



HUMAN SERVICES
D E P A R T M E N T

NEW MEXICO BEHAVIORAL HEALTH
AUDIT SUMMARIES

LEGISLATIVE HEALTH & HUMAN SERVICES COMMITTEE
JULY 3, 2012

Behavioral Health Provider Audit Results

06/24/2013

Summary

For the last five months, fifteen behavioral health and substance abuse providers in New Mexico (accounting for roughly 85% of the state's behavioral health spending for more than 30,000 of the most vulnerable and difficult to treat consumers) have been the subject of likely the most rigorous behavioral health audit in state history. The audit was prompted by a pattern of serious concerns that were identified by the Behavioral Health Collaborative during the first eight months of 2012, which point to the presence of endemic and egregious mismanagement throughout the State that undermines patient care, waste of state and federal Medicaid dollars, and in some cases, potential fraud that is being reported to the proper state and federal authorities. These deficiencies appear to have persisted for several years, and were identified as the result of a new software system designed to better detect errors and potential abuse, as part of ongoing quality control efforts.

The Human Services Department (HSD) has acted on this information, communicating with the Attorney General's Office (AGO) regularly and providing them with documentation that has already led to action being taken against a behavioral health provider in Carlsbad that had been billing improperly, and lacked documentation to substantiate that care had been provided. Full-scale audits of behavioral health providers were commissioned in February of this year to carefully document and explore the extent of the concerns raised by HSD and OptumHealth, as well as quantify the impact of erroneous billing and payments.

The audit results indicate that each of the fifteen providers audited failed to meet minimal compliance standards, with error rates far exceeding national documented averages, and \$36 million in definitive overpayments have been identified. The errors and overpayments were so widespread that the business and billing practices of every provider warrants careful scrutiny. In a few specific cases, the audit results point to potential fraudulent activity by certain behavioral health executives. Human Services Department officials have met with the U.S. Attorney's Office, the Attorney General's Office and other law enforcement agencies to report their findings.

HSD and the Behavioral Health Collaborative believe that our collective focus should always be on helping those who struggle with substance abuse, suicidal tendencies, and a myriad of other behavioral health afflictions. The audit was conducted to identify and overcome systemic problems that had been allowed to exist for far too long. As we continue this process of ensuring future compliance by all behavioral health providers and while any further investigations by the proper authorities are conducted, HSD is prepared to ensure that skilled providers will be available to maintain services across the state.

Introduction

New Mexico currently has some of the nation's highest rates of suicide (19.9 deaths per 100,000 people), drug overdose deaths (23.3 deaths per 100,000 people), and substance abuse deaths (42.2 deaths per 100,000 people). Clearly we face a very striking crisis in our communities that requires serious, immediate attention.

The State has an obligation to protect taxpayer dollars by investigating, reporting, and recovering any funds that may have been misspent or overpaid to ensure that some of our most vulnerable citizens are receiving the care they most need.

In early 2012, OptumHealth implemented an enhanced software system designed to more efficiently detect potential fraud, waste, and abuse to assist in monitoring providers within its network. From the beginning of implementation of this software, immediate concerns arose. Optum performed claims reviews, or desk audits, of the data that was being flagged in their system. Upon review of this data, they contacted the appropriate officials at the HSD which began a process of reviewing Optum's findings to make recommendations.

In February 2013, based on the review of the findings, HSD entered into a contract with Public Consulting Group, Inc. (PCG), a company with a strong record of providing similar services to other states and the federal government, to audit 15 behavioral health and substance abuse providers throughout the state. These audited providers accounted for approximately 85% of dollars spent to provide treatment for more than 30,000 of the most vulnerable and difficult to treat consumers of behavioral health services.

Audit Activity

Beginning on February 25, 2013, PCG, along with staff from OptumHealth and the State, began moving on the audit process. Visits to providers were unannounced and conducted under the terms of each provider's Medicaid contract. Random clinical files and human resources files were identified for the audit with each provider. Once all of these documents were obtained, the audit team began their work.

Each of the 15 providers audited failed to meet compliance standards. Through the PCG audits, \$36 million in overpayments has been identified, which relates to more than 14% of the amounts paid to these providers, funds which could have been reinvested into our fragile system for further treatment. This is well above the national documented average established by the federal General Accounting Office (GAO) of 3% to 9% of all payments that constitute fraud, waste, and abuse. Even after removing the claims submitted with human documentation errors, the audit found that more than 25% of the audited claims should not have been billed. When HSD examined the case files which impact health and safety of individual consumers, a more than 57% error rate was discovered.

