

U.S. Department of Health and Human Services  
**Office of Inspector General**



# New Mexico Medicaid Fraud Control Unit: 2020 Review

**Suzanne Murrin**  
Deputy Inspector General  
for Evaluation and Inspections  
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# Office of Inspector General

## Report in Brief

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### Unit Case Outcomes

Federal fiscal years (FYs) 2017–2019

- 24 indictments
- 13 convictions
- 44 civil settlements and judgments
- \$7 million in recoveries with \$5.4 million from “global”<sup>\*</sup> civil cases, \$1.6 million from nonglobal civil cases, and \$25,000 from criminal cases

### Unit Snapshot

The New Mexico Medicaid Fraud Control Unit (MFCU or Unit) is located within the New Mexico Office of the Attorney General.

The Unit has a total of 22 employees across its main office in Albuquerque and satellite offices in Las Cruces and Santa Fe.

### Why OIG Did This Review

The Office of Inspector General (OIG) administers the MFCU grant awards, annually recertifies each Unit, and oversees the Units’ performance in accordance with the requirements of the grant. As part of this oversight, OIG conducts periodic reviews of Units and issues public reports of its findings.

OIG conducted this review of the New Mexico MFCU to examine the Unit’s operations and to identify and address factors that contributed to the Unit’s low case outcomes during FYs 2017–2019.

<sup>\*</sup>“Global” recoveries derive from civil settlements or judgments involving the U.S. Department of Justice and a group of State MFCUs and are facilitated by the National Association of Medicaid Fraud Control Units.

## New Mexico Medicaid Fraud Control Unit: 2020 Review

### Key Takeaway

The New Mexico MFCU’s case outcomes were low compared to those of similarly sized MFCUs during FYs 2017–2019. We found significant turnover of Unit management and staff that contributed to inadequate referrals, investigative delays, limited collaboration with Federal partners, and insufficient case documentation—all of which affected the Unit’s case outcomes. This report provides the MFCU with recommendations designed to address these issues and improve its case outcomes.

### What OIG Found

We identified several factors that contributed to the MFCU’s low case outcomes during FYs 2017–2019. The Unit experienced significant turnover of management and staff, which hampered its operations and performance. The Unit did not take sufficient steps to ensure that it received quality referrals from the State Medicaid agency and other sources, and we found significant investigative delays; both factors affected the Unit’s case outcomes. Further, the Unit did not maintain regular communication and worked few cases jointly with Federal partners. Unit management practices also resulted in inconsistent periodic supervisory reviews and documentation in Unit case files.

Additionally, we identified areas in which the Unit should improve its compliance with Federal regulations. We found that the Unit did not report all convictions and adverse actions to Federal partners within the

appropriate timeframes. Further, the Unit’s memorandum of understanding (MOU) with the State Medicaid agency lacked procedures by which the Unit would receive managed care referrals. Finally, we found that the Unit did not exclude costs associated with non-MFCU activities from its Federal reimbursement request.

### What OIG Recommends

We recommend that the Unit (1) develop and implement an action plan to reduce turnover of management and staff and to ensure continuity of Unit operations should turnover occur; (2) develop and implement an action plan to ensure that the Unit receives adequate quality referrals of fraud and patient abuse or neglect; (3) ensure that investigations are completed within the appropriate timeframes and that delays are documented; (4) improve communication and seek more opportunities to investigate cases jointly with Federal partners; (5) ensure that supervisory reviews of case files are conducted periodically and documented in accordance with Unit policy; (6) ensure that all convictions and adverse actions are reported to Federal partners within the appropriate timeframes; (7) revise the Unit’s MOU with the State Medicaid agency to establish procedures by which the Unit will receive fraud referrals from managed care organizations; and (8) ensure that costs associated with non-MFCU activities are excluded from the Unit’s Federal reimbursement request. The Unit concurred with all eight recommendations.

# TABLE OF CONTENTS

<b>BACKGROUND</b>	<b>1</b>
<b>CASE OUTCOMES</b>	<b>7</b>
<b>FINDINGS</b>	<b>9</b>
The Unit experienced significant turnover of management and staff during FYs 2017–2019, which hampered its operations and performance	9
The Unit did not take sufficient steps to ensure that it received quality referrals from the State Medicaid agency and other sources, which limited the number of cases with successful outcomes	10
The Unit had significant investigative delays, which affected its case outcomes	12
The Unit did not maintain regular communication and worked few cases jointly with Federal partners	13
Unit management practices resulted in inconsistent periodic supervisory reviews and documentation in Unit case files	15
The Unit did not report all convictions and adverse actions to Federal partners within the appropriate timeframes	16
The Unit’s MOU with the State Medicaid agency generally reflected current practice, policy, and legal requirements with the exception of a regulatory requirement regarding procedures for the receipt of managed care referrals	17
Three Unit professional staff temporarily performed non-MFCU duties, and the Unit did not exclude the associated costs from claimed Unit expenditures	17
<b>CONCLUSION AND RECOMMENDATIONS</b>	<b>19</b>
Develop and implement an action plan to reduce turnover of management and staff and to ensure continuity of Unit operations should turnover occur	19
Develop and implement an action plan to ensure that the Unit receives adequate quality referrals of fraud and patient abuse or neglect	20
Ensure that investigations are completed within the appropriate timeframes and that delays are documented in the case files	20
Improve communication and seek more opportunities to investigate cases jointly with Federal partners	20
Ensure that supervisory reviews of case files are conducted periodically and documented in accordance with Unit policy	21
Ensure that all convictions and adverse actions are reported to Federal partners within the appropriate timeframes	21

Revise the Unit’s MOU with the State Medicaid agency to establish procedures by which the Unit will receive referrals of potential fraud from managed care organizations	21
Ensure that costs associated with non-MFCU activities are excluded from the Unit’s Federal reimbursement request	21
<b>UNIT COMMENTS AND OIG RESPONSE</b>	<b>22</b>
<b>APPENDICES</b>	<b>24</b>
A. Performance Assessment	24
B. New Mexico MFCU Referrals Received, by Source, for FYs 2017–2019	29
C. Detailed Methodology	30
D. Point Estimates and 95-Percent Confidence Intervals of Case File Reviews	33
E. Unit Comments	34
<b>ACKNOWLEDGMENTS AND CONTACT</b>	<b>38</b>
<b>ABOUT THE OFFICE OF INSPECTOR GENERAL</b>	<b>39</b>

# BACKGROUND

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## Objective

To examine the operations of the New Mexico Medicaid Fraud Control Unit (MFCU or Unit) and identify factors contributing to the Unit's low case outcomes.

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## Medicaid Fraud Control Units

The function of MFCUs is to investigate Medicaid provider fraud and patient abuse or neglect and to prosecute those cases under State law or refer them to other prosecuting offices.<sup>1</sup> By Federal law, a MFCU is a "single, identifiable entity" of State government; must be "separate and distinct" from the State Medicaid agency; and employs one or more investigators, attorneys, and auditors.<sup>2</sup> Each State must operate a MFCU or receive a waiver.<sup>3</sup> MFCUs operate in all 50 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands.<sup>4</sup>

Each Unit receives a Federal grant award equivalent to 90 percent of total expenditures for new Units and 75 percent for all other Units.<sup>5</sup> In Federal fiscal year (FY) 2020, combined Federal and State expenditures for the Units totaled \$306 million, with a Federal share of \$229 million.<sup>6</sup>

<sup>1</sup> SSA § 1903(q)(3). Regulations at 42 CFR 1007.11(b) add that the Unit's responsibilities may include reviewing complaints of misappropriation of patients' private funds in Medicaid-funded health care facilities and board and care facilities. As of December 27, 2020, MFCUs may also receive Federal financial participation to investigate and prosecute abuse or neglect of Medicaid beneficiaries in a noninstitutional or other setting. Consolidated Appropriations Act, 2021, Public Law 116-260, Division CC, Section 207.

<sup>2</sup> SSA § 1903(q).

<sup>3</sup> SSA § 1902(a)(61).

<sup>4</sup> The territories of American Samoa, Guam, and the Northern Mariana Islands have not established Units.

<sup>5</sup> SSA § 1903(a)(6). For a Unit's first 3 years of operation, the Federal government contributes 90 percent of funding and the State contributes 10 percent of Unit funding. Thereafter, the Federal government contributes 75 percent and the State contributes 25 percent.

<sup>6</sup> OIG analysis of MFCUs' FY 2020 reporting of expenditures. The Federal FY 2020 was from October 1, 2019, through September 30, 2020.

## OIG Grant Administration and Oversight of MFCUs

The Office of Inspector General (OIG) administers the grant award to each Unit and oversees Units.<sup>7, 8</sup> As part of its oversight, OIG recertifies each Unit annually and conducts periodic reviews or inspections.

In its annual recertification review, OIG examines the Unit's reapplication, the Unit's case statistics, and questionnaire responses from Unit stakeholders. Through the recertification review, OIG assesses a Unit's performance, as measured by the following: its adherence to published performance standards;<sup>9</sup> its compliance with applicable laws, regulations, and OIG policy transmittals;<sup>10</sup> and its case outcomes. See Appendix A for the 12 performance standards and OIG's assessment of the New Mexico MFCU's adherence to those standards.

