person Writing Attorney General's Office MFCU Amy Landau, AAG

Phone: 222-9069 **Email** alandau@nmag.gov

SECTION II: FISCAL IMPACT ** FOR LFC OFFICIAL PURPOSES**
AGO STAFF SHOULD LEAVE SHADED AREAS BLANK

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Non-Rec	Fund Affected
FY11	FY12		

(Parenthesis ( ) Indicate Expenditure Decreases)

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Non-Rec	Fund Affected
FY11	FY12	FY13		

(Parenthesis ( ) Indicate Expenditure Decreases)

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY11	FY12	FY13	3 Year Total Cost	Recurring or Non-Rec	Fund Affected
Total						

(Parenthesis ( ) Indicate Expenditure Decreases)

SECTION III: NARRATIVE

This analysis is neither a formal Attorney General's Opinion nor an Attorney General's Advisory Opinion letter. This is a staff analysis in response to the agency's, committee's or legislator's request.

BILL SUMMARY

Summary Synopsis:

General: This bill appears to ignore and/or delete Sections 27-11-3 *Review of medicaid providers; contract remedies; penalties*; 27-11-4, *Retention and production of records*; and 27-11-5, *Rules*, all of which **SHOULD NOT BE DELETED AND/OR REPEALED. The MFCU are currently relies upon and uses these provisions during its criminal and civil investigations and prosecutions**. The AG's MFCU recommends that proposed Sections 3-8 be renumbered as Section 27-11-6, 7, 8, 9, 10, and 11, leaving Sections -3, -4, and -5 **AS IS.**

Some of the activities listed in the HB 66 Medicaid Fraud Prevention & Detection are already contractually required to be performed by Medicaid managed care organizations (MCO - See Section 27-11-2(B)) and may already be required to be contractually performed by ACS, the state's Medicaid fiscal agent. It was the MFCU's understanding that the MAD contracts included payments to the MCOs for activities which the vendor(s) would be paid for again under HB 66, and that the MAD/ACS contract either already provides for some fraud detection activities and/or contains provisions for MAD adding fraud prevention activities to the ACS contract at costs substantially lower than those proposed in HB 66 to vendors. See attachment and links in attachment.

If these activities are now going to be contracted to new vendors, the parties currently contracted for the same duties and fraud detection activities and currently paid state funds to perform those activities should be terminated prior to any bidding and acceptance of contracts for the same activities with new funds. The overlap of HB 66 proposed vendor(s) activities and duties with current contractual activities and duties contracted to the MCOs and/or ACS will cause accounting and legal confusion (as well as judicial confusion) unless clarified in HB 66's new provisions. See discussion below for specific instances.

FISCAL IMPLICATIONS WITH ENACTING THIS BILL

See comments above. Many of the proposed services to be provided by the new vendor(s) are already contractually required to be provided by the MCOs and possibly ACS and are currently already being paid for by the State. Clarification of the scope of vendor statutory duties provided for under HB 66 and which HB 66 proposes to pay the vendor(s), needs to be made in HB 66 so that the State is not paying another vendor(s) for activities ACS and the MCOs are contractually required to perform already and which they are being paid to perform already.

From the AG MFCU's perspective, the most important fiscal issues to prevent loss of claims

during Medicaid fraud criminal and civil prosecutions under the Medicaid Fraud Act are the following:

1. **Vendor(s) should only be paid for claim amounts actually recovered and delivered back to the State**. There are numerous instances where fraud claims have been identified through claims review from all sorts of sources which were determined to be billing errors, overpayments allowed by HSD, overpayments due to ambiguities in regulations, waiver by supervising authorities, inadvertent oversights, honest billing errors, and/or administrative and judicial interpretations of claims as "not fraudulent" which were alleged as "fraudulent" by the MFCU and MAD and therefore do not result in any financial recovery. Vendor(s) should not be paid until the monies are actually received back by the State, no matter how long the judicial and/or administrative process takes. All claim recoveries by the vendor(s) and the State need to be tracked by transaction control numbers (TCN), so that proper auditing of payments and recoveries can occur and/or be proven under current legal standards before judicial bodies.

2. Vendor(s) should not be paid for check hold amounts requested by the AG MFCU. Various federal statutes and regulations require check holds be instituted against providers by MAD based upon the AG's MFCU's proceeding against a provider for "credible allegations of fraud." Those monies held under such circumstances pursuant to federal regulations, should not be credited to the vendor(s) under HB 66. *See* 42 C.F.R. § 455.23 Suspension of payments in cases of fraud; 42 C.F.R. § 447.90; 42 C.F.R. § 1007.9. HB 66 review requires verification that it does not conflict with federal statutes and regulations and/or that federal statutes and regulations do not conflict with and/or pre-empt HB 66.

SIGNIFICANT LEGAL ISSUES

Section 2. Definitions.

One of the most significant legal issues in HB 66 is the confusion caused by the use of the following words which are not specifically defined in HB 66 but which will cause confusion, ambiguity, and unnecessary litigation, if not defined in HB 66 due to its relationship with the Medicaid Fraud Act, Sections 30-44-1 *et seq.* and the Medicaid False Claims Act, Sections 27-14-1 *et seq.*:

1. "Fraud." [This word has different meanings and different standards of legal proof under the Medicaid Fraud Act and the Medicaid False Claims Act and federal and state criminal and civil statutes and regulations applicable to medicaid. Clarification and definition of this term's use within HB 66 is critical to avoid waste and abuse of prosecutorial resources. There is a pending civil appeal by the MFCU regarding whether violations of statutes and regulations constitutes civil fraud subject to overpayment recovery and civil penalties under the Medicaid Fraud Act. So at least two New Mexico civil judges have already agreed that what is "fraud" for purposes of recovering Medicaid monies needs to be better defined in applicable statutes and regulations, so enforcement is consistent and clear.]

2. "Abuse."

3. "Improper payment." (Compare with "validated overpayments" at page 5, line 24.)

4. "Waste."

5. "Nonfraudulent." *See* page 5, line 21.

6. "Loss."

7. "Error (erroneous)" versus "fraud." (Compare "inaccurate" and "inappropriate." Pg. 4, lines 17-20).

8. "Data entry error."

9. "Shared savings." See page 10, line 9. The definition should state how this amount is calculated and should only be based upon monies actually received back by the State.

