



# LFC Program Evaluation Progress Report

## Report Issued:

July 2011 • #11-07

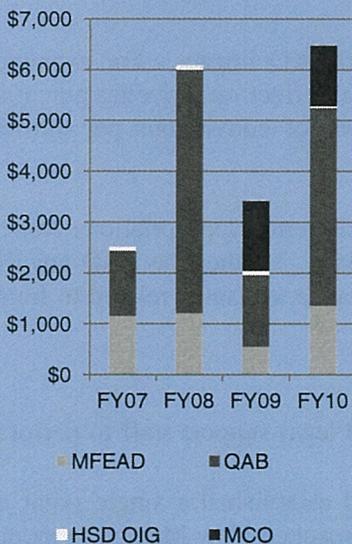
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### KEY FINDINGS (2011)

- 1) New Mexico has a poor return on its investment in reducing Medicaid fraud, waste, and abuse.
- 2) Fragmented Medicaid program integrity oversight fosters jurisdictional confusion, duplication of effort, and ineffectiveness.
- 3) Significant opportunities exist to strengthen Medicaid fraud, waste, and abuse controls.

**Total Medicaid Recoupments by Entity FY07-FY10**  
(in thousands)



Note: MCO data only available for FY09-FY12. PPIB/PI was formally QAB within HSD.

Source: OAG, HSD

### Medicaid Fraud, Waste and Abuse Control (HSD/OAG)

Reviewed the cost, responsibility, and coordination of state agencies and other entities for detection and correction of Medicaid fraud and abuse; assessed the performance and outcomes from efforts to combat fraud and abuse; and identified coordination efforts between the Office of Attorney General (OAG), Human Services Department (HSD), federal entities and other stakeholders.

### FROM THE EVALUATION (2011).

**Background.** In FY10, New Mexico's Medicaid program served 460 thousand New Mexicans at a cost of \$3.8 billion. The HSD, Medicaid Fraud and Elder Abuse Division (MFEAD) in the OAG, and managed care organizations (MCOs) responsible for Medicaid fraud, waste, and abuse controls have potential for preventing, reducing, and recovering the monies lost to such activities. The evaluation found that as a whole, they do not pay for themselves, suffer from fragmented program integrity oversight, and foster a pattern of wasteful spending.

### Key Recommendations.

- HSD should implement return-on-investment measures across fee-for-service programs and managed care organizations (MCOs) related to program integrity efforts to track success of program activities and program effectiveness.
- HSD should amend MCO contracts to include performance measures to reduce fraud, waste, and abuse.
- HSD should streamline and prioritize Medicaid program integrity functions by:
  - Moving the Office of the Inspector General (OIG) to report directly to the HSD secretary.
  - Consolidating selected staff from the Quality Assurance, Internal Audit and the Investigations Bureaus into a new Medicaid Program Integrity Bureau within the OIG.
  - Designating the Medicaid Program Integrity Bureau to be the single point of contact for receiving, detecting, investigating allegations of fraud and abuse; coordinate to prepare referrals to the OAG; oversee, with Medicaid's Contract Management Bureau, external quality review organization contract audits of MCOs and performance and compliance of MCO program integrity functions.
- The HSD should consider modifying its rate development and amounts available for administration and profit for MCOs, including increasing its pay-for-performance set-aside to 5 percent of total premium, administratively setting base capitation rates for all MCOs, sharing medical savings with MCOs that meet all of their performance targets, and using a competitive bid process for awarding administrative/ profit amounts.

### CURRENT SITUATION (2013).

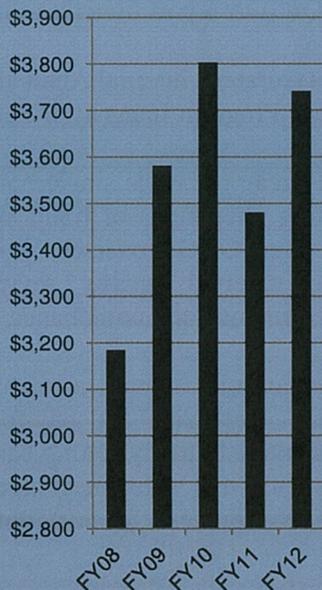
**Legislative Update.** The LFC evaluation recommended updating the language of the state's False Claims Act to gain approval from the U.S. Department of Health and Human Services Office of the Inspector General (DHHS OIG), allowing the state to retain an additional 10 percent of monetary fraud recoveries. Senate Bill 133 sought to conform the act to federal requirements during the 2013 Legislative Session, however the bill did not pass.



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*For FFY12, MFEAD recuperated \$2.23 for every dollar spent, an increase of 421 percent over the \$0.53 recuperated in FFY10.*

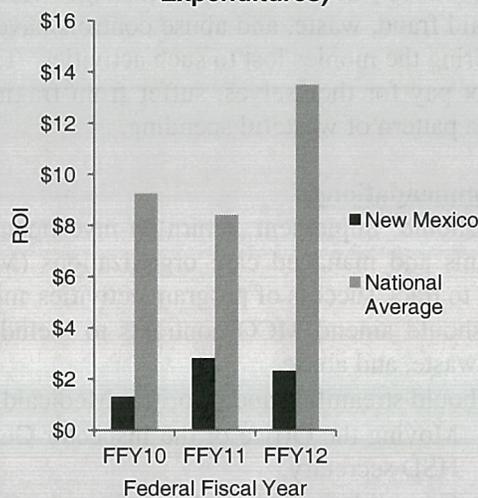
**Medicaid Expenditures in New Mexico**  
(In millions)