OIG further assesses Units' performance through periodic reviews of selected Units. OIG selects Units for these reviews on the basis of an annual risk assessment of all Units. Each of OIG's reviews may identify findings and result in recommendations for improvement. OIG may also make observations on Unit operations and practices, including identifying beneficial practices that may be useful to share with other Units. In addition, OIG provides training and technical assistance to Units, as appropriate, both during the review and on an ongoing basis.

## New Mexico MFCU

The New Mexico MFCU, also known as the Medicaid Fraud and Elder Abuse Division, is located within the New Mexico Office of the Attorney General. The MFCU has a main office in Albuquerque and satellite offices in Las Cruces and Santa Fe. The Unit has the authority to prosecute Medicaid fraud and patient abuse and neglect cases.<sup>11</sup> In September 2020, the Unit had 22 employees: 8 investigators, including 2 Special Agents in Charge and 2 nurse investigators; 4 attorneys, including the MFCU director;

<sup>7</sup> As part of grant administration, OIG receives from Units and examines financial information, such as budgets and quarterly and final Federal Financial Reports, that detail MFCU income and expenditures.

<sup>8</sup> The Social Security Act authorizes the Secretary of Health and Human Services to award grants (SSA § 1903(a)(6)) and to certify and annually recertify the Units (SSA § 1903(q)). The Secretary delegated these authorities to OIG in 1979.

<sup>9</sup> MFCU performance standards are published at 77 Fed. Reg. 32645 (June 1, 2012). OIG developed the performance standards in conjunction with the MFCUs, and the standards were originally published at 59 Fed. Reg. 49080 (Sept. 26, 1994).

<sup>10</sup> OIG occasionally issues policy transmittals to provide guidance and instruction to MFCUs. Policy transmittals can be found at <https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/>.

<sup>11</sup> At the time of our review, the Unit's authority to receive Federal financial participation to investigate and prosecute patient abuse and neglect cases was limited to allegations arising in facility settings. As of December 27, 2020, MFCUs can also receive Federal financial participation to investigate and prosecute abuse or neglect of Medicaid beneficiaries in a noninstitutional or other setting. Consolidated Appropriations Act, 2021, Public Law 116-260, Division CC, Section 207.

4 forensic auditors; 2 internet security specialists; 1 outreach and training coordinator; and 3 support staff, including legal and administrative assistants. During our review period of FYs 2017–2019, the Unit spent approximately \$8 million (with a State share of approximately \$2 million).

**Referrals.** The Unit reported receiving fraud referrals from several sources, including the State Medicaid agency and private citizens, during FYs 2017–2019. The Unit reported receiving most of its referrals of patient abuse and neglect from Adult Protective Services (APS), located within the New Mexico Aging and Long-Term Services Department. APS is the State agency responsible for investigating reports of suspected abuse, neglect, and exploitation of vulnerable adults.<sup>12</sup> Additionally, in FY 2017, OIG approved the New Mexico MFCU to engage in data mining, which allows the Unit to identify fraud through analysis of Medicaid claims data.<sup>13, 14</sup> See Appendix B for a list of Unit referrals by source for FYs 2017–2019.

When the Unit receives a referral of fraud or patient abuse or neglect, one of the Unit's administrative assistants completes an intake form for the referral. Unit managers meet on a weekly basis to review each referral and determine whether to assign a preliminary investigation.<sup>15</sup> If the managers determine that the referral is outside of the Unit's jurisdiction or otherwise decide not to proceed with the referral, the Unit may forward it to another agency.

**Investigations and Prosecutions.** Once the Unit accepts a referral for preliminary investigation, it enters the information into the Unit's case management system and Unit managers assign the referral to an investigator. Per Unit policy, a referral accepted for preliminary investigation must be assigned to an investigator within 1 month of the Unit's receipt of the referral. Unit policy also states that the preliminary investigation period for referrals of fraud and patient abuse or neglect should be no longer than 180 days from the date of assignment, during which the investigator determines whether there is sufficient evidence to warrant a formal investigation.

At the end of the preliminary investigation, the investigator prepares a form that indicates whether the referral should be closed or opened as a case, which the Special Agent in Charge and the Unit director or deputy director review and sign. If the Unit

<sup>12</sup> New Mexico Aging and Long-Term Services Department, *Adult Protective Services*. Accessed at [http://www.nmaging.state.nm.us/Adult\\_ProtectiveServices.aspx](http://www.nmaging.state.nm.us/Adult_ProtectiveServices.aspx) on April 5, 2021.

<sup>13</sup> Data mining is the practice of electronically sorting Medicaid or other relevant data, including but not limited to the use of statistical models and intelligent technologies, to uncover patterns and relationships within that data to identify aberrant utilization or billing, or other practices that are potentially fraudulent.

<sup>14</sup> On May 17, 2013, HHS issued the final rule "State Medicaid Fraud Control Units; Data Mining" (78 Fed. Reg. 29055). This rule permits Federal financial participation in costs of data mining if certain criteria are satisfied. MFCUs must submit data mining applications to OIG for approval.

<sup>15</sup> At the time of our review, the Unit management intake team consisted of the director, deputy director, outreach and training coordinator, and Special Agents in Charge.



determines that a formal investigation is warranted, the investigator develops an investigative plan and discusses the plan with the Special Agent in Charge before beginning the investigation.

Upon completion of the formal investigation, the investigator presents the findings and evidence to the Unit attorney assigned to the case. If the attorney determines that there is sufficient evidence to support either civil or criminal prosecution, the attorney will submit a memorandum to the Unit director proposing prosecution.

## New Mexico Medicaid Program

The New Mexico Medicaid program is administered by the New Mexico Human Services Department (HSD) and provides health coverage for approximately 756,000 beneficiaries enrolled in the program.<sup>16</sup> In FY 2020, New Mexico's Medicaid expenditures were approximately \$6.6 billion.<sup>17</sup> HSD administers the State's Medicaid fee-for-service and managed care programs.<sup>18</sup> There are three Medicaid managed care organizations (MCOs) in the State of New Mexico.<sup>19</sup> As of September 2020, 96 percent of New Mexico's Medicaid beneficiaries received their services through these 3 MCOs.<sup>20</sup>

**Medicaid Program Integrity.** The HSD-OIG functions as the State Medicaid Program Integrity Unit, and its mission is to prevent and detect fraud, waste, and abuse in the HSD public assistance programs and internal operations. The HSD-OIG is composed of three bureaus that are responsible for processing allegations, conducting preliminary investigations, and providing investigative support and internal audits.<sup>21</sup> The State's MCOs also have a role in program integrity. Each MCO

<sup>16</sup> CMS, *Monthly Medicaid & CHIP Application, Eligibility Determination, and Enrollment Reports & Data, September 2020*. Accessed at <https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/monthly-medicaid-chip-application-eligibility-determination-and-enrollment-reports-data/index.html> on June 23, 2021.

<sup>17</sup> OIG, *MFCU Statistical Data for FY 2020*. Accessed at [https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures\\_statistics/fy2020-statistical-chart.pdf](https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2020-statistical-chart.pdf) on April 5, 2021.

<sup>18</sup> New Mexico Human Services Department, *Providers Overview*. Accessed at <https://www.hsd.state.nm.us/providers/Default.aspx> on April 5, 2021.

<sup>19</sup> The three MCOs in New Mexico are Blue Cross Blue Shield of New Mexico, Presbyterian Health Plan, and Western Sky Community Care. Accessed at [https://www.hsd.state.nm.us/wp-content/uploads/PressRelease/2f473c14ee654f868b5a25b3cfd15a6d/Procurement\\_press\\_release\\_1.pdf](https://www.hsd.state.nm.us/wp-content/uploads/PressRelease/2f473c14ee654f868b5a25b3cfd15a6d/Procurement_press_release_1.pdf) on April 5, 2021.

<sup>20</sup> Kaiser Family Foundation reported that approximately 727,421 beneficiaries were enrolled in New Mexico MCOs in September 2020. Kaiser Family Foundation, *Growth in Medicaid MCO Enrollment during the COVID-19 Pandemic*. Accessed at <https://www.kff.org/coronavirus-covid-19/issue-brief/growth-in-medicaid-mco-enrollment-during-the-covid-19-pandemic/> on April 5, 2021.

<sup>21</sup> The HSD-OIG's three bureaus are the Investigations Bureau, the Internal Review Bureau, and the Central Office. New Mexico Human Services Department, *Office of Inspector General*. Accessed at [https://www.hsd.state.nm.us/about\\_the\\_department/office\\_of\\_inspector\\_general/](https://www.hsd.state.nm.us/about_the_department/office_of_inspector_general/) on January 14, 2021.



is responsible for notifying the HSD-OIG of suspected fraud, waste, or abuse within 5 business days of identification, and conducting preliminary investigations within 12 months. If the HSD-OIG determines that a referral meets the criteria for credible allegation of fraud, it sends the referral to the MFCU for further investigation.

## Previous OIG Report and Oversight

In 2015, OIG issued a report following its 2014 onsite review of the Unit.<sup>22</sup> OIG found that (1) a Unit supervisor approved the opening and closing of almost all case files, but 42 percent lacked documentation of periodic supervisory reviews; (2) 32 percent of case files had unexplained investigation delays of a year or more; (3) the Unit did not always refer sentenced individuals to OIG or adverse actions to the National Practitioner Data Bank (NPDB) within an appropriate timeframe; (4) the Unit's memorandum of understanding (MOU) with the State Medicaid agency did not reflect current law and practice, and the Unit's policies and procedures manual was incomplete; and (5) the Unit incorrectly reported program income and inappropriately claimed expenditures for indirect costs.