Key Statistics

New Mexico currently has some of the highest rates of suicide, drug overdose deaths, and substance abuse deaths in the nation.

*Suicides: 19.9 deaths
(5th Nationally)*

*Drug Overdose: 23.3 deaths
(2nd Nationally)*

*Substance Abuse: 42.2 deaths
(1st Nationally)*

*(Death rates per 100,000 people.
Substance abuse includes drug overdose
and alcohol related deaths. Numbers
and rankings are from 2010.)*

Audit Findings

Each of the 15 providers audited through this process failed to meet compliance standards.

\$36 million in overpayments have been identified, amounting to more than 14% of the dollars paid to these providers.

The most egregious claims that were audited were found to have a more than 25% error rate while the case files impacting individual health and safety were found to have a 57% error rate.

In order for New Mexico to reverse the high rate of suicide, drug overdose deaths, and substance abuse deaths, this systemic audit had to take place. Key findings demonstrate that, at the very least, widespread mismanagement has occurred that negatively affected the efficient and effective delivery of services, while some of the audits found potential cases of fraud, waste, and abuse.

Some of the key findings on the clinical case files include:

- Safety and risk assessments were not completed or updated for behavioral health patients who were determined to have current or past suicidal tendencies, homicidal tendencies, self-harm issues, or domestic violence issues;
- Treatment plans were not updated and individualized for each consumer, in many cases over several years; and
- A lack of proper licensing and training of the clinician or provider performing the service.

Real Life

Of course, these audits are not just about numbers and letters on pieces of paper in some office. These audits are about real people and the care that they may or may not be receiving.

Critical incidents reported by providers and tracked by

OptumHealth since July 2009 show an alarming rise in critical incidents affecting consumers' lives – from injuries and the need for emergency services, to homicide, attempted suicide, and suicide.

Table 1: OptumHealth NM Critical Incidents Report – Summary of CI-04 for FY10, FY11, FY12

Fiscal Year	Total Critical Incidents Reported	Attempted Suicides	Suicides	Homicides	Injuries/Emergency Services
2010	1659	60	6	2	362
2011	2067	44	11	4	351
2012	2410	51	13	5	577

Data is compiled by OptumHealth from provider reports

Some examples of mismanagement, fraud, waste, and abuse affecting real lives include:

Egregious lack of treatment resulted in a suicide when an individual sought help while feeling suicidal after being involved in a fatal shooting. The provider's records indicate "NO" was marked for conducting a safety assessment with the consumer. After 6 different clinical sessions – each of which indicated that the provider had failed to follow up with the primary care provider either for treatment, or to conduct any assessments on the consumer – the consumer committed suicide by hanging himself at his grandmother's home.

Disregard for follow up care after a suicide attempt was found in one case file where a consumer feeling suicidal came to a provider who did not conduct a safety assessment, which is a standard clinical

practice for consumers with thoughts of suicide. The consumer was hospitalized twice within the same year for suicide attempts, with no dates documented for the hospitalization. The consumer's eventual crisis plan involved the mother, who was at the time incarcerated. Even after a year of her incarceration, the crisis plan was not updated.

Other critical incident investigations have revealed **providers not responding to another provider's request to consult regarding prescription changes** for a consumer, although the consumer signed release of information forms, with four physicians prescribing a variety of potent medications throughout 2012 for one consumer.

In another case in 2012, an **inpatient psychiatric facility did not follow its policies of keeping all suicidal tendency consumers in the "line of sight"** and only "checked in" on the consumer every 15 minutes, resulting in a consumer committing suicide in the facility.

These are just a few examples of many egregious instances found while auditing case files throughout the behavioral health system. This illustrates the importance of conducting these audits. It also illustrates that we must hold providers accountable for every dollar that is spent so that we can ensure that some of our most vulnerable citizens are receiving the treatment they need. If we are to make an impact on our suicide, overdose, and substance abuse death rates, accountability is key.

Unusual Business Findings

Many other key findings on the business side of the audit include instances of highly unusual payments to family members, large golden parachutes to non-profit corporate CEOs, and irregular audit practices.

Some examples of questionable business practices include:

Unusual compensation and/or benefits for key stakeholders were found in some instances. In one instance, one CEO and family members were paid as much as \$1,500,000 as annual compensation for services and related transactions.

Various parties have financial relationships with related entities. One audited provider purchased services and rented space with a firm partially owned by the audited provider's CEO and COO. Another audited provider paid over \$200,000 to the same company for unspecified services.

A deferred compensation package for one CEO was found to be extremely excessive. The non-profit established a deferred compensation package that would provide payment of \$60,000 per year for seven years and on June 30, 2014 for ten years. This compensation package would kick in upon termination of the director's employment for any reason.