Source: LFC Volume II

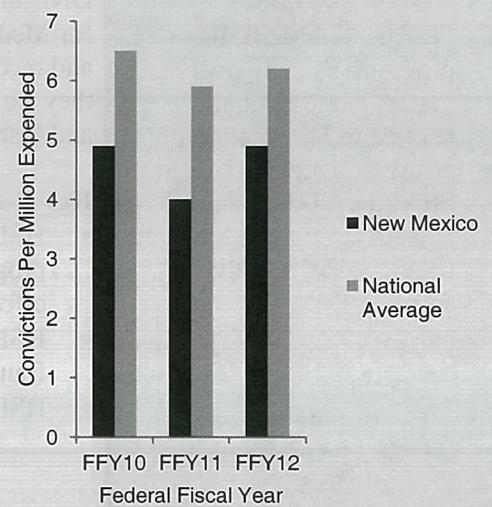
**Performance Measurement:** Federal Department of Health and Human Services data reflect that the OAG has improved performance and ranking in multiple categories but still performs below the national average on return on investment (ROI) and number of convictions per million, ranking 46<sup>th</sup> and 29<sup>th</sup> respectively.

**Chart 1. New Mexico MFEAD Return On Investment (ROI)**  
(Total Recoveries Divided by Expenditures)



Source: DHHS OIG

**Chart 2. New Mexico MFEAD Number of Convictions Per Million Expended**



Source: DHHS OIG

Performance measures, other than ROI, also assess MFEAD impact. For example, success in achieving convictions in criminal cases has an effect on reducing potential Medicaid fraud. One measure of this was the number of convictions per million expended (see Chart 2).

The OAG has one performance measure in the 2013 General Appropriations Act to measure total Medicaid recoveries in thousands of dollars. Neither the HSD nor the MCOs contracted to administer Medicaid have performance measures related to fraud and abuse detection and recovery efforts.

**Agency-reported Progress to Date.**

- MFEAD hired a special agent-in-charge and trained legal support staff to perform referral intake.
- HSD and MFEAD schedule monthly meetings and established a single point of contact. Due to these actions, other states have approached New Mexico to model practices.
- HSD reports that their Office of the Inspector General has been realigned to report directly to the HSD Secretary as of May 2013.
- MFEAD updated procedures to prioritize investigations by implementing investigative and legal reviews of all referrals and cases. This has resulted in a reduced caseload, focusing on cases with greater potential for a successful result.



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- HSD/MAD recently completed a re-organization of its Bureaus. The Medicaid Program Integrity Unit now resides in the new Program Policy & Integrity Bureau.
- HSD & MFEAD monthly Program Integrity Meetings have resulted in successful achievements such as agency cross training, referral guideline and template development and increased referrals from HSD to the MFEAD.
- HSD & MFEAD Program Integrity activities have increased overpayment recoveries since the last LFC review period.
- HSD has significantly modified its MCO contracts to include Program Integrity requirements.
- HSD has increased oversight of its MCO Program Integrity audits requiring the MCOs to report prepayment and post-payment activities by claim.
- HSD & MFEAD “points of contact” have jointly attended a CMS-sponsored national symposium at the Medicaid Integrity Institute in South Carolina. The Symposium is an opportunity for PI Directors to collaborate and discuss current program integrity issues and emerging trends related to Medicaid Program Integrity functions.
- CMS has named the New Mexico Program Integrity Unit as a best practice state to other states for its “Credible Allegation of Fraud” guideline.

### Outstanding Issues.

- HSD is continuing to review its practices regarding MCO program integrity activities.
- HSD is considering how to add contractual performance measures related to MCO program integrity.
- As it modernizes the Medicaid program, HSD is considering modifying rate development and amounts available for administration and profit for MCOs.
- MFEAD has not divided cases by geographic area.
- HSD/MAD has developed and implemented a rate of return on investment measure for Program Integrity recoveries.
  - FY13 Target: \$3.00 (higher better)
  - FY13 1<sup>st</sup> Qtr. \$2.88

**Emerging Issues.** A 2013 LFC program evaluation found that the Behavioral Health Services Division of the HSD needs to provide better oversight and monitoring of service delivery and program integrity for critical access services, particularly as the state transitions into a more complicated administrative arrangement. The HSD entered into a \$3 million dollar contract with an outside vendor to audit billing practices and quality of care of selected providers. The findings from this audit support the LFC findings around program integrity.

The HSD has reported \$19.3 million in Medicaid payment recoveries for FY12, due in large part to recovery of overpayments. While FY13 data is not yet finalized, the HSD anticipates another year of similarly high recoveries. The recovery process is being managed by the new Program Policy & Integrity Bureau, with a scope of recouping fee-for-service as well as managed care capitation overpayments. This goes beyond what the former Quality Assurance Bureau (QAB) reviewed, making comparison to recoveries identified in the original 2011 evaluation no longer pertinent. LFC staff has requested further detail on the source of recoveries from the agency to better analyze the HSD’s effectiveness in recovering inappropriate Medicaid payments.



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Implementation of the Affordable Care Act (ACA) increased the federal focus on fraud detection and recovery, impacting state Medicaid programs. The Centers for Medicare and Medicaid (CMS) have implemented protocols to combat fraud, including increased scrutiny of high risk providers looking to participate in Medicare, Medicaid, or CHIP and limiting fraudulent providers from moving from state to state or between programs such as Medicare and Medicaid by requiring states to terminate providers if Medicare has revoked billing privileges or if another state has terminated the provider through its Medicaid program.

CMS is also moving from “pay and chase” methodology for investigating fraud, implementing programs to prevent suspicious payments from being generated in the first place. As many providers in the state accept Medicare and Medicaid, the state stands to benefit from increased fraud scrutiny and prevention efforts at the federal level and from modeling emerging best practices from CMS.