OIG made four recommendations to the Unit. OIG recommended that the Unit (1) ensure that periodic supervisory reviews are documented in Unit case files; (2) ensure that any investigation delays are limited to situations imposed by resource constraints or other exigencies; (3) ensure that it reports all relevant information to OIG and the NPDB within an appropriate timeframe; and (4) revise its policies and procedures manual to reflect current Unit operations.

By August 2015, OIG considered all four recommendations to have been implemented by the Unit. The Unit began using a form to indicate in the case file that a supervisory review had been conducted and drafted a policy and procedures to describe the process for conducting and documenting these reviews. As part of this process, the Unit began discussing and documenting in the case files any reason for delays in the investigation and prosecution of a case. The Unit also implemented a policy and procedures outlining the reporting of convictions and adverse actions to OIG and the NPDB. Finally, the Unit revised its policies and procedures manual to reflect its current operations.

## Methodology

We conducted a review of the New Mexico Unit in September 2020. Our review covered the 3-year period of FYs 2017–2019. Due to the COVID-19 pandemic, we were unable to conduct the review onsite as planned; instead, we conducted the review remotely through a virtual format. The review team consisted of OIG

<sup>22</sup> OIG, *New Mexico State Medicaid Fraud Control Unit: 2014 Onsite Review*, OEI-09-14-00240, February 2015.

evaluators, OIG agents, a grant oversight analyst, and a director from another State MFCU.

The primary purpose of the review was to follow up on issues that OIG identified through its ongoing administration and oversight activities. Our pre-review analysis identified the Unit's low case outcomes as an area of concern. The analysis showed that the New Mexico MFCU's case outcomes were among the lowest when compared to those of similarly sized MFCUs during FYs 2017–2019. We focused our data collection and analysis on identifying factors contributing to low case outcomes and ways to help the Unit improve its case outcomes.

We also examined the Unit's operations and adherence to the 12 performance standards and applicable Federal laws, regulations, and policy transmittals. In examining the Unit's operations and performance, we applied the published MFCU performance standards listed in Appendix A, but we did not assess every performance indicator for each of the 12 standards. See Appendix C for a detailed methodology.

We based our review on an analysis of data from seven sources: (1) Unit documentation, such as policies and procedures; (2) structured interviews with key stakeholders; (3) structured interviews with Unit managers and selected staff; (4) review of a random sample of case files that were open at any point during the review period; (5) referrals received by the Unit; (6) review of all convictions submitted to OIG for program exclusion and all adverse actions submitted to the NPDB during the review period; and (7) documentation associated with the Unit's fiscal controls.

## Standards

OIG conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency. These inspections differ from other OIG evaluations in that they support OIG's direct administration of the MFCU grant program but are subject to the same internal quality controls as are other OIG evaluations, including internal and external peer review.

# CASE OUTCOMES

The New Mexico Unit reported low case outcomes for FYs 2017–2019, with 24 indictments, 13 convictions, and 44 civil settlements and judgments.<sup>23</sup> Of the 13 convictions, 11 involved provider fraud and 2 involved patient abuse or neglect. The Unit's total numbers of indictments, fraud convictions, and patient abuse or neglect convictions were low compared to those of other similarly sized MFCUs during FYs 2017–2019.<sup>24</sup> Specifically, when compared to MFCUs with similar staff sizes, the New Mexico Unit had the lowest numbers of indictments and fraud convictions and the second lowest number of patient abuse or neglect convictions.

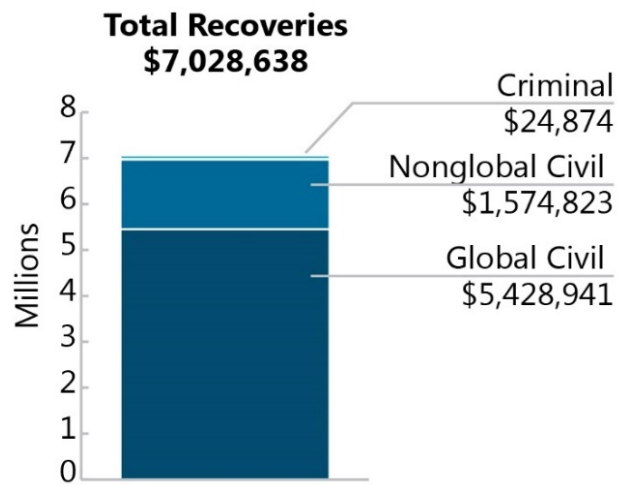


The Unit reported \$7 million in total recoveries for FYs 2017–2019. Of the \$7 million in total recoveries, global civil recoveries represented approximately \$5.4 million or 77 percent of the Unit's total recoveries during the review period. The remaining recoveries which came from the Unit's criminal and nonglobal civil casework totaled \$1.6 million during the 3-year review period. The New Mexico Unit had the least total criminal and nonglobal civil recoveries of all MFCUs with similar staff sizes. See Exhibit 1 on the next page for the sources of the New Mexico Unit's recoveries.

<sup>23</sup> OIG provides information on MFCU operations and outcomes, but it does not direct or encourage MFCUs to investigate or prosecute a specific number of cases. MFCU investigators and prosecutors should apply professional judgment and discretion in determining which criminal and civil cases to pursue.

<sup>24</sup> We compared the New Mexico MFCU to similarly sized MFCUs with staff sizes that ranged from 21 to 39 employees; the New Mexico MFCU had a staff of 22 employees. Although comparison across similarly sized MFCUs provides context for the case outcomes of a particular MFCU, many factors other than the size of a MFCU's staff can affect case outcomes.

Exhibit 1: The Unit reported combined civil and criminal recoveries of \$7 million during FYs 2017–2019.



Source: OIG analysis of Unit statistical data FYs 2017–2019.

# FINDINGS

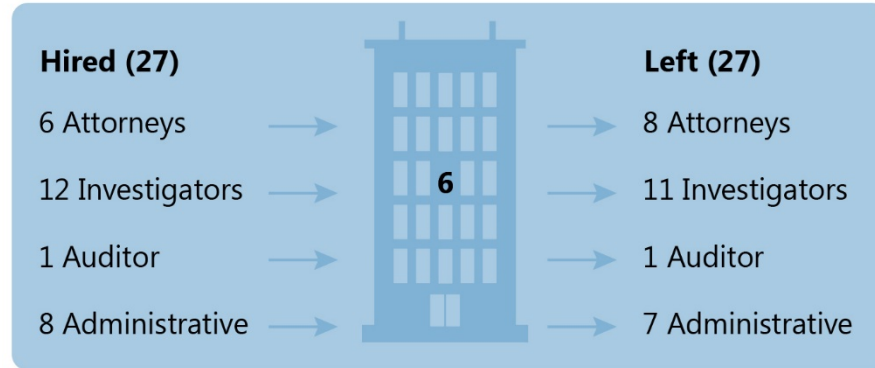
The New Mexico MFCU's case outcomes were low compared to those of similarly sized MFCUs during FYs 2017–2019; this review focused on identifying factors that limited case outcomes. We found that the primary cause for the low case outcomes during our review period was the frequent turnover of management and staff, which disrupted and negatively affected many aspects of Unit operations. We also identified several areas of potential improvement for which we are issuing recommendations. Finally, we assessed the Unit's adherence to each of the 12 MFCU performance standards outlined in Appendix A of the report.

## **The Unit experienced significant turnover of management and staff during FYs 2017–2019, which hampered its operations and performance**

While neither the number of staff for which the Unit was approved nor the number of staff that the Unit employed was low in relation to the State's Medicaid program expenditures, the Unit experienced significant turnover in both management and staff positions during our review period. Although the Unit's staffing levels were relatively constant with 23 employees at the end of FY 2017 and 21 employees at the end of FYs 2018 and 2019, we found that a total of 27 staff members left the Unit during the 3-year period. The departing staff included 8 attorneys, 2 of whom were Unit directors; 11 investigators; 1 auditor; and 7 administrative staff.<sup>25</sup> Some of the staff who left the Unit were new hires and stayed with the Unit only for a short period. See Exhibit 2 on the next page for a depiction of the total number of staff who joined the Unit and the total number of staff who left the Unit, by profession, during FYs 2017–2019. As a result of the frequent turnover of staff, most of the Unit's attorneys and investigators had been employed with the Unit for approximately 3 years or less at the time of our review. However, most of the Unit's newly hired staff had extensive experience relevant to their respective professions.

<sup>25</sup> One of the Unit directors who departed served in an "interim" capacity.

**Exhibit 2: During our review period, 27 staff were hired, 27 staff departed, and only 6 staff remained constant.**



Source: Unit-provided documentation.

In interviews, Unit management and staff attributed the turnover to circumstances such as employees leaving for other professional opportunities or because of changes in their personal lives. We did not identify any additional causes for the frequent turnover during our review period.