Unusual Business Findings

One CEO and family members were paid as high as \$1,500,000 as annual compensation for services and related transactions.

One audited provider purchased services and rented space with a firm partially owned by the audited provider's CEO and COO. Another audited provider paid over \$200,000 to the same company for unspecified services.

Billing System Findings

Fraudulent practices, such as double billing, over billing, or billing for services not provided, affect the entire system. In the long run we cannot get a good handle on how much progress is being made in our communities on behavioral health issues if the funding is being misspent or mismanaged. The audits have uncovered systemic problems in billing for services, many willful, some through poor business practices.

Examples include:

A provider was found “copying and pasting” progress notes. When this occurs, it is impossible to tell if consumers are getting the services they need, or if they are totally fabricated.

Many providers were found to bill for more units of service than provided -- such as providing 17 units of service, but billing and receiving payment for 41 units. In this instance, a **payment for 250% more than should have been received resulted because of potentially fraudulent billing.**

The **auditor was unable to complete a comprehensive review of billing systems** as one of the vendors prohibited auditors from reviewing the system manuals because they were considered proprietary. This **prevented the auditors from being able to complete a thorough review into billing systems to determine if billing malfeasance was purposefully programmed into systems.**

OptumHealth conducted research within their claims system that identified many instances where providers **billed for individual clinicians’ services of up to 15 hours within one work day.** Their research also identified **billing for a consumer for services at two providers in a business relationship on the same date of service.**

Next Steps

HSD recognizes that the behavioral health system is in crisis, and has been for years, as revealed by this audit. We remain committed to providing quality behavioral health services to some of our most vulnerable citizens while protecting the integrity of taxpayer funds and implementing recommendations from the audit. We must make wide and deep systemic changes in order to continue providing these services and to reduce the rate of suicide, drug overdose deaths, and substance abuse deaths.

Consumers of behavioral health services should rest assured that HSD and the Collaborative have their best interests at heart. We have made preparations to ensure little to no disruption of services occurs while this process takes place.

Protocall Crisis Hotline

1-855-NMCRISIS
(1-855-662-7474)

This crisis hotline is available 24/7 for any type of behavioral health crisis. Bilingual staff will follow up within 24 hours of the initial contact to help assist.

A crisis hotline called Protocall has been in operation since the beginning of the year. Any person can call 24 hours a day, 7 days a week for any type of behavioral health issue. The bilingual staff on the other end will help consumers navigate the system and follow up within 24 hours to help access care if there is an issue. Their phone number is 1-855-NMCRISIS (1-855-662-7474).

In addition, HSD and the Collaborative have identified providers that can help maintain services. These providers have more than 15 years of service in Arizona, a state with similar demographics. They have provided high quality services and excellent leadership in the behavioral health industry and will help ensure services continue in New Mexico.

We are also pledging to provide a variety of changes at the provider level, as well as to the system in general. The next steps to address provider and systemic issues will include:

- Providing deeper and ongoing technical assistance in the areas of clinical best practices and billing processes and procedures to providers;
- Overhauling and implementing a new ongoing, comprehensive program integrity program that will include more closely monitoring State contractors and provider networks. Pre-payment claims review will now occur;
- Increasing data mining efforts to identify trends based on utilization of services by behavioral health consumers and implementing specific targets to meet those trends;
- Reviewing and revising the behavioral health billing rules and regulations;
- Drafting legislation to reorganize the Collaborative and refocusing the mission on tracking and protecting the integrity of consumer centered services; and
- Importing best practices from other states to institute transparency scorecards of provider agencies.

HSD, in conjunction with the AGO, will also focus on recoupment of lost funds, if that option is available. While any credible allegations of fraud have been turned over to their office, we all have a duty to protect taxpayer dollars while trying to maintain quality services for some of our most vulnerable citizens, and will continue to work towards that goal.

Without these changes New Mexico will continue to be mired in a system that is not serving its consumers to the fullest potential, a system which should be providing quality care to our most vulnerable friends, relatives, and neighbors but is not. HSD and the Collaborative are fully committed to implementing these changes, while continuously monitoring the outcome of this audit and any investigations that take place as a result.



