19 PROGRAM INTEGRITY

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GENERAL INFORMATION

The Centennial Care Managed Care Organizations (MCOs) shall comply with all Program Integrity provisions of the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) (collectively "PPACA "), and its regulations.

FRAUD, WASTE AND ABUSE REQUIREMENTS

This section is to provide further guidance to the contract and clarify the requirements set forth in sections: 4.17.1 (Program Integrity - General); 4.17.2 (Program Integrity - Reporting and Investigating Suspected Fraud and Abuse); and 7.27 (Cooperation Regarding Fraud).

Provider profiling, auditing and data mining must occur on a regular basis to assist in the identification of potential fraud, waste and abuse. This includes, but is not limited to, an automated review of claims or a clinical audit. Information may also be used from external sources. When an MCO identifies potential fraud, or becomes aware of an allegation of potential fraud or suspicious activity, it must comply with the following:

A. Initial Report

1. For physical health or long term care services, make an initial report within five (5) business days from the time the MCO identifies potential fraud, or becomes aware of an allegation of potential fraud or suspicious activity to the New Mexico Human Services Department (HSD), Office of Inspector General's (OIG's) Program Integrity Unit (PIU). The MCO must identify whether it is an initial report.
2. For behavioral health services provided to Medicaid recipients, make an initial report within five (5) business days from the time the MCO identifies potential fraud, or becomes aware of an allegation of potential fraud or suspicious activity to PIU and the New Mexico Behavioral Health Collaborative (the "Collaborative"). The MCO must identify whether it is an initial report.
3. The MCO must document the identification of potential fraud, or allegation of potential fraud or suspicious activity on the HSD Program Integrity Report ("Report 56") pursuant to the "Centennial Care Reporting Instructions Program Integrity-Report #56".

B. MCO Investigation

1. Once initially reported, the MCO must begin and complete an investigation within twelve (12) months, including all reports as required by the Agreement or set forth

herein (see, B(4)), from when the MCO identified potential fraud, or became aware of an allegation of potential fraud or suspicious activity, from when it was initially reported to the PIU. The MCO must use the PIU supplied Special Investigative Unit (SIU) Case Summary form when reporting Fraud, Waste, and Abuse to the PIU. The SIU Case Summary form may include, but is not limited to, the following information:

a. Date of the initial report to PIU;
b. With each update to PIU, identify the report as an update and the date of the update;
c. Provider(s), member(s), and/or caregiver(s) full name, and any other known names used, that are the subject(s) of the referral;
d. Any known relationships between provider(s), member(s), and/or caregiver(s), i.e. business, personal, etc.;
e. If a provider, whether they are a billing or rendering provider, and the name(s), address, telephone number of the reciprocal billing or rendering provider;
f. If known, National Provider Identification, Tax Identification Number, Social Security Number, Date of Birth, Medicaid/Medicare Provider Number, Medicare Number, Medicaid Number, address, phone number, and/or product line for the subject(s) of the referral. If not known, identify as "Unk";
g. If known, the complainant's contact information to include, name, physical address, email address and phone number. If not known, identify as "Unk";
h. MCO's case file number, date the MCO opened the case, allegation description and code number, and source of the complaint, i.e. hotline, letter, email, etc.;
i. Verify whether the member, caregiver, or provider has been previously investigated during the previous five (5) years and summarize what was found previously;
j. Identify and review claim(s), billing(s), and payment history, and summarize what was found;
k. Identify and review internal policies and procedures, and summarize what was found;
l. Identify and review provider's credentials and member's eligibility status, and summarize what was found;
m. Identify and review state rules, service definitions, and manuals, and summarize what was found;
n. Determine if the MCO previously provided education to the provider or member as it relates to the suspicious activities, and summarize what was found;
o. Document all investigative findings in the SIU Case Summary form;
p. Identify the total potential overpayment resulting from fraud and the time period for the claims reviewed; and
q. Identify whether the potential overpayment was recovered in whole or in part, and if in part, the amount recovered and the remaining balance.

The information identified above is fundamental for the PIU to determine a

credible allegation of fraud and if the MCO has this information, it should be included in the MCO's SIU Case Summary form to the PIU. The MCO should also identify and summarize those investigative steps taken that have no results and include them in the MCO's SIU Case Summary form to the PIU.