Unit management and staff reported that turnover negatively impacted the Unit's operations and performance. Unit staff reported that management turnover led to inconsistency in leadership styles, which disrupted Unit operations. Further, most Unit directors did not stay with the Unit long enough to invest in long-term improvements, and thus potentially impeded the Unit's success. We found that the turnover of both managers and staff negatively affected many aspects of Unit operations, including quality of referrals, timeliness of Unit investigations, collaboration with Federal partners, and consistency of supervisory reviews. We found that these factors in turn contributed to the Unit's low case outcomes.

## **The Unit did not take sufficient steps to ensure that it received quality referrals from the State Medicaid agency and other sources, which limited the number of cases with successful outcomes**

Performance Standard 4 states that a Unit should take steps to maintain an adequate volume and quality of referrals from the State Medicaid agency and other sources. During FYs 2017–2019, the Unit received 1,014 fraud referrals and 640 referrals of patient abuse or neglect, which was similar to the total numbers of such referrals received by similarly sized Units during the same timeframe. Although the Unit received an adequate number of referrals, Unit management and staff explained that the referrals that the Unit received from its stakeholders were typically of poor quality or outside of the Unit's jurisdiction or authority. For example, while the State Medicaid agency should be a significant source of fraud referrals, Unit management

reported that many of the referrals from the Medicaid agency involved allegations of personal care services (PCS) fraud for which the expected investigative costs outweighed possible recoveries or the allegations had occurred several years prior, thus affecting the Unit's ability to obtain necessary evidence and successfully prosecute the cases.<sup>26</sup> Further, although APS was the largest source of referrals of patient abuse and neglect, Unit managers reported opening very few of those as cases because most of the referrals involved allegations that were outside of the Unit's authority. The Unit managers explained that the APS referrals typically involved allegations of patient abuse or neglect that occurred outside of the facility setting, for which the Unit could not receive Federal financial participation during the review period.

Despite the Unit's concerns regarding the quality of referrals, the Unit did not provide sufficient feedback to the State Medicaid agency, APS, or other referral sources to improve the quality of the referrals it received during our review period. We found that the frequent turnover of Unit management and staff disrupted the Unit's relationships with the referral sources and affected its ability to conduct outreach efforts to improve the quality of referrals. One of the

**Performance Standard 4(b):**  
A Unit should provide periodic feedback to the State Medicaid agency and other referral sources on the adequacy of both the volume and quality of its referrals.

Unit managers explained that in the past, the Unit had productive relationships with the referral agencies, but with the frequent change in leadership, the Unit had to rebuild those relationships each time new management came on board. In an interview with staff of the New Mexico Department of Health, which houses the State survey and certification agency, staff reported having limited knowledge about the MFCU's authority to investigate allegations of patient abuse or neglect and therefore rarely forwarding referrals to the Unit. One of the Unit's stakeholders said that it would be helpful if the MFCU provided outreach and feedback regarding the types of referrals the Unit would like to receive.

Because of the Unit's limited outreach and feedback to stakeholders during the review period, we found that it opened only a small percentage of those referrals as investigations, which limited the number of cases available for the Unit to investigate and prosecute. Specifically, the Unit opened cases for 9 percent of fraud referrals and 4 percent of patient abuse or neglect referrals, while on average, similarly sized MFCUs opened cases for 58 percent of fraud referrals and 42 percent of patient abuse or neglect referrals.

After our review period, the Unit took steps to improve the quality of referrals. The Unit hired an outreach and training coordinator. The Unit assigned the coordinator, who previously worked at the State Medicaid agency, to assist in educating and establishing relationships with stakeholders to improve the quality of referrals. The

<sup>26</sup> We observed that the Unit worked on a disproportionate number of cases involving PCS providers. For information regarding how referrals may have affected Unit case mix and case outcomes, see page 26.



Unit also reported that it had implemented algorithms to identify fraud through in-house analysis of Medicaid claims data. In FY 2017, the Unit requested and received OIG approval to conduct data mining to identify vulnerabilities and detect fraud, but the Unit did not generate any cases through data mining during our 3-year review period. However, in FY 2020, the Unit generated eight cases through its data mining efforts.

## The Unit had significant investigative delays, which affected its case outcomes

According to Performance Standard 5, a Unit should take steps to maintain a continuous case flow and to complete cases in an appropriate timeframe based on the complexity of the cases. Our review of a sample of Unit case files that were open at any point during FYs 2017–2019 identified significant delays in the Unit’s preliminary and formal investigations. Lengthy investigations can result in Unit failure to meet the appropriate statutes of limitations and allow continued commission of fraud and/or patient abuse or neglect. Investigative delays can also impact the Unit’s ability to obtain and use credible witness testimony and affect the prosecutorial viability of Unit cases, reducing the likelihood of convictions and appropriate sentencing.

### The Unit did not always complete preliminary investigations timely in accordance with its policy

Unit policy states that the Unit should conduct all preliminary investigations within 180 days and determine whether a formal investigation is warranted. For comparison, Federal investigators are generally required to complete preliminary investigations within 45 days of referral receipt, and in OIG’s experience, other MFCUs typically attempt to complete preliminary investigations within 30–60 days of referral receipt.

Despite the Unit’s unusually long preliminary phase, the Unit did not complete the preliminary investigation for most cases within the 180-day timeframe. Specifically, we found in 66 percent of case files that the Unit’s preliminary investigations were open longer than 180 days.<sup>27</sup> In some cases, the preliminary investigations were open for several years, which can be problematic and particularly concerning if the cases involve patient abuse or neglect. We observed that cases could have been opened as soon as a Medicaid nexus was established. Unit management attributed the lengthy preliminary investigations to staff turnover and described how one referral that had

<sup>27</sup> For the purposes of our case file review, we reviewed cases that were open at some point during FYs 2017–2019. We did not review a representative sample of all referrals opened for preliminary investigation, and therefore we did not formally assess the timeframe of all preliminary investigations conducted during our review period.

been open as a preliminary investigation for 2.5 years had been reassigned 5 times due to investigators leaving the Unit.

### **Staff turnover and inefficient processes caused significant delays in the Unit's formal investigations**

Our case file review also found significant delays in the Unit's formal investigations. Specifically, we found that 51 percent of case files had significant delays during the formal investigation stage. The investigative delays ranged from 6 months to 4 years. In reviewing the case files, we found that few cases contained documentation explaining the cause(s) of the delays. However, Unit managers reported to us that similar to the preliminary investigations, the delays during the formal investigations were largely due to staff turnover.

Some of the Unit's processes also contributed to investigative delays. We found that the Unit did not always reassign cases immediately when an investigator left the Unit and did not consistently prioritize cases on the basis of age, and therefore some of the older cases fell further behind. When investigators left the Unit, Unit managers usually waited to reassign those cases until the vacancies were filled. However, staff noted that even after the Unit filled vacancies, there were often investigative delays because of the steep learning curve, particularly for Medicaid fraud investigations, that required new employees to spend time on training and becoming familiar with their case assignments before they could actively begin investigating cases. Further, the lack of documentation explaining the reasons for the investigative delays made it difficult for new investigators to become familiar with the status of the cases that the Unit had reassigned to them.

We also found inefficiencies in the Unit's case management processes that may have contributed to investigative delays. We found that it was sometimes difficult to locate documents, such as interview reports and data analysis, in Unit case files. We also found that there was a lack of consistency in documentation of investigative activities and few standardized documentation forms. Inconsistent documentation in the case files can make it difficult for new investigators to become familiar with the status of cases upon assignment and can cause investigative delays. On the basis of our observations, during and after our review, we provided the Unit with technical assistance to enhance consistency and completeness of its case files.

### **The Unit did not maintain regular communication and worked few cases jointly with Federal partners**

Performance Standard 8 states that a Unit should cooperate with OIG and other Federal agencies in the investigation and prosecution of Medicaid and other health

care fraud.<sup>28</sup> We found that the Unit did not communicate regularly and worked few cases jointly with Federal partners during FYs 2017–2019.

Specifically, we found that the Unit investigated only 9 cases jointly with OIG and 6 cases with the U.S.

Attorney’s Office during the 3-year period.

According to OIG agents, with the exception of the Unit’s attendance at the biannual joint health care task force meetings, which OIG agents also attended, the Unit rarely communicated with OIG.

**Performance Standard 8(a):**  
A Unit should communicate on a regular basis with OIG and other Federal agencies investigating or prosecuting health care fraud in the State.

The OIG agents and officials in both the civil and criminal divisions of the U.S. Attorney’s Office attributed the limited communication and collaboration with the Unit to the frequent turnover of Unit management and staff. One OIG agent, who reported having a good working relationship with one of the Unit’s supervisory investigators, explained that it was difficult to maintain ongoing relationships with Unit investigators because of the frequent departure and replacement of Unit staff. OIG agents and Unit staff also indicated that the geographic distance between the OIG office and the Unit’s offices further limited collaboration. In addition, the Unit’s case mix contained a disproportionate amount of fraud cases involving personal care services, which are cases that typically do not involve Federal partners. See page 26 in Appendix A for further information about the Unit’s case mix.