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EXECUTIVE SUMMARY

In February 2013, the New Mexico Human Services Department (HSD) contracted with Public Consulting Group, Inc. (PCG) to audit fifteen (15) mental health and substance abuse providers statewide. In 2012, these providers constituted approximately 87% of all Core Service Agency (CSA) spending for Medicaid and non-Medicaid behavioral health services¹. PCG's audit consisted of three main components:

- 1) *Clinical Case File Audit* – a review of case file documentation, including staffing qualifications and credentials;
- 2) *IT/Billing Systems Audit* – a review of the billing system itself, as well as the protocols and processes employed by the provider; and,
- 3) *Enterprise Audit* – a review of the organization and its key stakeholders, third party contracts, and other stakeholder relationships.

Utilizing an approach developed and refined through auditing behavioral health providers nationally and tailored to New Mexico's payment rules and regulations, PCG's multi-faceted audit arrived at the following findings:

- 1) *Clinical Findings*: Identified more than \$36.0 million in overpayments to these 15 providers over a three-year period from 2009-2012. This amounts to nearly 15% of all payments made to these providers. A 2003 Congressional General Accounting Office (GAO) report stated that Medicaid fraud, waste, and abuse is expected to be 3% to 9% of all payments. PCG recommends the collection of these overpayments.
- 2) *IT/Billing System Findings*: No material findings, though PCG did identify weaknesses in provider billing processes, including lack of audit trails when it comes to changes made in systems. Generally, PCG recommends that providers tighten billing process controls.
- 3) *Enterprise Findings*: Identified potential conflicts of interests of some individuals and some of the audited providers. PCG recommends that the State of New Mexico further review instances of potential conflicts of interest.

¹ Core Service Agencies, or CSAs, are provider organizations that have been designated by the New Mexico Behavioral Health Collaborative to be responsible for clinical coordination of care for children and adults. PCG's audit included 12 of the state's 15 CSAs. Estimated percentage of CSA spending utilized 2009-2012 total spending for each CSA.



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Summary of Clinical Audit

PCG's clinical case file review utilized two different methodologies for each provider:

- 1) **Random sampling of provider claims** – Audit of 150 randomly sampled claims that were submitted by the providers. The sampling methodology allows for a statistically valid extrapolation of the findings.
- 2) **Consumer case file review** – A review of a full year's worth of case file documentation for selected consumers. These findings are not extrapolated, but can be used to identify deficiencies that cannot be identified when viewing a single claim.

PCG's clinical case file review revealed moderate to significant levels of non-compliance with state payment rules and regulations. Generally, the providers reviewed in this audit lack many of the appropriate safeguards against overbilling and would benefit from targeted technical assistance. Additionally, PCG's findings reveal deficiencies in accuracy of clinical documentation, which signifies potential quality of care concerns that should be further reviewed by the State of New Mexico.

PCG utilized an audit tool developed and refined through auditing behavioral health providers nationally and tailored to New Mexico's payment rules and regulations. For the randomly sampled claims PCG utilized a statistically significant extrapolation methodology to identify more than \$33.8 million in overpayments to these 15 providers over a three-year period from 2009-2012. With the consumer case file, or "longitudinal," reviews PCG identified an additional \$2.1 million in overpayments to these 15 providers over the same three year period, for total estimated overpayments of \$36.0 million (nearly 15% of claims paid during this period). Below are non-compliance rates and extrapolated overpayments by provider:



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Provider	Randomly Sampled Claims		Longitudinal Claims		Total Overpayment Amounts
	% Non-Compliance	Extrapolation - Lower Bound	% Claims Failed	\$Value Claims Failed	
Provider A	29.3%	\$ 2,046,690.0	64.8%	\$ 179,903	\$2,226,593
Provider B	35.3%	\$ 2,757,585.0	84.6%	\$ 210,548	\$2,968,133
Provider C	13.3%	\$ 772,016.0	27.8%	\$ 78,854	\$850,870
Provider D	14.9%	\$ 565,309.0	35.5%	\$ 291,436	\$856,745
Provider E	21.8%	\$ 3,629,976.0	70.7%	\$ 103,063	\$3,733,039
Provider F	6.0%	\$ 57,614.0	97.4%	\$ 22,736	\$80,350
Provider G	55.3%	\$ 3,138,735.0	38.2%	\$ 55,521	\$3,194,256
Provider H	27.3%	\$ 4,327,784.0	59.6%	\$ 161,843	\$4,489,627
Provider I	3.3%	\$ 7,856.0	41.1%	\$ 14,018	\$21,874
Provider J	36.7%	\$ 1,304,140.0	34.8%	\$ 44,239	\$1,348,379
Provider K	15.3%	\$ 1,028,069.0	98.6%	\$ 437,537	\$1,465,606
Provider L	21.1%	\$ 9,262,711.0	60.2%	\$ 335,833	\$9,598,544
Provider M	17.3%	\$ 612,663.0	20.0%	\$ 43,137	\$655,800
Provider N	40.0%	\$ 4,128,958.0	49.7%	\$ 64,907	\$4,193,865
Provider O	18.0%	\$ 228,309.0	97.1%	\$ 68,661	\$296,970
Grand Total	23.7%	\$33,868,415	57.1%	\$2,112,234	\$35,980,649

