Letter of Direction #109

DATE: **December 19, 2023**

TO: Centennial Care 2.0 Managed Care Organizations

FROM: Lorelei Kellogg, Acting Director, Medical Assistance Division
Adrian R. Gallegos, Inspector General

SUBJECT: **Program Integrity Requirements Update**

This Letter of Direction (LOD) is provided to define and clarify terms of the Medicaid Managed Care Services Agreement (Agreement) related to Program Integrity. This LOD supplements the requirements of the Agreement.

The Centennial Care 2.0 Managed Care Organizations (CONTRACTOR) shall comply with the supplemental direction regarding Program Integrity provisions contained herein.

1. PROGRAM INTEGRITY STAFFING RATIO

This section provides further guidance and clarifies the requirements set forth in section 4.17.1.4 (Program Integrity – General) instituting required staffing ratios based on Medicaid Member populations serviced. This section of the Agreement is revised to state: The CONTRACTOR shall have one dedicated full-time staff (FTS) for every one hundred thousand (100,000) enrolled Medicaid Members, based on a calendar year average, and adequate resources to conduct investigations, audits, or reviews, and develop and implement corrective action plans to assist the CONTRACTOR in preventing and detecting potential Fraud, Waste and Abuse. Should the CONTRACTOR have less than one hundred thousand (100,000) Medicaid Members, the CONTRACTOR shall have at least one dedicated FTS to conduct investigations, audits, or reviews.

2. PROGRAM INTEGRITY PERFORMANCE MEASURE

This section adds section 4.17.1.14 to the Agreement under 4.17.1 (Program Integrity - General). This section will institute a performance measure stating: The CONTRACTOR will have an average annual, based on calendar year, Medicaid Program Integrity Unit (Unit) Return on Investment (ROI) that is at least equal to the cost expended for the CONTRACTOR's Unit (Unit). The Unit is sometimes referred to as the Special Investigations Unit or Special Investigations Department or other similar name and function. The ROI is defined as the cost to operate the CONTRACTOR's Unit, to include full-time staff salary and benefits, and/or the CONTRACTOR's Unit vendor flat monthly fee, to the amount of monetary Medicaid related collections made by the CONTRACTOR's Unit. Monetary Medicaid related collections can include the CONTRACTOR's Unit reasonable attempts to collect Medicaid overpayments as defined in section 4.17.4.1.3 of this Agreement and after a referral has been made to HSD-OIG's Unit in accordance with the referenced section, Cost Avoidance and Prevented Loss. The CONTRACTOR's Unit can only claim monetary Medicaid related collections once when calculating their ROI.

Collections shall mean actual monies received by the CONTRACTOR for funds previously paid and as a direct result of action(s) taken by the CONTRACTOR's Unit and shall be reported in the same period as they are collected.

At times, the work performed by the CONTRACTOR's Unit may result in Cost Avoidance. Medicaid Cost Avoidance can be included in the monetary Medicaid collections amount provided the CONTRACTOR can quantify the level of effort the CONTRACTOR's Unit performed, i.e., number of hours worked on the activity. A level of effort percentage should then be applied to the total Medicaid Cost Avoidance the CONTRACTOR's Unit identified. The resulting amount can then be included in the CONTRACTOR's Unit monetary Medicaid collections. Only Medicaid Cost Avoidance can be considered. How Cost Avoidance is established should be reasonable and documented.

Cost Avoidance shall mean actual or appropriately estimated payments associated with a CONTRACTOR's Unit directed pre-payment denial of a claim, based upon the amount the CONTRACTOR would have paid, not necessarily the billed amount. The Claims must have received their final determination and denial must be as a direct

result of action(s) taken by the CONTRACTOR's Unit and shall be reported in the same period as the claim received final adjudication. Claim system edits that are not under the control of the CONTRACTOR's Unit shall not be reported under this category.

Prevented Loss can be included in the monetary Medicaid collections amount. Prevented Loss shall mean a quantifiable financial impact resulting from the direct action(s) of the CONTRACTOR's Unit. The quantifiable impact can be the result of a change in provider behavior, for example, a clear change in billing patterns. This impact must be measured in real time and not projected or forecasted into the future. The change in behavior measurement is recorded for the lesser of the length of the scheme, or 12 months from the resolution of the issue with the provider. A Process Improvement can be included but must be a specific and quantifiable impact resulting from the modification or adoption of internal policy, edit or process, or CONTRACTOR Unit program. These changes must be the direct result of action(s) taken or recommendations made by the CONTRACTOR's Unit. The measured results are limited to 12 months. Only Medicaid Prevented Loss can be considered. How Prevented Loss is established should be reasonable and documented.

Failure to meet the ROI requirement cited in this section of the Agreement will result in the CONTRACTOR refunding to HSD the difference between the monies collected annually to the annual cost to operate the CONTRACTOR's Unit. All based on a calendar year. If the CONTRACTOR's Unit monetary collections are greater than the cost of the CONTRACTOR's Unit, no refund of monies is required.