ACS is generally referred to as the State's medicaid fiscal agent. However clarification of whether ACS would now be considered a vendor or subcontractor or contractor under HB 66 would be helpful. Can ACS also become a vendor under HB 66? Would ACS still be required to perform its current duties which it is the MFCU's understanding already include fraud and waste and abuse detection?

PERFORMANCE IMPLICATIONS WITH ENACTING THIS BILL

Page 4, lines 17-20. This provision needs to reconciled with current MAD regulations and requirements for automated electronic payment within a specific time frame, and with a methodology to allow ease in MAD recovery quickly for payments already made using electronic funds transfers.

Page 4, line 24 to page 5, line 2. It is unclear what this provision means and how it would be performed.

Page 5, lines 3-14. It is unclear how this provision can be implemented, how transactions will be prioritized, and under what legal authority, payments can be withheld to allow time for review.

Page 5, line 19. This provision needs to be amended to include **ALL records** documenting all services for which Medicaid made and/or makes payments. Compare to MFA Section 30-44-5 which includes "all medical and business records," and Medicaid Provider Act, Section 27-11-4 (which should NOT be repealed) which includes "all medical and business records that are necessary to verify" what medicaid paid for."

Page 6, lines 1-20. How will the MFCU interact with the "fraud investigation procedures" described here and continue to perform its federally mandated statutory and regulatory duties? This interaction and/or relationship needs to be clarified. Does the vendor have the right to pursue recovery of the alleged fraud claims on behalf of the state, prior to, during and/or after; the AG MFCU has commenced its investigations and/or prosecutions? If the vendor identifies the alleged "fraud" but the MFCU investigates and prosecutes, does the vendor still recover a percentage of the recovered funds? Also who has authority to settle claims investigated and/or brought by the MFCU, if they were identified by the vendor(s)?

Page 6, line 11. What does it mean before a claim is filed or adjudicated? Under the MFA, if a claim is not filed, there can be no fraud. Alternatively, if the claims which the vendor(s) identifies as fraudulent are subject to judicial prosecution and/or administrative hearing and

judicial appeal, is that considered "adjudication?" When does a vendor get paid for a claim subject to "adjudication?" Will this provision require a "fair hearing" between the vendor and provider heard by MAD hearing officers?

Page 6, line 20. A valid mailing address is already required but does not prevent fraud since a provider can be in the Bahamas and bill electronically and receive electronic payments to an offshore account. MFCU requests that some other reasonable means also be used and added, to verify that the provider is "not just a store front."

Page 6, line 21 to page 7 line 5. The MFCU requests consideration for how the MFCU would interact with the vendor(s) under this provision given the MFCU's federally mandated operating requirements.

Page 7, Section 4. How would this database differ from what ACS currently maintains for the State? Would the new vendor(s) work with, oversee, direct and/or replace ACS?

Page 7, lines 16-20. Currently the MCOs provide ACS with encounter data only. Would HB 66 require that the MCOs provide all claims from subcontractors below them providing services for the MCOs' clients in the same format as the "fee for service" (FFS) data is maintained by ACS currently? Without the raw FFS data received by the MCOs that is currently not provided to ACS, the vendor(s) would presumably not be able to determine and/or ascertain fraud, waste and/or abuse relating to services provided under the MCOs.

Page 7, line 21 to page 8 line 1. It was the MFCU's understanding that MAD was already required to, and performing this service. Why would MAD need a new vendor(s), resulting in additional costs, to perform what it already does?

Page 8, line 14 to page 9, line 7. It is MFCU's understanding that MAD is already required to make this type of report to the LH&HS committee and the LFC and to the federal government. Is the vendor(s) going to now be preparing the report? How does this reporting requirement differ from what is already required? Does this report include a reporting requirement from the AG's MFCU and if so, how does this reporting requirement differ from what is already being done by the MFCU?

Page 8, starting line 14. Why is the state auditor required to make the report and how long will it take the state auditor to prepare this report? Provision (1) is an estimate which is based upon what? Here is a definitional problem which becomes a legal problem when providers who are prosecuted by the MFCU say it may be an "improper" payment, but it is not fraud and the State does not get to recover it. To date, the judges on the civil fraud side have held that even an "improper" payment does not rise to the level of fraud because the State cannot prove any intent to commit "fraud." This is why a definition of "fraud" in HB 66 is needed and critical to enforcement of these proposed statutory changes.

Page 8, line 23. What is meant by "savings?" By way of example only, defendant providers say even if their caregivers are not properly trained in accordance with MAD regulations and/or screened, the client still received the services so no fraud occurred, and no profit was made and the State cannot recover any damages for "improper payments." Under this rationale, there would be no savings. What would the vendor(s) get for identifying violations of statutes and regulations which the judiciary maintains do not rise to the level of "fraud?"

Page 9, lines 4-7. The AG's MFCU does not believe or support the use of return on investment (ROI) analysis for determining the "success" of the unit's activities. Because of the infinite number of variables in criminal and civil investigations and prosecutions of medicaid providers, actual dollar recoveries should not be the primary standard utilized to gauge the MFCU's unit's success. If the legislature should chose to use ROI as a standard for success in Medicaid fraud, abuse and waste detection and recovery, while allowing vendor(s) to profit under HB 66 for anything other than "actual monies paid back to the State," while requiring the MFCU to prosecute the "fraud" identified by a vendor(s) HB 66, the MFCU's performance will be greatly impacted.

Page 10, line 9. The MFCU recommends HB 66 define what is meant by "shared savings," how it calculated, and that it only be based upon monies paid and actually received back by the State. See page 10, line 15. What is meant by "losses due to fraud?" If a provider is convicted of medicaid fraud and ordered to pay restitution but the State never receives the monies back, does the vendor(s) still get to recover a percentage of the restitution ordered, though never received by the State?

Page 10, line 4 to page 12, line 20. Do the costs and expenses that can be deducted from the vendor(s) recovery include MFCU's costs and expenses of investigation and prosecution?

Page 11, line 24 to page 12, line 6. Any prosecution, criminal or civil, under any other state statutes identified here use different definitions of "fraud" and can take years from investigation to indictment and/or filing a complaint to judgment and recovery. What happens to the vendor(s) contracts and recovery of monies in the meantime under HB 66?

Page 12, lines 7-20. See above regarding MFCU position that only monies actually paid and received by the State should be used to pay vendor(s). If monies in the fund are subject to recovery by a provider through administrative and/or judicial process, the vendor(s) should not be paid the monies until such actions are settled fully and finally. Any other method creates a situation where the State is lending the vendor(s) federal funds. See also coordination required with Section 30-44-8(C) regarding penalties and costs of investigation recovered on behalf of the state and well as Section 30-44-8(A)(4).