It is important to note that only the more egregious errors were used to extrapolate the amounts owed across the universe of claims for these providers. A more strict review of the randomly sampled provider claims originally indicated a non-compliance rate of 74%. PCG classified a number of these findings as “poor documentation practices” that should be remedied through a combination of trainings, technical assistance, and clinical and management assistance. These errors included missing signatures, inadequate case note completion, and below standard preparation of plans of care. Had PCG used these errors in the extrapolation, the resulting overpayment amounts would have been much greater.

PCG considers the extent of its findings to be a significant concern for the State of New Mexico. In a 2003 report², the Congressional General Accounting Office (GAO) estimated that fraud, waste, and abuse amounted to between 3% and 9% of total Medicaid spending. Using this GAO study as a base, this audit reveals overpayments that are double what can be expected.

² General Accounting Office, “Major Management Challenges and Program Risks: Department of Health and Human Services.” 2003. <http://www.gao.gov/assets/240/237027.pdf>



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Summary of IT/Billing Systems Audit

PCG did not identify any specific instances of tampering with the providers' billing systems. This finding must be qualified for several reasons. First, PCG was unable to complete a comprehensive review of all billing systems as one of the billing systems vendors, Anasazi, prohibited providers from sharing system manuals, as they were considered proprietary (noted in an email that PCG viewed from Anasazi to one of the audited providers). Additionally, PCG identified areas of weaknesses in provider practices, including:

- Lack of audit trail for the creation of and changes made to claim records in provider billing systems;
- Lack of audit trail for any changes made to the 837 reports (billing system outputs) prior to finalizing in the Automated Clearing House portal.

Summary of Enterprise Audit

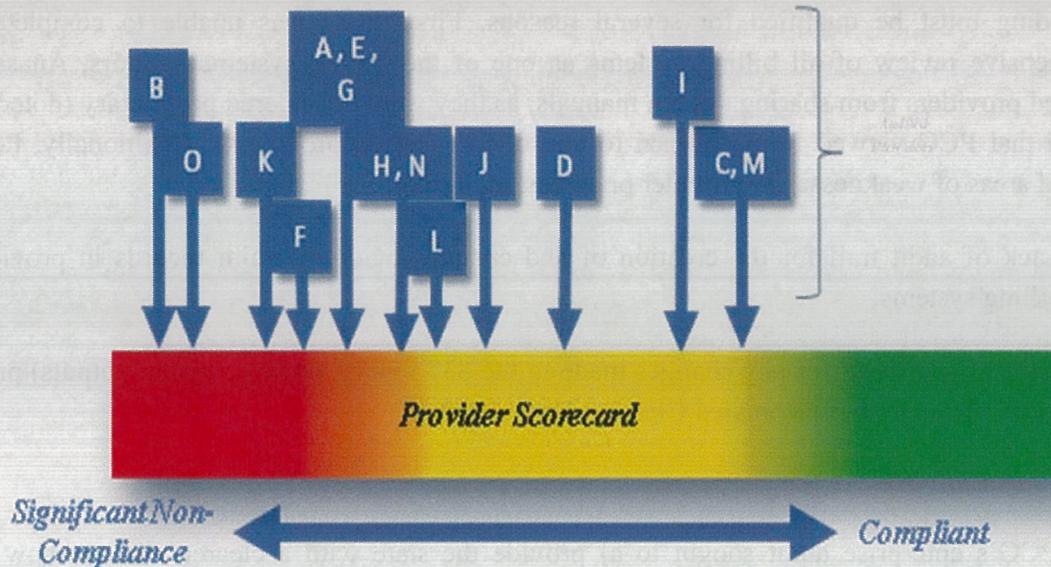
Lastly, PCG's enterprise audit sought to a) provide the state with a clearer view of how its provider system is organized and b) identify any potential appearances of conflicts of interest for the organization and its key board members and employees. The enterprise audit revealed that some providers may have potential conflicts of interest that should be further reviewed by the State of New Mexico. Examples of the types of potential conflicts of interest and areas that PCG recommends further research include:

- Unusual compensation and/or benefits to some key stakeholders;
- Key stakeholders' relationships with related parties with financial interests in transactions;
- Some arrangements with third parties are unclear as to the level of effort and compensation for some executives; and,
- Non-disclosure of all third party contracts.