2. In conducting their investigation, the MCO should keep in mind the definition of a credible allegation of fraud, 42 C.F.R. § 455.2, and the obligations for an investigation set forth in 42 C.F.R. § 455.14.
3. During the time that the MCO is conducting its investigation, it shall provide the PIU, and when appropriate the Collaborative, with updates as requested.
4. Within the twelve (12) month-period and within ten (10) business days of completing their investigation, the MCO shall report the results to the PIU, and when appropriate the Collaborative, using the SIU Case Summary form and state whether the MCO determined:
    a. The allegations are unsubstantiated and no further action is recommended;
    b. The allegations resulted in a potential overpayment; or
    c. The allegations resulted in a referral to the PIU with a recommendation that a credible allegation of fraud may have been identified.

    The MCO will use their last significant investigative action resulting in information that is significant and relevant to the investigation as the date their investigation was completed. This may include, but is not limited to, interview, document analysis, document receipt, etc.
5. Upon completion of their investigation, the MCO shall update Report 56 pursuant to the "Centennial Care Reporting Instructions Program Integrity-Report #56".

C. Overpayments

1. If, as a result of their investigation, the MCO determines that an overpayment exists, the MCO shall report to the PIU, and when appropriate to the Collaborative, using the SIU Case Summary form:
    a. The overpayment amount;
    b. The claims identified for overpayment recoupment such claims being reflected on the MCO's encounter data;
    c. If the overpayment amount is extrapolated, the methodology used for the extrapolation;
    d. The date the provider was notified of the overpayment;
    e. The terms of any repayment; and
    f. Whether the overpayment was recovered in whole or in part, and if in part, the amount recovered and the remaining balance.
2. Providers may also self-disclose overpayments to the MCO as indicated in 4.17.4 (Recoveries of Overpayments and/or Fraud) and 42 U.S.C. § 1320a-7k(d)(l), codifying Section 6402(a) of PPACA.

3. All overpayments resulting from situations other than fraud, including self-reported overpayments to the MCO, shall be considered the MCO's property unless:
    a. The HSD, OIG, Centers for Medicare and Medicaid Services (CMS) or its contractors, HSD's Recovery Audit Contractor (RAC), or the New Mexico Attorney General's Office, Medicaid Fraud and Elder Abuse Division (MFEAD, also commonly referred to as the Medicaid Fraud Control Unit (MFCU)) notified the provider that an overpayment existed;
    b. The MCO fails to initiate recovery within twelve (12) months from the date the MCO first paid the claim; or
    c. The MCO fails to complete the recovery within fifteen (15) months from the date the MCO first paid the claim.

D. Credible Allegations of Fraud

1. If, as a result of their investigation, the MCO determines that the allegations appear credible, a SIU Case Summary form and all supporting documentation must be submitted to the PIU within twelve (12) months from when the MCO identifies potential fraud, or becomes aware of an allegation of potential fraud or suspicious activity, and ten (10) business days from completion of the MCO's investigation. The MCO shall also document the referral on Report 56 pursuant to the "Centennial Care Reporting Instructions Program Integrity -Report #56".
2. If the PIU does not refer the matter to MFEAD or other law enforcement agency, the MCO may take whatever action it deems appropriate, including but not limited to, seeking overpayment from the provider and/or conducting educational training with the provider.
3. If the PIU refers the matter to MFEAD, the PIU shall, within ten (10) business days, notify the MCO of such referral. Thereafter, the PIU shall attempt provide the MCO with quarterly updates based on the State Fiscal Year cycle. This is in addition to any other requirements, including payment suspension, as outlined in the Agreement, specifically 7.27.1 1 (Referrals for Credible Allegations of Fraud).
4. If the PIU refers the matter to MFEAD and it is not accepted or it is later returned by MFEAD, the PIU shall, within thirty (30) calendar days notify the MCO. In such a situation, HSD, at its sole discretion and related to administrative and civil remedy available to HSD, may seek recovery against the provider for any overpayments and any refund shall be HSD's property. This is in addition to any other requirements set forth in 7.27.1 1 (Referrals for Credible Allegations of Fraud) of the Agreement.
5. If MFEAD accepts the matter and brings a civil or criminal charge against the provider which results in a recovery, 7.27.12 of the Agreement shall apply.