Page 12, Section 7. MFCU recommends that some type of provision be added similar to Section 30-44-8(D), so that the unit has the right and jurisdiction to proceed under HB 66 to prosecute a vendor(s) for a breach of contract provided under proposed HB 66, Section 6(B) at page 11, line 24 to page 12, line 6.

ADMINISTRATIVE IMPLICATIONS WITH ENACTING THIS BILL

Extensive regulations would be required to define rights and responsibilities of the vendor(s) under HB 66, as well as sanctions and remedies for failure to perform under HB 66 and the subsequent contracts. In addition, extensive review of current MAD regulations and existing contracts would be required to prevent conflicts between existing regulations and the new regulations.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP WITH BILLS INTRODUCED THIS SESSION

No other bills have been provided to this reviewer for review, as of the date and time of this

review so no response is possible at this time.

TECHNICAL ISSUES OR DRAFTING ERROR

See Section numbering issues discussed above deleting and/or repealing existing Sections 3, 4, and 5 which should not be repealed.

OTHER SUBSTANTIVE LEGAL ISSUES

According to the MFCU's understanding of federal law, Medicaid is generally funded 75% by the federal government and 25% by the state. If the State, is giving monies to the vendor(s) which must be returned statutorily to the federal government, will the state have to pay the vendor(s) out of pocket for their fees, thereby costing the state significant revenues?

In addition, does this bill need to be approved by the federal government before it is submitted to a vote by the state legislature because it involves federal funds?

ALTERNATIVES TO ENACTING THIS BILL

The MFCU would suggest that careful review of existing contracts with the MCOs and ACS regarding what type of fraud detection they are currently contractually required to perform, whether it is being performed, and what it is currently costing the state needs to be done prior to enactment of HB 66, so there is a baseline of responsibilities, contractual duties, and costs prior to proceeding with the use of vendor(s) proposed in HB 66.

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL

The MFCU cannot comment at this time on this question without additional time and information.

AMENDMENTS NEEDED TO IMPROVE THIS BILL

The MFCU believes that addressing the issues raised above in amendments to HB 66 would be a good start.

See attachments and links regarding ACS and MCOs current contractual duties regarding fraud, abuse and waste detection. The MFCU does not know the status of these contractual provisions between MAD and the individual entities, ACS and MCOs, and/or whether MAD has amended, paid for, added and/or terminated any contractual provisions which may overlap and/or conflict with the HB 66 proposed provisions.

s/1-19-2012, 4:30 PM. AL

Landau, Amy <alandau@nmag.gov>

House Bill 66 (Fraud and Abuse Detection System)

Santiago Baca <sbaca@nmag.gov> **Thu, Jan 19, 2012 at 2:37 PM**
To: Amy Landau <alandau@nmag.gov>

Amy,

Please see the following citations regarding House Bill 66 (Fraud and Abuse Detection System). The citations involve systems that are currently required (MCOs = ~75% of total Medicaid spending) and potentially already in place or available (FFS = ~25% of total Medicaid spending). I underlined the sections I believe to be relevant to your response. The citations were copied from the ACS and MCO contracts available on MADs website (http://www.hsd.state.nm.us/mad/Contracts.html). Since the documents on MAD's website were not searchable, I have to perform an OCR within the PDFs. As such, typos may have occurred in the pasted text below.

It appears that a system may be in place with ACS (system edits, payment review, etc.) at a significantly lower rate. It also appears that a system is already required to be in place with the MCOs.

ACS Contract (http://www.hsd.state.nm.us/mad/pdf_files/salud/ACS-Contract.PDF):

4.2.2.1 SURS Fraud and Abuse Detection System

Following receipt and acceptance of the strategic analysis deliverable, including a cost benefit analysis that compares the current system to the proposed enhancement and the impact on future operational and maintenance costs, the DEPARTMENT shall provide the CONTRACTOR with the anticipated scope and preferred options for the SURS Fraud and Abuse Detection System enhancement. The CONTRACTOR shall provide any required additional information to the DEPARTMENT necessary for the DEPARTMENT to make a final decision to proceed with the optional enhancement. At the request of the DEPARTMENT, the CONTRACTOR shall enhance the MMIS with a SURS replacement system that includes a specialized Fraud and Abuse Detection System. The Department shall have the option to waive the inclusion of the SURS Fraud and Abuse Detection System in the strategic analysis deliverable.

4.2.2.1.2

The CONTRACTOR shall customize the system for the DEPARTMENT by conducting a requirements analysis with anticipated users of the system.

4.2.2.1.3

The CONTRACTOR shall implement and operate a Fraud and Abuse Detection system according to the specifications proposed by the CONTRACTOR and accepted by the DEPARTMENT.

4.2.2.1.3.1

The replacement system shall meet all federal standards for MMIS Certification and have the following functions, capabilities, and features:

4.2.2.1.3.1.1

Utilize the capabilities of a dedicated MMIS Data Warehouse and include Decision Support System tools, a PC-based client server SURS-type system, and additional software tools designed specifically for fraud and abuse detection.

4.2.2.1.3.1.2

Incorporate simple user interfaces appropriate for all levels of MMIS staff; provide drill-to-detail and export data-to-spreadsheet capability; serve as an effective investigative tool and provide over all program statistics at both a high level view and at a detailed view as defined by the user.

4.2.2.1.3.1.3

Provide fraud and abuse detection tools with algorithms and statistical modeling that look at claims and providers in a multitude of ways to identify fraud and permit fast investigations and provide for case documentation.

4.2.2.1.3.1.4

Use a relational database that is available to the user at the user's PC workstation on a re8l-time basis with turn-around to longer queries available within 24 hours.

4.2.2.1.3.1.5

Equipped to detect possible program abuse and over-utilization by providing structures to compare business practices, medical services, quantities of service, treatment patterns, billing patterns,

trending, and utilization patterns; beginning with general detection and provide the ability to continue the analysis to the claim detail level.

4.2.2.1.3.1.6

Able to produce a broad range of statistical data from claim payment information, such as frequency of use and expenditures associated with procedures, diagnoses, provider types, client categories of eligibility, demographic information, and other user defined parameters and include all services and claim types, including pharmacy claims.

4.2.2.1.3.1.7

Provide and maintain predefined groupings of codes and diagnoses.

