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TITLE 8 SOCIAL SERVICES
CHAPTER 305 MEDICAID MANAGED CARE
PART 13 FRAUD AND ABUSE

8.305.13.1 ISSUING AGENCY: Human Services Department
[8.305.13.1 NMAC - N, 7-1-01]

8.305.13.2 SCOPE: This rule applies to the general public.
[8.305.13.2 NMAC - N, 7-1-01]

8.305.13.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See NMSA 1978 27-2-12 et. seq. (Repl. Pamp. 1991).
[8.305.13.3 NMAC - N, 7-1-01]

8.305.13.4 DURATION: Permanent
[8.305.13.4 NMAC - N, 7-1-01]

8.305.13.5 EFFECTIVE DATE: July 1, 2001, unless a later date is cited at the end of a section.
[8.305.13.5 NMAC - N, 7-1-01]

8.305.13.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid managed care program.
[8.305.13.6 NMAC - N, 7-1-01]

8.305.13.7 DEFINITIONS: See 8.305.1.7 NMAC.
[8.305.13.7 NMAC - N, 7-1-01]

8.305.13.8 MISSION STATEMENT: The mission of the medical assistance division is to reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.
[8.305.13.8 NMAC - N, 7-1-01; A, 7-1-09]

8.305.13.9 FRAUD AND ABUSE: HSD is committed to the development and implementation of an aggressive prevention, detection, monitoring and investigation program to reduce provider/member fraud and abuse and member abuse and neglect. If fraud or abuse is discovered, HSD shall seek applicable administrative, civil and criminal penalties, sanctions and other forms of relief. This applies to all individuals participating in or contracting with HSD for provision or receipt of medicaid services. The MCO/SE shall comply with provisions of state and federal fraud and abuse laws and regulations.
[8.305.13.9 NMAC - Rp 8 NMAC 4.MAD.606.12, 7-1-01; A, 7-1-05]

8.305.13.10 MANAGED CARE ORGANIZATION AND SINGLE STATEWIDE ENTITY REQUIREMENTS: The MCO/SE shall have in place internal controls, policies and procedures for the prevention, detection, investigation and reporting of potential fraud and abuse activities concerning providers and members. The MCO/SE specific internal controls, policies and procedures shall be described in a comprehensive written plan submitted to HSD, or its designee, for approval. Substantive amendments or modifications to the plan shall be approved by HSD. The MCO/SE shall maintain procedures for reporting potential and actual fraud and abuse by clients or providers to HSD. The MCO/SE shall:

A. have internal procedures that facilitate preliminary investigating and reporting of potential and actual fraud and abuse to HSD, or its designee, for further investigation;

B. have specific controls in place for prevention and detection of potential cases of fraud and abuse, such as claims edits, post processing review of claims, provider profiling/exception reporting and credentialing prior authorizations, utilization/quality management monitoring;

C. have a mechanism to work with HSD, or its designee, to further develop prevention and detection methods and best practices and to monitor outcomes for medicaid managed care;

D. have internal procedures to prevent, detect and investigate program violations to recover funds misspent due to fraudulent or abusive actions;

E. report to HSD the names of all providers identified with aberrant utilization, according to provider profiles, regardless of the cause of the aberrancy;

F. report to HSD any administrative action taken to limit the ability of an individual or entity to participate in the program;

G. report to HSD any individual or entity that has been excluded from providing items or services to medicaid members;

H. designate a compliance officer and a compliance committee who are accountable to senior management;

I. provide effective fraud and abuse detection training, administrative remedies for false claims and statements and whistleblower protection under such laws to the MCO/SE's employees that includes:

(1) written policies for all employees, agents or contractors that provide detailed information regarding the New Mexico Medicaid False Claims Act, NMSA 1978, and the federal False Claims Act established under sections 3729 through 3733 of Title 31, United States Code, administrative remedies for false claims and statements 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 provision regarding the MCO/SE's policies and procedures for detecting and preventing fraud, waste and abuse; and

(3) include in any employee handbook, a specific discussion of the laws described in Paragraph (1) above, 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;

J. implement effective lines of communication between the compliance officer and the MCO/SE's employees;

K. require enforcement of standards through well-publicized disciplinary guidelines; and

L. have a provision for prompt response to detected offenses and for development of corrective action initiatives relating to the MCO/SE's contract.

[8.305.13.10 NMAC - Rp 8 NMAC 4.MAD.606.12.1, 7-1-01; A, 7-1-05; A, 7-1-07; A, 7-1-09]

HISTORY OF 8.305.13 NMAC: The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives:
8 NMAC 4.MAD.606.12, Managed Care Policies, Fraud and Abuse, 6-19-97.

History of Repealed Material:
8 NMAC 4.MAD.606.12, Managed Care Policies, Fraud and Abuse - Repealed, 7-1-01.