Increased communication and collaboration with Federal partners who also investigate or prosecute health care fraud in the State, such as OIG, the U.S. Attorney’s Office, the Drug Enforcement Agency (DEA), and the Federal Bureau of Investigation (FBI), could result in additional fraud referrals to the MFCU and more joint cases, which could improve the Unit’s case outcomes. Further, working more cases jointly with Federal partners could create more opportunities for the Unit to access and share resources (e.g., equipment and personnel) more effectively with other law enforcement agencies. OIG agents reported that joint casework could also provide the Unit with guidance and training opportunities from other agencies that could be particularly helpful for newer staff and for complex Medicaid fraud cases. The agents expressed an interest in collaborating more regularly with the Unit on complex cases and encouraged the Unit to reach out to OIG to work jointly on cases. Officials in the U.S. Attorney’s Office also stated that they were open to enhancing their relationship with the Unit.

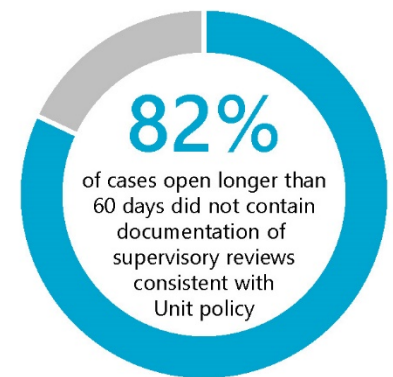
Although Federal partners expressed an interest in improving collaboration with the Unit, they raised concerns about the potential impact of a recently enacted State statute on future joint casework with the Unit. The new statute, which went into effect in January 2020, requires the State Medicaid agency to provide written notice to providers of preliminary findings of overpayment before reaching a final

<sup>28</sup> Effective May 21, 2019, 42 CFR § 1007.11(e)(3) requires the Unit to establish a practice of regular Unit meetings or communication with OIG investigators and Federal prosecutors.

determination of overpayment or a credible allegation of fraud.<sup>29</sup> When the Medicaid agency identifies a credible allegation of fraud, it is generally required to suspend payments to the provider and refer the allegation to the MFCU for further investigation. However, the MFCU may specifically request that a payment suspension not be imposed on the provider because such a payment suspension may compromise or jeopardize the investigation.<sup>30</sup> Federal partners expressed concerns that notifying providers of a preliminary finding of overpayment as required by the State statute could jeopardize an investigation. Given the potential challenges introduced by the new statute, there may be a disincentive for the Unit and its Federal partners to work jointly on cases.

## Unit management practices resulted in inconsistent periodic supervisory reviews and documentation in Unit case files

According to Performance Standard 7(a), supervisory reviews should be conducted periodically, consistent with Unit policies and procedures, and noted in the case files. Although the Unit had a policy for the frequency of periodic supervisory reviews—every 60 days or more frequently—we found that most of the Unit’s case files did not contain consistent documentation of such reviews.<sup>31</sup> For cases that were open longer than 60 days, 82 percent of the case files did not contain documentation of periodic supervisory reviews consistent with Unit policy. Of these case files, 76 percent did not contain documentation of supervisory reviews every 60 days (i.e., the supervisory reviews were conducted less frequently), and 7 percent did not contain documentation of any supervisory review. See Appendix D for an expanded list of case file review point estimates and confidence intervals.



Despite having a policy in place for conducting periodic supervisory reviews, Unit staff reported that turnover in the management positions led to inconsistency in leadership styles that disrupted the Unit’s supervisory review practices. Staff explained that when new Unit managers came on board, they did not conduct or document the supervisory reviews consistently. Although the case files often lacked documentation, staff reported that they would informally ask questions and discuss their cases with the Unit supervisors.

Periodic supervisory reviews of case files are important because they provide an opportunity for Unit managers to provide case oversight, promote engagement

<sup>29</sup> NM Stat. § 27-11-7 (2019).

<sup>30</sup> 42 CFR § 455.23(e).

<sup>31</sup> According to the Unit’s policies and procedures manual, updated in 2014, supervisory case reviews should be conducted once every 2 months, or at least once every 60 days.

between Unit staff and managers, and help ensure timely completion of investigations. Regular case file reviews can also constitute on-the-job training and development opportunities for new investigators, and consistent documentation of these reviews can help newly assigned investigators more quickly become familiar with the status of cases, particularly if they are taking over a case from a staff member who left the Unit.

## **The Unit did not report all convictions and adverse actions to Federal partners within the appropriate timeframes**

According to Performance Standard 8(f), a Unit should transmit to OIG—within 30 days of sentencing—reports of all convictions so that convicted individuals can be excluded from Federal health care programs.<sup>32</sup> Although the Unit had procedures in place for reporting its convictions to OIG within 30 days of sentencing, the Unit did not report 3 of its 9 convictions within the appropriate timeframe. Specifically, the Unit reported 1 conviction to OIG within 31 to 60 days after sentencing and 2 convictions more than 90 days after sentencing. We found that near the end of our 3-year review period (around May 2019), the Unit stopped submitting documentation to OIG’s Exclusions Portal.

In interviews, Unit managers explained that the departure of one of the Unit’s staff members, who had been assigned to submit convictions to OIG, disrupted the Unit’s submissions because the remaining staff were unfamiliar with the process. Unit managers also reported that delays in court procedures resulted in late submissions to OIG. After our review period, OIG provided technical assistance to the Unit to aid in the submission of any outstanding convictions to the Exclusions Portal. Late reporting of convictions to OIG delays the initiation of the program exclusion process, which may result in improper payments to providers by the Medicaid program or other Federal health care programs as well as possible harm to beneficiaries.

Federal regulations also require Units to report any adverse actions resulting from investigations or prosecutions of health care providers to the NPDB within 30 calendar days of the date of the final adverse action.<sup>33, 34</sup> Although the Unit had procedures in place for reporting adverse actions to the NPDB, the Unit did not report 6 of its 9 adverse actions to the NPDB within the appropriate timeframe. Of the 6 adverse

<sup>32</sup> Effective May 21, 2019, 42 CFR § 1007.11(g) requires the Unit to transmit information on convictions within 30 days of sentencing, or as soon as practicable, if the Unit encounters delays in receiving the necessary information from the court. Convictions include those obtained by either Unit prosecutors or non-Unit prosecutors in any case investigated by the Unit.

<sup>33</sup> 45 CFR § 60.5. Examples of final adverse actions include, but are not limited to, convictions, civil judgments (but not civil settlements), and program exclusions. See SSA § 1128E(g)(1).

<sup>34</sup> Performance Standard 8(g) states that the Unit should report “qualifying cases to the Healthcare Integrity & Protection Databank [HIPDB], the NPDB, or successor data bases.” The HIPDB and the NPDB merged in 2013; therefore, OIG reviewed the reporting of adverse actions under NPDB requirements. See 78 Fed. Reg. 20473 (April 5, 2013).

actions submitted late, 4 were submitted within 31 to 60 days after sentencing and 2 were submitted more than 90 days after sentencing.

The NPDB is intended to restrict the ability of physicians, dentists, and other health care practitioners to move from State to State without disclosure or discovery of previous medical malpractice and adverse actions. If a Unit fails to report adverse actions to the NPDB, individuals may be able to find new health care employment with an organization that is not aware of the adverse action taken against them.

## **The Unit's MOU with the State Medicaid agency generally reflected current practice, policy, and legal requirements with the exception of a regulatory requirement regarding procedures for the receipt of managed care referrals**

The New Mexico Office of the Attorney General and the State Medicaid agency had an MOU in place that was executed in February 2020. The MOU generally reflected current practice, policy, and legal requirements with the exception of the regulatory requirement that the Unit and the State Medicaid agency establish procedures by which the Unit will receive referrals of potential fraud from MCOs, if applicable.<sup>35</sup>

MFCU regulations effective on May 21, 2019, require the Unit and the Medicaid agency to agree to establish procedures by which the Unit will receive referrals of potential fraud from MCOs either directly or through the Medicaid agency.<sup>36</sup> We found that the New Mexico Unit's MOU did not include procedures by which the Unit would receive MCO referrals. During our review, the Unit director expressed her intent to revise the MOU to include such procedures.

## **Three Unit professional staff temporarily performed non-MFCU duties, and the Unit did not exclude the associated costs from claimed Unit expenditures**

Federal regulations state that a Unit may request Federal reimbursement only for costs attributable to the establishment and operation of the Unit.<sup>37</sup> Although OIG guidance permits Unit staff to temporarily engage in non-MFCU activities, the Unit must document and maintain records of the time spent on these activities, and

<sup>35</sup> 42 CFR § 1007.9(d)(3)(iv).

<sup>36</sup> Ibid.

<sup>37</sup> 42 CFR § 1007.19(d).

exclude the time from the Unit's claimed expenditures for purposes of Federal reimbursement.<sup>38</sup>

We found that in May 2018 and November 2019, a total of three Unit staff members performed activities that were not MFCU-related and that the Unit had not excluded the appropriate portion of the staff members' salaries from claimed Unit expenditures. In this case, the Unit staff members assisted another division of the Attorney General's Office with the execution of search warrants. Although the Unit documented and maintained records of the time spent on non-MFCU activities, it did not exclude the 14 total hours (equaling a Federal share of \$433) from its reimbursement request for the staff members' salaries. After our review, the Unit returned the Federal share of the associated costs.