4.2.2.1.3.1.8

Track cues for investigation from the point of opening the case to its final disposition and provide for the storage of reports, statistics, and analyses, in order to document the progress of the case and the validity of the conclusions.

4.2.2.1.3.1.9

Provide for flexibility, user-friendly tools, and clear presentations of data and options the user can master with limited training including using standard GUI point and click technology.

4.2.2.1.3.1.10

Allow reports to be displayed on-line for immediate user viewing and also be printed.

4.2.2.1.3.1.11

Utilize as inputs, claims history (including encounters as well as fee-for-service claims, provider demographic and enrollment data, client beneficiary demographic and eligibility data, reference data for descriptions of diagnosis and service codes.

4.2.2.1.3.1.12

Utilize user-maintained parameters that define report processes and content.

4.2.2.1.3.2

FADS shall include the following functionality:

4.2.2.1.3.2.1

Uses proven focused detection algorithms (i.e. a comparison of procedure code and diagnosis codes to known fraud and abuse schemes).

4.2.2.1.3.2.2

Uses multiple identification models to detect fraud. These include, but are not limited to, looking at a single potentially-abusive claim transaction and/or examining relationships between one provider and one patient such that it examines the overall volume and nature of services delivered to the patient by that provider; and examining relationships based on the history of a patient (aggregating across all providers) or overall practice patterns of providers (aggregating over-all patients).

4.2.2.1.3.2.3

Identifies potential fraud or abuse where providers may deliberately distribute fraudulent activity across several patients; which may be distributed within one practice; for billing patterns that might occur for a particular group of patients such as those in a nursing home or other care home; for patterns of claims activity by groups of practitioners affiliated with one another through practices, clinics, or other cooperative business arrangements; where several providers continually refer to and from themselves for unnecessary tests and services; and for billings of combinations of codes that represent unbundling or unnecessary services.

4.2.2.1.3.2.4

Permits a wide range of statistical modeling; allows comprehensive analysis of both providers and beneficiaries; and provides the enhanced flexibility to query by several variables and combination of variables, including provider, type of service, place of service, date of service, beneficiary, modifiers, and code combinations.

4.2.2.1.3.2.5

Provides early detection of new billing schemes, and the ability to identify new or emerging fraud or abuse billing schemes. The system must provide an artificial intelligence in the sense of logically detecting potentially fraudulent activity in the same manner that an individual, reviewing data manually would detect certain occurrences as illogical, irrational, or unlikely, including detecting changing practice patterns. Detection of these circumstances must produce an alert to the user.

4.2.2.1.3.2.6

Illustrates suspected fraud or abusive billing graphically and geographically (mapping).

4.2.2.1.3.2.7

Has an ad-hoc query platform that enables users to develop and modify queries rapidly and easily.

4.2.2.1.3.2.8

Readily produces management and utilization reports.

4.2.2.1.3.2.9

Includes an integrated and sophisticated case tracking application that can open and track cases, and supports development of case packages, including documentation and comparative data analysis for use in pursuing fraud and abuse recoveries.

4.2.2.1.3.2.10

Provides flexible, fully controlled, and easy changes to security levels and privileges.

4.2.2.1.3.3

The SURS component of FAD shall provide for enhanced SURS reporting as follows:

4.2.2.1.3.3.1

Develops a comprehensive statistical profile of health care delivery and utilization patterns established by provider and beneficiary participants in various categories of services.

4.2.2.1.3.3.2

By means of computerized exception processing techniques, provides the ability to perform analyses and produces reports responsive to the changing needs of authorized users; be capable of developing provider, physician, and patient profiles sufficient to provide specific information as to the use of covered types of services and items, including prescribed drop.

4.2.2.1.3.3.3

Produces reports that rank providers using exception weighting according to user designed exception criteria and according to peer grouping defined by the user, using weights and parameters also defined by the user.

4.2.2.1.4

If the DEPARTMENT proceeds with the option to purchase the SURS Fraud and Abuse Detection System, the DEPARTMENT shall have a separate and additional option to purchase resources from the CONTRACTOR to provide maintenance and support of the system. The DEPARTMENT shall also have a separate and additional option to purchase resources from the CONTRACTOR related to developing fraud and abuse cases for investigation and/or prosecution and for overpayment recoveries. The DEPARTMENT shall have the option of purchasing all or any portion of the following services, including resources for training and developing capability within the DEPARTMENT for fraud and abuse detection and recovering overpayments.

4.2.2.1.5

If the DEPARTMENT proceeds with the option to purchase the SURS Fraud and Abuse Detection System, the DEPARTMENT shall have a separate and additional option to purchase resources from the CONTRACTOR related to investigating fraud and abuse cases.

4.2.2.1.6

The DEPARTMENT shall have a separate and additional option to purchase resources from or through the CONTRACTOR to provide expertise to help the DEPARTMENT establish and/or train units to specialize in fraud and abuse detection, including using proven detection and case development techniques, system use, and principles of audit and investigation.

8.4.1 Fraud and Abuse Detection System and Support

At the option of the DEPARTMENT, the DEPARTMENT may purchase any or all of the following components and services of a Fraud and Abuse Detection System:

8.4.1.1 For a SURS replacement system and ongoing support as specified in section 4.2.2.1 of this AGREEMENT and as approved by the DEPARTMENT, the DEPARTMENT shall pay to the CONTRACTOR upon successful completion of the enhancement:

$ 1,001,416.00

8.4.1.2 For the option allowed by section 4.2.2.1.4 of the AGREEMENT for supplying maintenance and support of the FADS system, at the level specified in the CONTRACTOR's proposal in response to the MMIS RFP, and as approved by the DEPARTMENT, the DEPARTMENT shall pay to the CONTRACTOR for each month:

State Fiscal Year 2006 $24,712.00

State Fiscal Year 2007 $26,090.17

State Fiscal Year 2008 $27,786.58

State Fiscal Year 2009 $28,411.58

State Fiscal Year 2010 $29,055.42

State Fiscal Year 2011 $29,718.50

8.4.1.2.1 In the event the AGREEMENT is extended to include any or all of the optional years available under the contract, the CONTRACTOR shall be paid for the option allowed by section 4.2.2.1.4 of the AGREEMENT for supplying maintenance and support of the FADS system, at the level specified in the CONTRACTOR's proposal in response to the MMIS RFP, and as approved by the DEPARTMENT. The DEPARTMENT shall pay to the CONTRACTOR for each month:

State Fiscal Year 2011 $29,718.50

State Fiscal Year 2012 $30,401.42

State Fiscal Year 2013 $31,104.92

State Fiscal Year 2014 $31,104.92

8.4.1.3 For the option allowed by section 4.2.2.1.5 of the AGREEMENT, for supplying additional staff and resources for field audits and on-site investigations of fraud and abuse and overpayments, at the level specified in the CONTRACTOR's proposal in response to the MMIS RFP, and as approved by the DEPARTMENT, the DEPARTMENT shall pay to the CONTRACTOR for each month:

State Fiscal Year 2006 $43,970.25

State Fiscal Year 2007 $45,096.75

State Fiscal Year 2008 $46,434.17

State Fiscal Year 2009 $47,811.75

State Fiscal Year 2010 $49,230.67

State Fiscal Year 2011 $50,692.08

8.4.1.3.1

In the event the AGREEMENT is extended to include any or all of the optional years available under the contract, the CONTRACTOR shall be paid for the option allowed by section 4.2.2.1.5 of the AGREEMENT, for supplying additional staff and resources for field audits and on-site investigations of fraud and abuse and overpayments, at the staffing levels specified in the CONTRACTOR's proposal in response to the MMIS RFP, and as approved by the DEPARTMENT. The DEPARTMENT shall pay to the CONTRACTOR for each month:

State Fiscal Year 2011 $50,692.08

State Fiscal Year 2012 $52,197.42

State Fiscal Year 2013 $53,747.92

State Fiscal Year 2014 $53,747.92

8.4.1.4

For the option allowed by section 4.2.2.1.6 of the AGREEMENT, for supplying additional staff and resources for training the DEPARTMENT on fraud and abuse and overpayment recoveries and as approved by the DEPARTMENT an amount shall to be paid to the CONTRACTOR for each month, as negotiated by the DEPARTMENT and the CONTRACTOR based on costs for similar level staff as for Section 8.4.1.2 and Section 8.4.1.3 of this AGREEMENT.

Amerigroup Contract (http://www.hsd.state.nm.us/mad/pdf_files/Amerigroup%20Final%20Contract%200808.PDF):

3.12 PROGRAM INTEGRITY

The CONTRACTOR shall:

(A) have written policies and procedures to address prevention, detection, preliminary investigation, and reporting of potential and actual Medicaid fraud and abuse that articulate the CONTRACTOR's commitment to comply with all state and federal standards. The policies and procedures shall address how coordination with DOH will occur in the case of fraud and abuse in nursing facilities;

(B) have a comprehensive internal program that includes the designation of a compliance officer ands a compliance committee that are accountable to senior management to prevent, detect, preliminarily investigate and report potential and actual program violations to help recover funds misspent due to fraudulent actions while enforcing standards through well-publicized disciplinary guidelines;

(C) have an effective training and education program for the compliance officer and the CONTRACTOR's employees and have specific controls for prevention, such as claim edits, post processing, review of claims, provider profiling and credentialing, prior authorizations, utilization/quality management and relevant provisions in the CONTRACTOR's contracts with its Network Providers and subcontractors;

(D) cooperate with the Medicaid Fraud Control Unit (MFCU), DOH, DEA, FBI and other investigatory agencies;

(E) comply with the CMS Medicaid Integrity Program and the Deficit Reduction Act of 2005;

(F) establish effective lines of communication between the compliance officer and the CONTRACTOR's employees to facilitate the oversight of systems that can monitor service utilization and encounters for fraud and abuse and have a provision for a prompt response to detected offenses, and for the development of corrective action initiatives relating to the CONTRACTOR's contract. The CONTRACTOR shall demonstrate how coordination with DOH will occur as related to the monitoring of nursing facilities;

(G) immediately report to the State any activity giving rise to a reasonable suspicion of fraud and abuse, including aberrant utilization derived from provider profiling. The CONTRACTOR shall promptly conduct a preliminary investigation and report the results of the investigation to the State. A formal investigation shall not be conducted by the CONTRACTOR but the full cooperation of the CONTRACTOR as mutually agreed to in writing between the parties during the formal investigation will be required; and

(H) send to the State as required, the names of all providers identified with aberrant utilization according to provider profiling the cause of the aberrancy, and not use the CONTRACTOR's determination as to whether questionable patterns in provider profiles are acceptable or not, as a basis to withhold this information from the State. As required in 42 C.F.R. §455.l7, the CONTRACTOR shall report to the State:

(a) the number of complaints of fraud and abuse made that warranted preliminary investigation; and

(b) for each complaint which warrants investigation, supply the: (l) name and ID number; (2) source of complaint; (3) type of provider; (4) nature of complaint; (5) approximate dollars involved; and (6) legal and administrative disposition of the case.

(1) The CONTRACTOR and all its subcontractors shall:

(a) establish written policies and for all their employees, agents, or contractors; provide detailed information regarding the New Mexico Medicaid False Claims Act, NMSA 1978, §§27-14-1, et seq.; and the Federal False Claims Act established under sections 3729 through 3733 of title 31, United States Code; administrative remedies for false claims and statement established under chapter 38 of Title 31, United States Code, including but not limited to, preventing and detecting fraud, waste, and

abuse in Federal health care programs (as defined in Section 1128B(f) of the Social Security Act);

Evercare Contract (http://www.hsd.state.nm.us/mad/pdf_files/Evercare%20Final%20Contract%200808.PDF):

3.12 PROGRAM INTEGRITY

The CONTRACTOR shall:

(A) have written policies and procedures to address prevention, detection, preliminary investigation, and reporting of potential and actual Medicaid fraud and abuse that articulate the CONTRACTOR's commitment to comply with all state and federal standards. The policies and procedures shall address how coordination with DOH will occur in the case of fraud and abuse in nursing facilities;

(B) have a comprehensive internal program that includes the designation of a compliance officer ands a compliance committee that are accountable to senior management to prevent, detect, preliminarily investigate and report potential and actual program violations to help recover funds misspent due to fraudulent actions while enforcing standards through well-publicized disciplinary guidelines;

(C) have an effective training and education program for the compliance officer and the CONTRACTOR's employees and have specific controls for prevention, such as claim edits, post processing, review of claims, provider profiling and credentialing, prior authorizations, utilization/quality management and relevant provisions in the CONTRACTOR's contracts with its Network Providers and subcontractors;