The CONTRACTOR shall maintain documented support for costs to operate the CONTRACTOR's Unit and the CONTRACTOR's identified monetary Medicaid collections claimed. The CONTRACTOR should retain and provide the documented support to HSD in accordance with this Agreement.

3. DATA MINING FREQUENCY FOR POTENTIAL FRAUD, WASTE AND ABUSE

This section provides further guidance and clarifies the requirements set forth in section 4.17.2.2 (Reporting and Investigating Suspected Fraud, Waste and Abuse). This section of the Agreement is revised to state: The CONTRACTOR shall have methods for identifying, investigating, auditing, or reviewing, to include at least quarterly data mining activities of their oversight systems that monitor service utilization and claims, and referring potential Fraud, Waste and Abuse cases pursuant to Title 42 C.F.R. § 455.13, § 455.14 and § 455.21. The CONTRACTOR shall use the results of data mining activities to focus on outlier Contract Providers, in addition to defined high-risk Contract Providers, or Members for investigation, audits or reviews.

4. FRAUD, WASTE AND ABUSE CASE TRACKING SYSTEMS

This section adds section 4.17.2.9 to the Agreement under 4.17.1 (Program Integrity - General) stating: Whether automated or manual, the CONTRACTOR shall have a case tracking system that maintains detailed tracking elements for all investigations, audits, or reviews, from initiation through final disposition and have a reliable audit trail, to include documentation to substantiate evidence collected and actions taken. Case tracking systems should include identifying information on original source and witnesses, and Members contacted when verifying services received, along with documented results of those contacts. Procedures for this process should be developed and maintained and revised as circumstances change.

The CONTRACTOR's case tracking system should identify the number of investigations that result from the Explanation of Benefit (EOB) and/or Recipient Explanation of Medical Benefits (REOMB) verification process, site visits, audits or reviews performed, and over/under payment(s) identified, along with any supporting documentation for the over/under payment(s) identified. Should over/under payment(s) be negotiated with the Contract Provider, based on supporting documented evidence provided, and deviate from the final initial total of the over/under payment(s) identified, the Contract Provider's supporting documentation should also be included in the case tracking system.

The CONTRACTOR's case tracking system should accurately capture, track and report over/under payment(s) identified and collected.

The CONTRACTOR's case tracking system should track all reportable program integrity activities including, but not limited to, CONTRACTOR for-cause terminations of Contract Providers.

5. VERIFICATION OF SERVICES PROVIDED

This section provides further guidance and clarifies the requirements set forth in section 4.17.1.13 of the agreement (Program Integrity – General). Section 4.17.1.13 of the Agreement is revised to state: The CONTRACTOR shall employ methods to verify, for example, through EOBs and/or REOMBs, or similar means, by sampling or other methods, whether services that have been represented to have been delivered by Contract Providers and were received by Members and apply this verification method on an annual calendar year basis. The CONTRACTOR shall perform this verification on at least fifty-one (51) percent of their Members enrolled each calendar year and verifying at least two (2) claims per verification method.

The CONTRACTOR should analyze their EOB and/or REOMB, or other similar method, verification processes each calendar year to ensure effectiveness and revise those processes used, should effectiveness not be realized.

6. ANNOUNCED/UNANNOUNCED PROVIDER SITE VISITS AND AUDITS/REVIEWS

This section adds section 4.17.1.14 to the Agreement under 4.17.1 (Program Integrity - General) stating: The CONTRACTOR must perform in-person Contract Provider, both announced and unannounced, site visits, audits, or reviews to ensure services are being rendered and billed correctly. Unannounced means no advanced notice made to the Contract Provider prior to arrival. The CONTRACTOR should conduct point zero nine percent (.09%) audits or reviews of their total average annual calendar year Contract Provider enrollment, with twenty-five percent (25%) of those audits or reviews being performed unannounced. The in-person site visits, audits or reviews should also target outlier Contract Providers identified by the CONTRACTOR through its data mining. The outlier Contract Providers identified are in addition to

the defined high-risk Contract Providers that should be considered for site visits, audits, or reviews.

7. AUDIT SAMPLES AND EXTRAPOLATION

This section adds section 4.17.1.15 to the Agreement under 4.17.1 (Program Integrity - General) stating: The CONTRACTOR, when sampling a Contract Provider's claims to ensure services are being rendered and billed correctly, and in accordance with 27-11 NMSA 1978, as amended (the Medicaid Providers and Managed Care Act), will not extrapolate audit findings unless a Contract Provider's error rate exceeds ten percent (>10%) based upon an appropriate sampling and a representative sample of claims computed by valid statistical methods in accordance with the most recently published Medicare program integrity manual and using statistical software approved by the United States Department of Health and Human Services.