<sup>38</sup> OIG, OIG State Fraud Policy Transmittal Number 2014-1. Accessed at [https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/policy\\_transmittals/State%20Fraud%20Policy%20Transmittal%20No%20%202014-1.pdf](https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/policy_transmittals/State%20Fraud%20Policy%20Transmittal%20No%20%202014-1.pdf) on April 5, 2021.



# CONCLUSION AND RECOMMENDATIONS

The New Mexico MFCU's case outcomes were low compared to those of similarly sized MFCUs during FYs 2017–2019. We identified several factors that contributed to the low case outcomes during the 3-year review period, many of which related to the Unit's frequent turnover of management and staff. We make several recommendations below that are designed to improve Unit operations and improve case outcomes.

Through our review, we found that staff turnover disrupted and negatively affected many aspects of Unit operations. The Unit did not take sufficient steps to ensure that it received quality referrals from the State Medicaid agency and other sources, which limited its number of cases with successful outcomes. The Unit also had significant investigative delays that affected its case outcomes. The Unit did not maintain regular communication and worked few cases jointly with Federal partners. Further, Unit management practices resulted in inconsistent periodic supervisory reviews and documentation in Unit case files, which potentially affected the progression of cases.

Additionally, we identified areas in which the Unit should improve its compliance with Federal regulations. We found that the Unit did not report all convictions and adverse actions to Federal partners within the appropriate timeframes. We also found that the Unit's MOU with the State Medicaid agency lacked procedures by which the Unit would receive managed care referrals. Lastly, we found that the Unit did not exclude costs associated with non-MFCU activities from its Federal reimbursement request.

To address the issues identified in this report and further improve Unit operations, we make eight recommendations to the New Mexico MFCU. OIG is also prepared to provide further technical assistance, and if necessary, to conduct follow-up to ensure that the recommendations are adequately implemented.

## **We recommend that the New Mexico MFCU:**

### **1. Develop and implement an action plan to reduce turnover of management and staff and to ensure continuity of Unit operations should turnover occur**

The Unit should examine in detail any possible institutional reasons for its low employee retention and develop an action plan to address the findings in this report regarding management and staff turnover. The plan should include provisions for improving employee retention as well as provisions for ensuring continuity of Unit operations and processes if the Unit experiences turnover in the future. In designing

the plan, the Unit should consult with OIG and address recommendations 2 through 6 below.

## **2. Develop and implement an action plan to ensure that the Unit receives adequate quality referrals of fraud and patient abuse or neglect**

The Unit should develop and implement a plan for conducting outreach efforts and providing education to referral sources, such as the State Medicaid agency, APS, and the Department of Health, to ensure that the Unit receives adequate quality referrals. As part of these efforts, the Unit should provide periodic feedback to the referral sources on the quality of their referrals, including the types of referrals the Unit would like to receive and helpful information to include in a quality referral. The Unit should also consider incorporating education on quality referrals into its in-house training to ensure that all Unit staff have the same expectations and can provide the same feedback to the referral sources. Additionally, to the extent possible, the Unit should continue to utilize its data mining authority to generate additional cases.

## **3. Ensure that investigations are completed within the appropriate timeframes and that delays are documented in the case files**

To avoid investigative delays and disruption to Unit casework, the Unit should take steps to ensure timely completion of preliminary and formal investigations and develop a process for quickly reassigning and prioritizing cases if turnover occurs. The Unit should also consider reducing the current 180-day preliminary investigation timeframe.

In addition, the Unit should improve access to case information and ensure that investigative activities, including any delays, are documented consistently in the case files. The Unit should also ensure that investigative delays are limited to situations imposed by resource constraints or other exigencies.

## **4. Improve communication and seek more opportunities to investigate cases jointly with Federal partners**

The Unit should build relationships and establish regular meetings or communication with OIG and other Federal agencies investigating or prosecuting health care fraud in the State, such as DEA, the FBI, and the U.S. Attorney's Office. The Unit should also seek more opportunities, as appropriate, to conduct casework jointly with Federal partners, although doing so may be challenging given the new statute. Increased communication and collaboration with Federal partners could result in additional fraud referrals to the Unit and more joint cases, both of which could improve the

Unit's case outcomes. To improve communication and increase joint casework, the Unit could inquire about receiving training from OIG's Office of Investigations and the U.S. Attorney's Office.

## **5. Ensure that supervisory reviews of case files are conducted periodically and documented in accordance with Unit policy**

The Unit should ensure that supervisory reviews of case files are conducted periodically, consistent with Unit policy, and documented in the case files. The Unit could consider implementing automatic reminders to ensure that reviews are conducted according to Unit policy and that documentation is maintained in the case files.

## **6. Ensure that all convictions and adverse actions are reported to Federal partners within the appropriate timeframes**

The Unit should ensure that it consistently reports all convictions to OIG within 30 days of sentencing and all adverse actions to the NPDB within 30 days of the action, or as soon as practicable if the Unit encounters delays in receiving the necessary information from the court. The Unit could train staff in reporting convictions and adverse actions to Federal partners and could implement automated reminders to alert Unit staff about when to report the convictions or adverse actions.

## **7. Revise the Unit's MOU with the State Medicaid agency to establish procedures by which the Unit will receive referrals of potential fraud from MCOs**

To ensure compliance with Federal regulations, the Unit should revise its MOU with the State Medicaid agency to establish procedures by which the Unit will receive referrals of potential fraud from MCOs either directly or through the Medicaid agency.

## **8. Ensure that costs associated with non-MFCU activities are excluded from the Unit's Federal reimbursement request**

The Unit should ensure that it excludes all future costs not related to the establishment or operations of the Unit from its MFCU grant reimbursement requests. For example, the Unit should consider incorporating processes for appropriately tracking and excluding unallowable costs into its policies and procedures manual and should train Unit management and staff on the costs that are allowable under the MFCU grant.

# UNIT COMMENTS AND OIG RESPONSE

The New Mexico MFCU concurred with all eight of our recommendations, but expressed that it faces challenges that may impact the Unit's performance. OIG will seek to work with the Unit to address these challenges and to implement the recommendations in this report.

First, the Unit concurred with our recommendation to develop and implement an action plan to reduce turnover of management and staff and to ensure continuity of Unit operations should turnover occur. The Unit reported that it has developed an action plan to improve management and staff retention. As part of this plan, the Unit is developing procedures for recruitment, onboarding, cross-training, and in-house Medicaid training, as well as conducting regularly scheduled meetings with Unit staff. The Unit also reported that the New Mexico Office of the Attorney General is now part of the New Mexico State personnel system. The Unit stated that this change will assist the Unit in implementing the employee retention plan by ensuring that nondirector Unit employees may only be removed for cause, thus providing staff with increased job security and stability.

Second, the Unit concurred with our recommendation to develop and implement an action plan to ensure that the Unit receives adequate quality referrals of fraud and patient abuse or neglect. The Unit reported that it has implemented an action plan to improve relationships with potential referral sources such as State and Federal agencies. The Unit reported that the plan includes conducting regularly scheduled meetings with potential referral sources and providing them with a written description of the types of cases the Unit will pursue. The Unit also reported that it has worked with State partners to improve the quality of referrals by ensuring that referrals are within the Unit's authority and contain sufficient information and requisite support to aid in conducting an investigation. Moreover, the Unit noted that it has implemented a procedure to notify referral sources of the reason(s) it may decline to open specific referrals as investigations. Additionally, the Unit reported hiring an intake manager and outreach coordinator, who has developed outreach materials to provide to potential referral sources.

Third, the Unit concurred with our recommendation to ensure that investigations are completed within the appropriate timeframes and that delays are documented in the case files. The Unit reported that in 2020, its management began reviewing, documenting, and assigning all referrals and complaints within 1 week of receipt. The Unit also reported that Unit managers now review open investigations during weekly and quarterly team meetings to track case progression and address delays in a timely manner.

Fourth, the Unit concurred with our recommendation to improve communication and seek more opportunities to investigate cases jointly with Federal partners. The Unit reported that it has begun meeting regularly with the Assistant U.S. Attorney in

Albuquerque and is working with the FBI's health care fraud unit and DEA. The Unit also reported that it has implemented a new case deconfliction and parallel proceedings process that it plans to use together with data mining to identify and propose potential joint investigations to Federal partners.

Fifth, the Unit concurred with our recommendation to ensure that supervisory reviews of case files are conducted periodically and documented in accordance with Unit policy. The Unit reported that its new data management system helps the Unit ensure that supervisory reviews are consistently and efficiently documented. The Unit noted that it will amend its policy to reflect the current practice of documenting supervisory reviews at least every 90 days. The Unit also reported that supervisors conduct a 180-day review management meeting for all open referrals to promote awareness of pending deadlines.

Sixth, the Unit concurred with our recommendation to ensure that all convictions and adverse actions are reported to Federal partners within the appropriate timeframes. The Unit reported that it has instituted monthly status meetings to promote timely reporting to the OIG and the NPDB. The Unit also reported that in 2020, Unit staff received training on the proper reporting protocol and have cross-trained to ensure consistency in reporting in the event of turnover.

Seventh, the Unit concurred with our recommendation to revise the Unit's MOU with the State Medicaid agency to establish procedures by which the Unit will receive referrals of potential fraud from MCOs. The Unit reported that the Unit director is working with the State Medicaid agency on amendments to establish procedures by which the Unit will receive referrals of potential fraud from the MCOs.