(D) cooperate with the Medicaid Fraud Control Unit (MFCU), DOH, DEA, FBI and other investigatory agencies;

(E) comply with the CMS Medicaid Integrity Program and the Deficit Reduction Act of 2005;

(F) establish effective lines of communication between the compliance officer and the CONTRACTOR's employees to facilitate the oversight of systems that can monitor service utilization and encounters for fraud and abuse and have a provision for a prompt response to detected offenses, and for the development of corrective action initiatives relating to the CONTRACTOR's contract. The CONTRACTOR shall demonstrate how coordination with DOH will occur as related to the monitoring of nursing facilities;

(G) immediately report to the State any activity giving rise to a reasonable suspicion of fraud and abuse, including aberrant utilization derived from provider profiling. The CONTRACTOR shall promptly conduct a preliminary investigation and report the results of the investigation to the State. A formal investigation shall not be conducted by the CONTRACTOR but the full cooperation of the

CONTRACTOR as mutually agreed to in writing between the parties during the formal investigation will be required; and

(H) send to the State as required, the names of all providers identified with aberrant utilization according to provider profiling the cause of the aberrancy, and not use the CONTRACTOR's determination as to whether questionable patterns in provider profiles are acceptable or not, as a basis to withhold this information from the State. As required in 42 C.F.R. §455.I7, the CONTRACTOR shall report to the State:

(a) the number of complaints of fraud and abuse made that warranted preliminary investigation; and

(b) for each complaint which warrants investigation, supply the: (l) name and ID number; (2) source of complaint; (3) type of provider; (4) nature of complaint; (5) approximate dollars involved; and (6) legal and administrative disposition of the case.

(1) The CONTRACTOR and all its subcontractors shall:

(a) establish written policies and for all their employees, agents, or contractors; provide detailed information regarding the New Mexico Medicaid False Claims Act, NMSA 1978, §§27-14-1, et seq.; and the Federal False Claims Act established under sections 3729 through 3733 of title 31, United States Code; administrative remedies for false claims and statement established under chapter 38 of Title 31, United States Code, including but not limited to, preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in Section 1128B(f) of the Social Security Act);

Lovelace Contract (http://www.hsd.state.nm.us/mad/pdf_files/salud/LCHP%20Contract%20(Signed)%20July%202008.PDF):

2.14 PROGRAM INTEGRITY

A. The CONTRACTOR shall:

(1) have written policies and procedures to address prevention, a way to verify that services are actually provided, detection, preliminary investigation, reporting of potential and/or actual Medicaid fraud and abuse; policies and procedures shall articulate the CONTRACTOR'S commitment to comply with all federal and state standards;

(2) have a comprehensive internal program that includes the designation of a compliance officer and a compliance committee that are accountable to senior management to prevent, detect, preliminarily investigate and report potential and actual program violations to help recover funds misspent due to fraudulent actions while enforcing standards through well-publicized disciplinary guidelines;

(3) have an effective training and education program for the compliance officer and the CONTRACTOR'S employees, which must be submitted to HSDIMAD for review upon request, and

have specific controls for prevention such as claim edits, post processing, review of claims, provider profiling and credentialing, prior authorizations, utilization/quality management and relevant provisions in the CONTRACTOR'S contracts with its network providers and subcontractors;

(4) cooperate with the Medicaid Fraud Control Unit (MFCU) and other investigatory agencies as mutually agreed to by the parties in writing;

(5) comply with the CMS Medicaid Integrity Program and the Deficit Reduction Act of 2005;

(6) establish effective lines of communication between the compliance officer and the CONTRACTOR'S employees to facilitate the oversight of systems that monitor service utilization and encounters for fraud and abuse, have a provision for a prompt response to detected offenses and for the development of corrective action initiatives relating to the CONTRACTOR'S contract;

(7) immediately report to HSDIMAD any activity giving rise to a reasonable suspicion of fraud and abuse including aberrant utilization derived from provider profiling. The CONTRACTOR shall promptly conduct a preliminary investigation and report the results of the investigation to HSDIMAD. A formal investigation shall not be conducted by the CONTRACTOR but the full cooperation of the CONTRACTOR with HSD/MAD and the Medicaid Fraud Control Unit (MFCU) as mutually agreed to in writing between the parties will be required; and

(8) send to HSD/MAD as required, the names of all providers identified with aberrant utilization according to provider profiling, regardless of the cause of the aberrancy, and do not utilize the CONTRACTOR'S determination as to whether questionable patterns in provider profiles are acceptable or not, as a basis to withhold this information from HSD/MAD. As required in 42 CFR 455.17, the CONTRACTOR shall report to HSD/MAD:

a. the number of complaints of fraud and abuse made that warranted preliminary investigation; and

b. for each complaint that warrants investigation, provide the:

c. provider's name and ill number;

d. source of complaint;

e. type ofprovider;

f. nature of complaint;

g. approximate dollars involved; and

h. legal and administrative disposition of the case.

B. The CONTRACTOR and all subcontractors shall:

(1) establish written policies for all employees, agents, or contractors, that provide detailed information regarding the New Mexico Medicaid False Claims Act, NMSA 1978, §§27-14-1, et seq.; and the Federal False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statement established under chapter 38 of title 31, United States Code, including but not limited to, preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f) of the Social Security Act);

(2) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste and abuse;

(3) may not knowingly have a relationship with the following:

a. an individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; and

b. For purposes of this section, an "individual" includes an affiliate, as defined in the Federal Acquisition Regulation.

c. For purposes of this section, an individual who is an affiliate, as defined in the Federal Acquisition Regulation, has a "relationship" if such individual is:

i. a director, officer or partner of a CONTRACTOR;

ii. a person with beneficial ownership of five percent (5%) or more ofthe CONTRACTOR'S equity; or

iii. a person with an employment, consulting or other arrangement with the CONTRACTOR obligations under its Agreement with HSDIMAD.

C. include in any employee handbook, a specific discussion of the laws described in subparagraph (A.[1]), the rights of employees to be protected as whistleblowers, and the CONTRACTOR'S or subcontractor's policies and procedures for detecting and preventing fraud, waste, and abuse.

D. HSDIMAD may, at its sole discretion, exempt the subcontractor from the requirements set forth in this section; however, HSDIMAD shall not exclude the CONTRACTOR or subcontractor, if the CONTRACTOR or subcontractor receives at least $5,000,000 in annual payments from the HSDIMAD.