SUSPENSION OF MEDICAID PAYMENTS FOR CREDIBLE ALLEGATIONS OF FRAUD

All providers are required to comply with PPACA's program integrity requirements and its corresponding federal regulations. This includes 42 C.F.R. § 455.23 which requires payment suspension of pending investigations when the OIG has verified, on a case-by-case basis, that there is a credible allegation of fraud. In addition to the requirements set forth in 7.27.11 (Referrals for Credible Allegations of Fraud):

A. The OIG will provide written notice of provider payment suspension, in whole or in part, as follows:
    1. Notice to MFEAD;
    2. Notice to the MCO to impose suspension of payments to the provider; and
    3. Notice to the provider within five (5) days, or thirty (30) days if requested by law enforcement, in writing requesting a delay in sending the notice.
        a. Law enforcement's request to delay sending notice may be renewed in writing up to twice and in no event may exceed ninety (90) days.
        b. In such instances, the PIU will notify the MCOs in writing that an initial delay has been requested and when twenty (20) days after law enforcement's request has been rescinded or the ninety (90) days has passed, advise the MCOs whether payment suspension should be imposed in whole or in part.

B. The MCO shall adjudicate the provider's suspended claims as part of their regular course of business and track the total amount(s) suspended. These amounts shall be reported to the PIU quarterly and updated through ad hoc reporting, as requested.

C. The MCO shall continue the suspension of payments, in whole or in part, until further notified in writing by the PIU to release suspended funds. Release of funds will be authorized when law enforcement agencies, such as MFEAD, determine that there is insufficient evidence of fraud by the provider; or legal proceedings, to include any type of administrative or civil action, either by MFEAD or HSD, related to the provider's alleged fraud are completed. The MCO shall release funds as directed within ten (10) business days of the date of release authorization.

ADVERSE ACTION REPORTING

Federal regulations, specifically 42 C.F.R. § 1002.3(b)(3) requires a state to report all adverse actions taken on provider applications in the Medicaid program directly to the federal Department of Health and Human Services, Office of Inspector General (DHHS/OIG). Adverse actions that must be reported include a denial of credentialing or enrollment of a provider when the denial is due to concerns other than fraud, such as integrity or quality, or termination. For entities that are not natural persons, the information required includes those individuals that have control of, ownership interest in, or managing employees of the business entity. Examples of conduct that would constitute reporting to HSD (the PIU and the Medical Assistance Division (MAD)) include providers that are denied enrollment or termination:

1. As a result of adverse licensure actions, e.g., providers who are reported to the Medicare Exclusion Database (MED), DHHS/OIG/General List of Excluded Individual Entities (LEIE);
2. Due to the engagement of fraudulent conduct;
3. Due to abuse of billing privileges, e.g., billing for services not rendered or unnecessary Medical services;
4. Due to misuse of their Medicaid provider billing number;
5. Due to falsification of information on enrollment application or information submitted to maintain enrollment;
6. Due to continued billing after suspension or revocation of the provider's professional licensure or certification;
7. Based on a State and/or Federal exclusion; or
8. Due to falsification of medical records which support services billed to Medicaid.

A. The MCO is directed to notify the PIU Manager and the MAD Provider Enrollment unit in writing of identified provider adverse actions within five (5) business days from the date the adverse action was taken. An e-mail is acceptable.

B. The MCO is required to develop policies and procedures for reporting all adverse actions taken on provider applications in accordance with this provision and in accordance with HSD's requirements set forth in 42 C.F.R. § 1002.3(b)(3).

C. The MCO is required to document and report all adverse actions taken on providers on Report 56 pursuant to the "Centennial Care Reporting Instructions Program Integrity-Report #56".

RECIPIENT EXPLANATION OF MEDICAL BENEFITS (REOMB)

The MCO is required to develop and implement policies and procedures for verifying with managed care beneficiaries whether billed services were received through Recipient Explanation of Medical Benefits (REOMB' s) correspondence verification process and procedures as set forth in 42 C.F.R. § 455.20.

FRAUD, WASTE, AND ABUSE COMPLIANCE PLAN

The MCO is required to have a written Fraud, Waste and Abuse Compliance Plan ("Compliance Plan") per 4.17.3 of the Agreement. The Compliance Plan must contain procedures designed to detect and prevent fraud, waste and abuse in the administration and delivery of services under the Agreement. The Compliance Plan is due to the PIU on July 1 of every State Fiscal Year. In addition to what is stated in the contract, the Compliance Plan must also contain:

A. Written policies and procedures that supports the execution of the Compliance Plan to prevent

and detect fraud, waste and abuse in the administration and delivery of services under the Centennial Care Program;

B. Designate a Compliance Officer and Compliance Committee;

C. Training and Education of the MCO's employees, contractors, and providers;

D. Auditing and Monitoring;

E. Responding to identified or alleged potential fraud and suspicious activities; and

F. Whistleblower protection and non-retaliation policy.