Eighth, the Unit concurred with our recommendation to ensure that costs associated with non-MFCU activities are excluded from the Unit's Federal reimbursement request. The Unit reported that it recently briefed staff on the proper procedure for conducting work outside of the Unit and will remind staff on a quarterly basis in the Unit's monthly staff meetings. The Unit also reported that it has informed management within the Attorney General's Office of these requirements.

This summary is based on the Unit's comments (see Appendix E) and additional follow-up with Unit management.

# APPENDIX A

## Performance Assessment

We assessed the New Mexico MFCU's adherence to applicable laws, regulations, policy transmittals, and each of the MFCU performance standards. From this review, we identified eight findings (they are presented here and in the body of the report). We also made observations about Unit operations and practices that are included in this appendix. The complete MFCU performance standards, including performance indicators, were published at 77 Fed. Reg. 32645 (June 1, 2012), and appear on OIG's website at <https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/>.

### STANDARD 1

A Unit conforms with all applicable statutes, regulations, and policy directives.

### Observation

**From the information we reviewed, we identified three compliance-related concerns.** We found that the Unit did not consistently report convictions and adverse actions to Federal partners within the appropriate timeframes, which potentially delayed the process for excluding providers from the Federal health care programs (see page 16). We found that the Unit's MOU with the State Medicaid agency lacked procedures by which the Unit would receive managed care referrals (see page 17). Finally, we found that the Unit did not exclude costs associated with non-MFCU activities from its Federal reimbursement request (see page 17). For each of these findings, we include recommendations in the body of the report to ensure that the Unit corrects the issues. We also made findings and recommendations related to compliance concerns during our previous, onsite review of the Unit in 2014.<sup>39</sup>

<sup>39</sup> OIG's 2014 onsite review of the New Mexico Unit included five findings and four recommendations. Prior to the release of the report, the Unit provided OIG with an updated MOU with the State Medicaid agency that reflected current law and practice, and worked with OIG to correct the financial issues identified during the review. As such, recommendations for these two findings were not included in the final report.

## STANDARD 2

A Unit maintains reasonable staff levels and office locations in relation to the State's Medicaid program expenditures and in accordance with staffing allocations approved in its budget.

### Finding

The Unit experienced significant turnover of management and staff during FYs 2017–2019, which hampered its operations and performance. See page 9.

### Observation

The Unit maintained adequate staffing levels and the Unit's professional staff had extensive backgrounds related to their field. Despite frequent turnover of management and staff, we found that the Unit's total staff levels were comparable to those of other MFCUs in relation to the State's Medicaid program expenditures and remained relatively constant, ranging from 21 to 23 employees at the end of each fiscal year during our review period. We also found that most employees had extensive experience relevant to their respective professions. For example, the Unit's Special Agent in Charge had been employed with the Unit for more than 16 years, and all special agents had previous experience in law enforcement. The Unit's nurse investigators had previously worked as nurses in medical facilities. All Unit attorneys had previous experience in white collar or health care-related crimes. Further, many staff previously worked with MFCU stakeholders, such as the State Medicaid agency, the FBI, the District Attorney's Office, and local law enforcement agencies. For example, the current Unit director was previously employed as an attorney at the State Medicaid agency and had existing relationships with staff at the agency at the time of our review.

## STANDARD 3

A Unit establishes written policies and procedures for its operations and ensures that staff are familiar with, and adhere to, policies and procedures.

### Observation

**The Unit maintained written policies and procedures.** The Unit maintained a Policies and Procedures Resource Guidebook that was available to Unit staff on a shared network drive. The manual was last updated in 2014. The Unit also maintained discipline-specific procedures manuals, such as investigations and litigations guidebooks, which were updated in 2018. Although the Unit maintained written policies and procedures for its operations, OIG observed that some policies and procedures, particularly with regard to periodic supervisory reviews (see page 15) and reporting convictions and adverse actions to Federal partners within the appropriate timeframes (see page 16), were not consistently applied by Unit management during our review period.



**STANDARD 4**

A Unit takes steps to maintain an adequate volume and quality of referrals from the State Medicaid agency and other sources.

**Finding**

The Unit did not take sufficient steps to ensure that it received quality referrals from the State Medicaid agency and other sources, which limited the number of cases with successful outcomes. See page 10.

**STANDARD 5**

A Unit takes steps to maintain a continuous case flow and to complete cases in an appropriate timeframe based on the complexity of the cases.

**Finding**

The Unit had significant investigative delays, which affected its case outcomes. See page 12.

**Observation**

All case files contained documentation of supervisory approval of the opening and closing of investigations. According to Performance Standard 5(b), supervisors should approve the opening and closing of all investigations, review the progress of cases, and take action as necessary to ensure that each stage of the investigation and prosecution is completed within an appropriate timeframe. Our review found that all of the sampled case files contained documentation of supervisory approval of case openings and closings. See Appendix D for the point estimates and the confidence intervals for the case file reviews.

**STANDARD 6**

A Unit's case mix, as practicable, covers all significant provider types and includes a balance of fraud and, where appropriate, patient abuse and neglect cases.

**Observation**

The Unit's case mix included both cases of fraud and cases of patient abuse or neglect, but the Unit worked a disproportionate number of cases involving personal care services. Of the Unit's 564 cases that were open during FYs 2017–2019, 92 percent (518 cases) involved provider fraud and 8 percent (46 cases) involved patient abuse or neglect. Although the Unit's open fraud cases covered 40 different provider types (e.g., nursing facilities and pharmacies), more than a quarter (29 percent) of the Unit's fraud cases involved PCS agencies and attendants. During the 3-year period, all but one of the Unit's fraud indictments and all of its fraud convictions involved PCS providers.

Unit management attributed the high number of PCS fraud cases to stakeholders referring a disproportionate number of PCS referrals to the Unit. While investigation of PCS fraud is important, Performance Standard 6(c) states that the Unit should allocate its resources among provider types on the basis of levels of Medicaid expenditures or other risk factors.

A diverse case mix also allows for a broader range of on-the-job training opportunities for new Unit investigators.

#### STANDARD 7

A Unit maintains case files in an effective manner and develops a case management system that allows efficient access to case information and other performance data.

#### Finding

Unit management practices resulted in inconsistent periodic supervisory reviews and documentation in Unit case files. See page 15.

#### STANDARD 8

A Unit cooperates with OIG and other Federal agencies in the investigation and prosecution of Medicaid and other health care fraud.

#### Findings

The Unit did not maintain regular communication and worked few cases jointly with Federal partners. See page 13.

The Unit did not report all convictions and adverse actions to Federal partners within the appropriate timeframes. See page 16.

#### STANDARD 9

A Unit makes statutory or programmatic recommendations, when warranted, to the State government.

#### Observation

The Unit made several recommendations to the State Medicaid agency during our review period. Performance Standard 9(b) states that a Unit, when it is warranted and appropriate, should make recommendations regarding program integrity issues to the State Medicaid agency. During FYs 2017–2019, the New Mexico Unit made 15 recommendations to the State Medicaid agency. The Unit recommended, among other items, that the State Medicaid agency (1) revise regulations to include additional screening and training requirements for caregivers; (2) require that out-of-state laboratories be paid only for tests that correspond to codes listed as their specialty/subspecialty in the Certification of Compliance; and (3) require MCOs to refer any fraud detected as a result of member audits immediately to the Unit and the New Mexico Department of Health. As a result of the third recommendation, the Unit worked with the State Medicaid agency to clarify the MCO referral process, which led to an update to the managed care contract language specifying a timeframe for reporting fraudulent activities. The Unit reported that it was in discussions with the State Medicaid agency regarding implementation of several other recommendations.<sup>40</sup> Unit management also stated that the

<sup>40</sup> At the time of OIG's review, the State Medicaid agency had not yet implemented any of the Unit's recommendations.

outreach and training coordinator, hired in August 2020, will conduct further outreach regarding implementation of program recommendations.

#### STANDARD 10

A Unit periodically reviews its Memorandum of Understanding (MOU) with the State Medicaid agency to ensure that it reflects current practice, policy, and legal requirements.

#### Finding

The Unit's MOU with the State Medicaid agency generally reflected current practice, policy, and legal requirements with the exception of a regulatory requirement regarding procedures for the receipt of managed care referrals. See page 17.

#### STANDARD 11

A Unit exercises proper fiscal control over its resources.

#### Finding

Three Unit professional staff temporarily performed non-MFCU duties, and the Unit did not exclude the associated costs from claimed Unit expenditures. See page 17.

#### STANDARD 12

A Unit conducts training that aids in the mission of the Unit.

#### Observation

During part of our review period, the Unit's training plan did not include minimum training hour requirements for each professional discipline. Performance Standard 12(a) states that a Unit should maintain a training plan for each professional discipline that includes an annual minimum number of training hours and that is at least as stringent as required for professional certification. During FYs 2017–2018, the Unit's training plan included minimum training hours for each professional discipline. However, during FY 2019, the Unit submitted a revised training plan that lacked minimum training hour requirements for each professional discipline. Specifically, the Unit's training plan contained a required minimum number of Medicaid fraud-related training hours for all staff, but lacked hourly requirements for investigators, attorneys, and auditors. Although the revised training plan lacked minimum training hours, most staff continued to meet or exceed the minimum training hour requirements contained in the Unit's previous training plan. After our review, the Unit revised its training plan to include minimum training hour requirements that are at least as stringent as those required for professional certification.