Molina Contract (http://www.hsd.state.nm.us/mad/pdf_files/salud/MHC%20Contract%20(Signed)%20July%202008.PDF):

2.14 PROGRAM INTEGRITY

A. The CONTRACTOR shall:

(1) have written policies and procedures to address prevention, a way to verify that services are actually provided, detection, preliminary investigation, reporting of potential and/or actual Medicaid fraud and abuse; policies and procedures shall articulate the CONTRACTOR'S commitment to

comply with all federal and state standards;

(2) have a comprehensive internal program that includes the designation of a compliance officer and a compliance committee that are accountable to senior management to prevent, detect, preliminarily investigate and report potential and actual program violations to help recover funds misspent due to fraudulent actions while enforcing standards through well-publicized disciplinary guidelines;

(3) have an effective training and education program for the compliance officer and the CONTRACTOR'S employees, which must be submitted to HSDIMAD for review upon request, and have specific controls for prevention such as claim edits, post processing, review of claims, provider profiling and credentialing, prior authorizations, utilization/quality management and relevant provisions in the CONTRACTOR'S contracts with its network providers and subcontractors;

(4) cooperate with the Medicaid Fraud Control Unit (MFCU) and other investigatory agencies as mutually agreed to by the parties in writing;

(5) comply with the CMS Medicaid Integrity Program and the Deficit Reduction Act of 2005;

(6) establish effective lines of communication between the compliance officer and the CONTRACTOR'S employees to facilitate the oversight of systems that monitor service utilization and encounters for fraud and abuse, have a provision for a prompt response to detected offenses and for the development of corrective action initiatives relating to the CONTRACTOR'S contract;

(7) immediately report to HSDIMAD any activity giving rise to a reasonable suspicion of fraud and abuse including aberrant utilization derived from provider profiling. The CONTRACTOR shall promptly conduct a preliminary investigation and report the results of the investigation to HSDIMAD. A formal investigation shall not be conducted by the CONTRACTOR but the full cooperation of the CONTRACTOR with HSD/MAD and the Medicaid Fraud Control Unit (MFCU) as mutually agreed to in writing between the parties will be required; and

(8) send to HSD/MAD as required, the names of all providers identified with aberrant utilization according to provider profiling, regardless of the cause of the aberrancy, and do not utilize the CONTRACTOR'S determination as to whether questionable patterns in provider profiles are acceptable or not, as a basis to withhold this information from HSD/MAD. As required in 42 CFR 455.17, the CONTRACTOR shall report to HSD/MAD:

a. the number of complaints of fraud and abuse made that warranted preliminary investigation; and

b. for each complaint that warrants investigation, provide the:

c. provider's name and ill number;

d. source of complaint;

e. type ofprovider;

f. nature of complaint;

g. approximate dollars involved; and

h. legal and administrative disposition of the case.

B. The CONTRACTOR and all subcontractors shall:

(1) establish written policies for all employees, agents, or contractors, that provide detailed information regarding the New Mexico Medicaid False Claims Act, NMSA 1978, §§27-14-1, et seq.; and the Federal False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statement established under chapter 38 of title 31, United States Code, including but not limited to, preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f) of the Social Security Act);

(2) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste and abuse;

(3) may not knowingly have a relationship with the following:

a. an individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; and

b. For purposes of this section, an "individual" includes an affiliate, as defined in the Federal Acquisition Regulation.

c. For purposes of this section, an individual who is an affiliate, as defined in the Federal Acquisition Regulation, has a "relationship" if such individual is:

i. a director, officer or partner of a CONTRACTOR;

ii. a person with beneficial ownership of five percent (5%) or more ofthe CONTRACTOR'S equity; or

iii. a person with an employment, consulting or other arrangement with the CONTRACTOR obligations under its Agreement with HSDIMAD.

C. include in any employee handbook, a specific discussion of the laws described in subparagraph (A.[1]), the rights of employees to be protected as whistleblowers, and the CONTRACTOR'S or subcontractor's policies and procedures for detecting and preventing fraud, waste, and abuse.

D. HSDIMAD may, at its sole discretion, exempt the subcontractor from the requirements set forth in this section; however, HSDIMAD shall not exclude the CONTRACTOR or subcontractor, if the CONTRACTOR or subcontractor receives at least $5,000,000 in annual payments from the HSDIMAD.

Presbyterian Contract (http://www.hsd.state.nm.us/mad/pdf_files/salud/PHP%20Contract%20(Signed)%20July%202008.PDF):

2.14 PROGRAM INTEGRITY

A. The CONTRACTOR shall:

(1) have written policies and procedures to address prevention, a way to verify that services are actually provided, detection, preliminary investigation, reporting of potential and/or actual Medicaid fraud and abuse; policies and procedures shall articulate the CONTRACTOR'S commitment to comply with all federal and state standards;

(2) have a comprehensive internal program that includes the designation of a compliance officer and a compliance committee that are accountable to senior management to prevent, detect, preliminarily investigate and report potential and actual program violations to help recover funds misspent due to fraudulent actions while enforcing standards through well-publicized disciplinary guidelines;

(3) have an effective training and education program for the compliance officer and the CONTRACTOR'S employees, which must be submitted to HSDIMAD for review upon request, and have specific controls for prevention such as claim edits, post processing, review of claims, provider profiling and credentialing, prior authorizations, utilization/quality management and relevant provisions in the CONTRACTOR'S contracts with its network providers and subcontractors;

(4) cooperate with the Medicaid Fraud Control Unit (MFCU) and other investigatory agencies as mutually agreed to by the parties in writing;

(5) comply with the CMS Medicaid Integrity Program and the Deficit Reduction Act of 2005;

(6) establish effective lines of communication between the compliance officer and the CONTRACTOR'S employees to facilitate the oversight of systems that monitor service utilization and encounters for fraud and abuse, have a provision for a prompt response to detected offenses and for the development of corrective action initiatives relating to the CONTRACTOR'S contract;

(7) immediately report to HSDIMAD any activity giving rise to a reasonable suspicion of fraud and abuse including aberrant utilization derived from provider profiling. The CONTRACTOR shall promptly conduct a preliminary investigation and report the results of the investigation to HSDIMAD. A formal investigation shall not be conducted by the CONTRACTOR but the full cooperation of the CONTRACTOR with HSD/MAD and the Medicaid Fraud Control Unit (MFCU) as mutually agreed to in writing between the parties will be required; and

(8) send to HSD/MAD as required, the names of all providers identified with aberrant utilization according to provider profiling, regardless of the cause of the aberrancy, and do not utilize the CONTRACTOR'S determination as to whether questionable patterns in provider profiles are acceptable or not, as a basis to withhold this information from HSD/MAD. As required in 42 CFR 455.17, the CONTRACTOR shall report to HSD/MAD:

a. the number of complaints of fraud and abuse made that warranted preliminary investigation; and

b. for each complaint that warrants investigation, provide the:

c. provider's name and ill number;

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g. approximate dollars involved; and

h. legal and administrative disposition of the case.