8. AUDIT/REVIEW WORKPLANS

This section provides further guidance and clarifies the requirements set forth in section 4.17.3.2.8 of the agreement (Program Integrity – General). Section 4.17.3.2.8 of the Agreement is revised to state: Include work plans for conducting both announced and unannounced in-person site visits and audits/reviews of Contract Providers defined as high-risk (Contract Providers with cycle/auto billing activities, and Contract Providers offering DME, home health, Behavioral Health, telehealth, private nursing facilities, and transportation services) to ensure services are rendered and billed correctly. The CONTRACTOR should develop work plans prior to conducting in-person site visits and audits/reviews that include steps which would identify potential Fraud, Waste or Abuse and the observance of the quality of care being delivered by the Contract Provider.

9. CONTRACT PROVIDER TERMINATIONS FOR CAUSE

This section adds section 4.17.2.10 to the Agreement under 4.17.1 (Program Integrity - General) stating: CONTRACTORs should apply Contract Provider terminations for cause when issues are identified that involve integrity, quality, or fraud. If a Contract Provider is referred to the HSD-OIG's Program Integrity Unit, the CONTRACTOR should consider whether the Contract Provider should be terminated for cause. This

consideration, whether adverse action is taken or not, should be documented in the CONTRACTOR's case tracking system along with the substantive reason for such action or inaction. Should a New Mexico Contract Provider be identified as operating in another state and who has been terminated for-cause in that other state, the CONTRACTOR should consider whether that Contract Provider should also be terminated for-cause in New Mexico. Should that occur, the CONTRACTOR should monitor that Contract Provider should they be reinstated in that other state and consideration should be given as to whether the Contract Provider should be reinstated in New Mexico. This consideration, whether adverse action is taken or not, should be documented in the CONTRACTOR's case tracking system along with the substantive reason for such action or inaction.

10. RECOVERIES OF OVERPAYMENTS

This section adds section 4.17.4.1.3 to the Agreement under 4.17.4 (Recoveries of Overpayment and/or Fraud) stating: When CONTRACTORS are confronted with a Contract Provider who has been notified of an identified and substantiated overpayment and their obligation to reimburse the CONTRACTOR but is refusing to make reimbursement or ceases to complete reimbursement, the CONTRACTOR should first adjust payment on the Contract Provider's submitted claims for the amount of overpayment. Should the Contract Provider not have claims submitted, terminate their contract or cease treating the members for the medical area in question, the CONTRACTOR should attempt to collect the overpayment by notifying the Contract Provider of the required reimbursement and the CONTRACTOR's authority to collect the overpayment, citing regulatory and/or contractual requirements. If the provider does not comply within a reasonable time, i.e., 30 calendar days, the MCO should immediately notify HSD-OIG's Unit and provide documentary evidence of the CONTRACTOR's audit work that substantiated and identified the overpayment, any agreements made between the CONTRACTOR and Contract Provider for the reimbursement, the CONTRACTOR's attempts to adjust claims, any notifications made to the provider of the required reimbursement and any Contract Provider explanation and evidence supporting the Contract Provider's challenge of the overpayment. Prior to taking this action, the CONTRACTOR should provide the Contract Provider with a reasonable opportunity and time to challenge the identified overpayment and provide supporting evidence. Should the Contract Provider's explanation and supporting evidence not support their challenge, as deemed by the CONTRACTOR, the Contract Provider should be notified of such and informed of

their obligation to make reimbursement and the CONTRACTOR's authority to collect it. Should the Contract Provider not make reimbursement within a reasonable time, the above steps cited in this section should be followed.

This section adds section 4.17.4.1.4 to the Agreement under 4.17.4 (Recoveries of Overpayment and/or Fraud) stating: The CONTRACTOR shall report identified overpayments pursuant to Contract Provider audits performed using the most recent version of the SIU Case Summary form. Included with the SIU Case Summary form, the CONTRACTOR will provide all supporting documentation for the identified overpayment and findings. The supporting documentation should include, but not be limited to, the period covered during the audit, the sampling method or statistical software used, the population from where the sample was retrieved, the sample size, the confidence and precision level of the sample, the claims number and claim lines overpaid, to include patient's full name, patient identification, procedure code billed, billed amount, allowed amount, error, and refund amount, and if extrapolated should include, but not be limited to, the population to which the extrapolation was applied and the claim number and claim lines overpaid, to include patient's full name, patient identification, procedure code billed, billed amount, allowed amount, error, and refund amount. The CONTRACTOR shall provide any documented interaction with the Contract Provider that is relevant to the audit performed.

The title of this section will be changed to "Collections of Overpayments and/or Fraud" to differentiate it from recoveries pursued by MFEAD.

This LOD will sunset upon completion of the Centennial Care Program on June 30, 2024.