Scorecard and Risk Tier Results

Based on the clinical case file compliance outcomes and findings related to IT controls, PCG developed, in conjunction with HSD, a "scorecard" for each provider. Below, PCG has

organized the providers' scorecard results in relation to each other. The scorecard ranges from "Significant Non-Compliance" to "Compliant."



PCG then used these provider scorecard ratings to categorize providers into "Risk Tiers," replete with recommended state actions, as follows:

<i>Tier</i>	<i>Types of Findings</i>	<i>Recommended State Actions</i>
1	Findings that include missing documents, etc.	<ul style="list-style-type: none"> • Provide trainings and clinical assistance as needed.
2	Significant volume of findings that include missing documents	<ul style="list-style-type: none"> • Provide trainings and clinical assistance as needed. • Potentially embed clinical management to improve processes.
3	Significant findings, including significant quality of care findings.	<ul style="list-style-type: none"> • Provide trainings and clinical assistance as needed. • Potentially embed clinical management to improve processes. • Potential change in management.
4	Credible Allegation of Fraud	<ul style="list-style-type: none"> • Mandatory change in management.



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Based on PCG’s scorecard methodology, each of the 15 providers was categorized into a Risk Tier, the results of which are shown below.

<i>Tier</i>	<i>Recommended State Action</i>	<i>Provider</i>
1	<ul style="list-style-type: none"> • Provide trainings and clinical assistance as needed. 	
2	<ul style="list-style-type: none"> • Provide trainings and clinical assistance as needed. • Potentially embed clinical management to improve processes. 	M, C, I, D, J, L, H, and N
3	<ul style="list-style-type: none"> • Provide trainings and clinical assistance as needed. • Potentially embed clinical management to improve processes. Potential change in management. 	E, G, A, F, K, O and B
4	<ul style="list-style-type: none"> • Mandatory change in management. 	<i>See NOTE, below</i>

NOTE:- Please note that Tier 4: Credible Allegation of Fraud is a determination that can only be made by the State of New Mexico. PCG utilized results from its clinical case file audit and IT/billing system audit to develop the scorecard, which translated into providers being categorized in Tiers 1, 2, and 3. The State of New Mexico may determine that information provided in the case file, IT/billing system, and enterprise audits constitutes a re-categorization of one or more providers into a higher risk tier, including Tier 4.

Background

In February 2013, the New Mexico Human Services Department (HSD) determined the need for a comprehensive clinical and billing audit of select providers within its behavioral health system and engaged Public Consulting Group (PCG) to conduct these audits. Claims data mining by the state’s behavioral health vendor revealed a significant number of potential billing abnormalities. These potential billing abnormalities included, but were not limited to, the following data and case file “findings:”



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- Cross billing at different locations for the same member potentially overlapping time; uncertainty as to who rendered the service (if rendered at all);
- Insufficient documentation;
- Cross billing multiple codes and double billing (e.g. individual and group therapy);
- Upcoding individual therapy (compared to the average time billed per code in the peer group);
- Excessive billing for psychosocial rehab; including requesting authorization for a consumer on medical leave;
- Suspicious high volume days per one code; overbilling for inappropriate codes; psychosocial rehabilitation billed for large units on a given date to one clinician; excessive hours per day billed by practitioner; excessive hours of service billed per patient per code; billing for services duplicative in nature;
- Identifying Provider as the rendering clinician;
- No medical necessity reviews to determine basis for long-term psychotherapy;
- Forging clinician records to incorporate more time than truly performed;
- Out of home placement services outside norm of service; doubtful medical need;
- Billing outpatient services the same day as bundled services.

Not all of the aforementioned potential billing issues can be addressed with a single audit, particularly when an objective of the audit is to identify recoupable overpayments. In order to recoup across a universe of paid claims, a more comprehensive review is required. Narrowly focusing on one particular suspicious trend in a provider's claims history inhibits the ability of the auditor and the state to extrapolate those results across the entire claims history. Rather than attempting to address each provider's uniquely identified issues, PCG worked with HSD to develop a comprehensive approach that would scrutinize individual providers *holistically* (as opposed to looking at a few aberrant trends that may or may not run afoul of policy even if substantiated) and the system at large. This approach was characterized by three main goals:

- 1) Identify potential credible allegations of fraudulent activity.
- 2) Identify regulatory compliance levels of behavioral health providers.
- 3) Identify areas of weakness that must be strengthened prior to the implementation of Centennial Care.