B. The CONTRACTOR and all subcontractors shall:

(1) establish written policies for all employees, agents, or contractors, that provide detailed information regarding the New Mexico Medicaid False Claims Act, NMSA 1978, §§27-14-1, et seq.; and the Federal False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statement established under chapter 38 of title 31, United States Code, including but not limited to, preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f) of the Social Security Act);

(2) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste and abuse;

(3) may not knowingly have a relationship with the following:

a. an individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; and

b. For purposes of this section, an "individual" includes an affiliate, as defined in the Federal Acquisition Regulation.

c. For purposes of this section, an individual who is an affiliate, as defined in the Federal Acquisition Regulation, has a "relationship" if such individual is:

i. a director, officer or partner of a CONTRACTOR;

ii. a person with beneficial ownership of five percent (5%) or more ofthe CONTRACTOR'S equity; or

iii. a person with an employment, consulting or other arrangement with the CONTRACTOR obligations under its Agreement with HSDIMAD.

C. include in any employee handbook, a specific discussion of the laws described in subparagraph (A.[1]), the rights of employees to be protected as whistleblowers, and the CONTRACTOR'S or subcontractor's policies and procedures for detecting and preventing fraud, waste, and abuse.

D. HSDIMAD may, at its sole discretion, exempt the subcontractor from the requirements set forth in this section; however, HSDIMAD shall not exclude the CONTRACTOR or subcontractor, if the CONTRACTOR or subcontractor receives at least $5,000,000 in annual payments from the HSDIMAD.

BlueCross BlueShield Contract (http://www.hsd.state.nm.us/mad/pdf_files/salud/BCBSNM%20Contract%20(Signed)%20July%202008.PDF):

2.14 PROGRAM INTEGRITY

A. The CONTRACTOR shall:

(1) have written policies and procedures to address prevention, a way to verify that services are actually provided, detection, preliminary investigation, reporting of potential and/or actual Medicaid fraud and abuse; policies and procedures shall articulate the CONTRACTOR'S commitment to comply with all federal and state standards;

(2) have a comprehensive internal program that includes the designation of a compliance officer and a compliance committee that are accountable to senior management to prevent, detect, preliminarily investigate and report potential and actual program violations to help recover funds misspent due to fraudulent actions while enforcing standards through well-publicized disciplinary guidelines;

(3) have an effective training and education program for the compliance officer and the CONTRACTOR'S employees, which must be submitted to HSDIMAD for review upon request, and have specific controls for prevention such as claim edits, post processing, review of claims, provider profiling and credentialing, prior authorizations, utilization/quality management and relevant provisions in the CONTRACTOR'S contracts with its network providers and subcontractors;

(4) cooperate with the Medicaid Fraud Control Unit (MFCU) and other investigatory agencies as mutually agreed to by the parties in writing;

(5) comply with the CMS Medicaid Integrity Program and the Deficit Reduction Act of 2005;

(6) establish effective lines of communication between the compliance officer and the CONTRACTOR'S employees to facilitate the oversight of systems that monitor service utilization and encounters for fraud and abuse, have a provision for a prompt response to detected offenses and for the development of corrective action initiatives relating to the CONTRACTOR'S contract;

(7) immediately report to HSDIMAD any activity giving rise to a reasonable suspicion of fraud and abuse including aberrant utilization derived from provider profiling. The CONTRACTOR shall promptly conduct a preliminary investigation and report the results of the investigation to HSDIMAD. A formal investigation shall not be conducted by the CONTRACTOR but the full cooperation of the CONTRACTOR with HSD/MAD and the Medicaid Fraud Control Unit (MFCU) as mutually agreed to in writing between the parties will be required; and

(8) send to HSD/MAD as required, the names of all providers identified with aberrant utilization according to provider profiling, regardless of the cause of the aberrancy, and do not utilize the CONTRACTOR'S determination as to whether questionable patterns in provider profiles are acceptable or not, as a basis to withhold this information from HSD/MAD. As required in 42 CFR 455.17, the CONTRACTOR shall report to HSD/MAD:

a. the number of complaints of fraud and abuse made that warranted preliminary investigation; and

b. for each complaint that warrants investigation, provide the:

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B. The CONTRACTOR and all subcontractors shall:

(1) establish written policies for all employees, agents, or contractors, that provide detailed information regarding the New Mexico Medicaid False Claims Act, NMSA 1978, §§27-14-1, et seq.; and the Federal False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statement established under chapter 38 of title 31, United States Code, including but not limited to, preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f) of the Social Security Act);

(2) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste and abuse;

(3) may not knowingly have a relationship with the following:

a. an individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; and

b. For purposes of this section, an "individual" includes an affiliate, as defined in the Federal Acquisition Regulation.

c. For purposes of this section, an individual who is an affiliate, as defined in the Federal Acquisition Regulation, has a "relationship" if such individual is:

i. a director, officer or partner of a CONTRACTOR;

ii. a person with beneficial ownership of five percent (5%) or more ofthe CONTRACTOR'S equity; or

iii. a person with an employment, consulting or other arrangement with the CONTRACTOR obligations under its Agreement with HSDIMAD.

C. include in any employee handbook, a specific discussion of the laws described in subparagraph (A.[1]), the rights of employees to be protected as whistleblowers, and the CONTRACTOR'S or subcontractor's policies and procedures for detecting and preventing fraud, waste, and abuse.

D. HSDIMAD may, at its sole discretion, exempt the subcontractor from the requirements set forth in this section; however, HSDIMAD shall not exclude the CONTRACTOR or subcontractor, if the CONTRACTOR or subcontractor receives at least $5,000,000 in annual payments from the HSDIMAD.

If you have any questions or concerns, please feel free to see me.

Thank you,
Santiago Baca, MBA, BSIT, CEECS
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Medicaid Fraud & Elder Abuse Division
Office of the State Attorney General
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