PCG was tasked with conducting onsite audits of selected providers to examine case files supporting specific claims, IT systems and processes, and adherence with compliance protocols, and to examine existing relationships, financial or other, among providers and other entities. The onsite audits were conducted in February and March and included interviews with relevant



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provider staff, collection of hard copy and electronic file documents related to the above mentioned areas, and examination and manual testing of IT systems. The onsite visits were supplemented by desk reviews of collected documentation at a location separate from the provider site.

Key Findings

While each provider is unique with respect to clinical findings, PCG identified certain common themes across many of the 15 providers reviewed, which are described below. For each provider, a section is included in the appendix that shows the detailed clinical findings specific to that provider. PCG's findings include:

- **More than \$36.0 million in overpayments** for these 15 providers over a three and a half year period (July 2009-January 2013). This extrapolated overpayment amounts to 15% of total payments from state sources to these providers during this time period.
- **Non-compliance with many New Mexico state rules and regulations.** Pervasive issues that PCG identified across providers include:

Randomly Sampled Claims

- Community Support Workers lacked evidence of completion of the required training per the service definition.
- Assessments (psychosocial/psychiatric evaluations) were not up to date (within last 12 months) to determine if the consumer continued to meet the need of the rendered service.
 - Incomplete critical information such as Five Axis diagnosis.
 - Substance abuse history was absent for most consumers with a dual-diagnosis of mental health and substance abuse.
- Treatment plans were not up-to-date and individualized per consumer. Updated treatment plans are necessary to determine any changes to goals/objectives in addition to progress or lack of progress by the consumer. Without continuously updated treatment plans, it is impossible to determine if the treatment interventions still meet the behavioral health needs of the consumer.
 - Goals/Objectives were not measurable and did not document achievable target dates based on the consumer's needs.
 - Service specific clinical interventions used to reach goals/objectives were absent.



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- Discharge plans and estimated length of treatment were not documented for all consumers. Documented discharge plans were rarely individualized.
- Consumer Documentation
 - Consents for medications rendered were absent.
 - Documentation frequently did not describe the clinical interventions, progress or lack of progress toward goals, and next steps in treatment.
 - Interventions in the progress notes did not always link to the consumer's treatment plan or support the program definition of the billed service.
 - Progress notes did not contain a start and stop time or a duration that would enable a determination as to whether the billed time was accurate.
 - Billed units did not match the units documented on the progress notes.
 - Intensive Outpatient Program progress notes did not contain the treatment modalities used as required in the service definition.
 - Documented evidence of the required treatment team was absent for most team services.

Longitudinal File Review Findings

- Safety/Risk Assessments were not completed or updated for consumers who were assessed to have current or past suicidal ideations (SI), homicidal ideations (HI), self harm or domestic violence issues.
- Treatment plans were not up-to-date and individualized per consumer.
 - Plans contained the same goals/objectives for more than 12 months.
 - Potential overutilization of services without documented justification of the service related to extensive length of stay.
- Consumer Documentation
 - Documentation frequently did not describe the clinical interventions, progress or lack of progress toward goals, and next steps in treatment.
 - Progress notes did not contain a start and stop time or a duration that would enable a determination as to whether the billed time was accurate.
 - Billed units did not match the units documented on the progress notes.
- **Weaknesses identified in providers' billing processes.** PCG identified weaknesses in internal claims processes. PCG was unable to complete a comprehensive review of all billing



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systems as one particular billing software vendor was unwilling to allow providers to share with PCG important documentation and information about the system.

- **Potential conflicts of interest in selected providers.** PCG identified areas of potential conflicts of interest among some providers, individuals, and related parties. Examples of the types of potential conflicts of interest and areas that PCG recommends further research include:
 - Unusual compensation and/or benefits to some key stakeholders;
 - Key stakeholders' relationships with related parties with financial interests in transactions;
 - Some arrangements with third parties are unclear as to the level of effort and compensation for some executives; and,
 - Non-disclosure of all third party contracts.

Key Recommendations

- **Standardize clinical documentation across providers.** In order to ensure that all critical behavioral health consumer information is gathered and properly documented, PCG recommends that standardized forms be used across all providers. The standardized forms at a minimum would include assessments, treatment plans, and progress notes (daily/weekly/logs).
- **Implement a comprehensive program integrity effort for behavioral health services.** PCG recommends this PI effort be written into MCO contracts and be implemented by the state for non-Medicaid programs. This means more than just post-payment auditing. Traditional “pay and chase” models should be supplemented by pre-payment measures and more proactive provider education, oversight and monitoring efforts to proactively prevent errors from occurring prior to payment.
- **Provide technical assistance** to providers in the areas of clinical best practices and billing processes and procedures.



State of New Mexico
Behavioral Health Provider Audits
Executive Summary

- **Review and revamp New Mexico’s behavioral health provider billing rules and regulations.** Specifically, PCG recommends certain “best practices” that should be required information.
- **Enforce payment regulations.** Payment rules and regulations are developed for several reasons, the primary of which is to ensure that consumers receive high-quality care.
- **Maximize the utility of the editing capabilities of claims processing systems to prevent overpayments.** Where functionality is lacking or inadequate to sufficiently vet claims pre-submission to avoid inappropriate billing, providers should engage in discussions with their EMR vendors to identify and implement the requisite safeguards. Thorough training of billing staff on new or previously unused system functionality will further ensure proper front end billing.
- **Complete additional reviews of potential conflicts of interest.**

Beyond the recommendations mentioned above, PCG was asked to provide additional recommendations for the New Mexico behavioral health system, based on the firm’s national experience working with behavioral health and other community based providers. PCG recommends the following:

- **Convene stakeholder (state, vendors, and providers) workgroups to develop Outcomes Measures.** Working together, stakeholders can define the particular outcomes that New Mexico chooses to pursue. With specific measures in hand, work can begin on collecting the relevant information and data points, which will spawn fruitful conversations about quality of care and reimbursement reform.
- **Enforce Behavioral Health Providers’ important role in Health Care Reform.** A primary argument in favor of health care reform is its potential to achieve cost savings by focusing attention on the small percentage of the population that consumes the largest share of health care services. Better management of care for those individuals can concurrently yield improvements in quality and decreased costs for services. Particularly in the case of publicly funded programs, individuals with chronic illnesses often have a primary or secondary behavioral health diagnosis. Behavioral health providers must be front and center in conversations regarding proactive management of care for this population.

OptumHealth New Mexico Referrals Executive Summary

Situation Overview:

Part of Optum's responsibility as stewards of New Mexico's behavioral health care dollars is to control fraud, waste and abuse. As part of this commitment, Optum has been making referrals of suspicious activity in the provider network to the State, as required by contract, since the contract inception in July 2009.

As part of its fraud, waste and abuse program, Optum conducted research and desk audits on all providers in the Optum network. Optum detected irregularities in the claims data, indicating potentially unusual activity. Optum reported these irregularities within the behavioral health system as a whole to the State in November 2012. The State then moved to conduct a comprehensive audit. The State of New Mexico then conducted formal audits of 15 providers beginning in February 2013. Optum has continued to conduct additional research and desk audits on the entire provider network as part of ongoing fraud, waste and abuse efforts. The following is a summary of items found in our research.

Issues Specific to the 15 Providers Audited:

- Practitioners billing long hours, providers billing long days for consumers
- Providers unbundling bundled (all-inclusive and/or per diem) services Violation of CMS NCCI
- Up-coding and double-billing – research has shown providers using excessive billing of specific codes, or billing for two services but only providing one
- Overuse of codes
- Research identified outliers for out of home placement services.
- Consumer research identified billing for a consumer at two providers in a business relationship on the same date of service.
- Cross-billing for mutually exclusive codes on the same day at same provider or at different providers for the same consumer.
- In the course of an audit being conducted by Optum at a provider site, it became apparent that the provider's electronic medical records system was connected to a separate provider's electronic medical records system. Optum found this suspicious because the providers do not have a disclosed business relationship.

We take our responsibility as stewards of New Mexico's behavioral health care dollars to control waste, fraud and abuse very seriously and will continue to be vigilant in uncovering it.

Quantitative Research Methods in Health Policy Analysis

Abstract

Quantitative research methods are essential for understanding the complex interactions between health policy and population health. This article discusses the strengths and limitations of quantitative methods and provides a framework for their application in health policy analysis.

As part of the quantitative research process, researchers must first identify the research question and then select the appropriate quantitative method. This article discusses the strengths and limitations of quantitative methods and provides a framework for their application in health policy analysis. The article also discusses the importance of data collection and analysis in quantitative research and provides a framework for their application in health policy analysis.

Keywords

- Quantitative research methods
- Health policy analysis
- Population health
- Data collection and analysis
- Research design
- Statistical analysis
- Policy evaluation
- Health equity
- Health disparities
- Health care access
- Health care quality
- Health care costs
- Health care financing
- Health care delivery
- Health care workforce
- Health care regulation
- Health care reform
- Health care innovation
- Health care research
- Health care education
- Health care training
- Health care leadership
- Health care management
- Health care organization
- Health care culture
- Health care change
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- Health care organization
- Health care culture
- Health care change
- Health care improvement