# APPENDIX B

## New Mexico MFCU Referrals Received, by Source, for FYs 2017–2019

Exhibit B-1: New Mexico Unit referrals received during FYs 2017–2019, separated by source and FY

Referral Source	FY 2017		FY 2018		FY 2019		3-Year Total		Total
	Fraud	Abuse & Neglect <sup>1</sup>	Fraud	Abuse & Neglect	Fraud	Abuse & Neglect	Fraud	Abuse & Neglect	
Adult Protective Services	29	147	8	106	8	137	45	390	435
Anonymous	1	2	2	1	1	0	4	3	7
Dept. of Health	21	1	13	0	0	0	34	1	35
HHS—Office of Inspector General (OIG)	2	1	1	0	2	0	5	1	6
Licensing Board	0	0	0	0	0	0	0	0	0
Local Prosecutor	1	0	0	0	0	0	1	0	1
Long-Term Care Ombudsman	0	0	0	0	1	0	1	0	1
Managed Care Organizations	0	0	0	0	0	0	0	0	0
Medicaid Agency Program Integrity Unit (HSD-OIG)	70	2	121	2	64	11	255	15	270
Medicaid Agency Other	14	3	3	3	9	7	26	13	39
Other Law Enforcement	5	1	4	1	2	1	11	3	14
Private Citizens	58	88	57	54	119	63	234	205	439
Private Health Insurer	0	0	0	0	0	0	0	0	0
Provider	1	0	1	0	0	0	2	0	2
Provider Association	0	0	0	0	0	0	0	0	0
State Agency Other	58	1	13	2	3	0	74	3	77
Other	20	3	202	2	100	1	322	6	328
<b>Total</b>	<b>280</b>	<b>249</b>	<b>425</b>	<b>171</b>	<b>309</b>	<b>220</b>	<b>1,014</b>	<b>640</b>	<b>1,654</b>

Source: OIG analysis of Unit Annual Statistical Reports for FYs 2017–2019.

<sup>1</sup>The category “Abuse & Neglect” includes patient fund referrals.

# APPENDIX C

## Detailed Methodology

The review team consisted of OIG evaluators, agents, a grant oversight analyst, and a director from another State MFCU. Our pre-review analysis identified low case outcomes as an area of concern. To assist the Unit in identifying ways to improve its case outcomes, we focused our data collection and analysis primarily on the factors that contributed to low case outcomes during FYs 2017–2019.

We analyzed qualitative and quantitative data from a variety of sources, including:

- case outcome data;
- referral data;
- other documentation, such as policies and procedures;
- structured interviews with key stakeholders and MFCU staff;
- review of case files;
- review of Unit submissions to OIG and the NPDB; and
- documentation related to the MFCU's fiscal controls.

## Data Collection and Analysis

**Review of case outcome data.** Prior to our review, we examined statistical reports and other documentation that the MFCU submitted to OIG. This included Unit case outcome data pertaining to the 3-year review period (FYs 2017–2019). We examined five case outcome measures: (1) the number of indictments of fraud and patient abuse or neglect; (2) the number of convictions of fraud and patient abuse or neglect; (3) the amount of monetary recoveries associated with criminal convictions; (4) the number of civil settlements and judgments; and (5) the amount of monetary recoveries associated with civil cases. We also compared the Unit's case outcomes to those of other MFCUs with similar staff sizes and expenditures during FYs 2017–2019.

**Exhibit C-1: New Mexico MFCU case outcomes during FYs 2017–2019 compared to those of other similarly sized MFCUs**

Type of Case	Outcome	New Mexico MFCU	Median of Similarly Sized MFCUs
Criminal	Indictments	24	69
	Fraud convictions	11	42
	Patient abuse or neglect convictions	2	16
	Criminal recoveries	\$24,874	\$5,007,858
Nonglobal Civil	Settlements and judgments	18	15
	Recoveries	\$1,574,823	\$6,059,000
Global Civil	Settlements and judgments	26	30
	Recoveries	\$5,428,941	\$21,626,428

Source: OIG analysis of Annual Statistical Reports.

**Referrals of fraud and patient abuse or neglect.** We examined data associated with the referrals of fraud and patient abuse or neglect that the Unit received from a variety of sources. This included the number of referrals that the Unit reported receiving during FYs 2017–2019 and the number of referrals received by other similarly resourced MFCUs during the same 3-year period. We also examined the processes that the Unit used for monitoring the opening of cases, as well as its processes for ensuring the receipt of adequate volume and quality of referrals from the State Medicaid agency as outlined in the Unit’s MOU with the State Medicaid agency.

**Other documentation.** We examined the Unit’s policies and procedures and held discussions with Unit management to gain an understanding of those policies and procedures. We also examined data associated with the Unit’s staff, both to identify the number of Unit staff and to determine how long each staff member had been with the Unit during FYs 2017–2019. Finally, we analyzed data on annual training to evaluate the Unit staff’s adherence to its training plans.

**Interviews with key stakeholders.** In August and September 2020, we interviewed five key stakeholders who were familiar with the Unit’s operations, including officials in the New Mexico State Medicaid Program Integrity Unit, the New Mexico Department of Health, the New Mexico Aging and Long-Term Services Department, the U.S. Attorney’s Office, and the FBI. We also interviewed Special Agents from OIG’s Office of Investigations in Dallas. We focused these interviews on the Unit’s relationship and interaction with the stakeholders as well as opportunities for improvement. We used the information from these interviews to develop subsequent interview questions for Unit management and followed up with stakeholders as needed.

**Interviews with Unit management and staff.** In September 2020, we conducted structured interviews with 16 Unit staff, including the director, attorneys, and

investigative supervisors. We also interviewed staff in the Attorney General's Office; these included the Chief Deputy of the Criminal Affairs Division, who is the supervisor of the Unit director, and the Director of the Special Investigations Division. These interviews focused on case outcomes—specifically, why they were low during FYs 2017–2019 and how to improve them. The interviews were informed by OIG's analysis of the Unit's case outcomes data, other documentation, and stakeholder interviews. We asked Unit staff to provide us with any additional context that could help us understand the Unit's operations. After our review, we followed up with the Unit director to clarify certain data and to gather further information.

**Review of case files.** We asked the Unit to provide us with a list of cases that were open at any point during FYs 2017–2019, and we asked the Unit to include the current status of those cases; whether the case was criminal, civil, or global; and the dates on which the case was opened and closed, if applicable. The total number of cases that met these parameters was 373. We excluded a total of 155 global cases because they were civil false claims actions that typically involve multiple agencies, such as the U.S. Department of Justice and a group of State MFCUs.

From the 218 remaining case files, we selected a simple random sample of 76 cases. This sample allowed us to make estimates of the overall percentage of case files with various characteristics with an absolute precision of +/- 10 percent at the 95-percent confidence level. With the assistance of OIG agents and the MFCU director from another State, we reviewed the Unit's processes for monitoring the opening, status, and outcomes of these 76 cases. We also reviewed the Unit's approach to investigating and prosecuting cases that were open at some point during FYs 2017–2019. Throughout the review of the sampled cases, we consulted Unit staff to address any apparent issues with individual case files, such as missing documentation.

**Review of Unit submissions to OIG and the NPDB.** We reviewed all convictions submitted to OIG for program exclusion and all adverse actions submitted to the NPDB during FYs 2017–2019 and assessed the timeliness of these submissions.

**Review of Unit financial documentation.** We conducted a limited review of the Unit's control over its fiscal resources. Prior to our review, we analyzed the Unit's response to an internal controls questionnaire and conducted a review of the Unit's financial status reports. We followed up with Unit officials to clarify issues identified in the internal controls questionnaire.



# APPENDIX D

## Point Estimates and 95-Percent Confidence Intervals of Case File Reviews

**Exhibit D-1: Estimates for All Case File Reviews**

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower	Upper
Percentage of All Cases That Had Supervisory Approval To Open	76	100.0%	95.9%	100.0%
Percentage of All Cases Closed at the Time of Our Review	76	73.7%	64.2%	81.7%
Percentage of All Closed Cases That Had Supervisory Approval To Close	56	100.0%	94.4%	100.0%
Percentage of All Cases Open Longer Than 60 Days	76	97.4%	91.7%	99.1%
Percentage of All Cases With a Referral Stage Longer Than 180 Days	76	65.8%	56.0%	74.8%
Percentage of All Cases That Had Significant Investigative Delays	76	51.3%	41.3%	61.0%

Source: OIG analysis of New Mexico Unit case files, 2020.

**Exhibit D-2: Estimates for Case Files Open Longer Than 60 Days**

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower	Upper
Percentage of All Cases Open Longer Than 60 Days That Had Documentation of Supervisory Reviews Consistent With Unit Policy (i.e., Every 60 Days or More Frequent)	74	17.6%	10.8%	26.4%
Percentage of All Cases Open Longer Than 60 Days That Did Not Contain Documentation of Supervisory Reviews Consistent With Unit Policy	74	82.4%	73.6%	89.2%
Percentage of All Cases Open Longer Than 60 Days That Had Documentation of Supervisory Reviews, But Were Inconsistent With Unit Policy	74	75.7%	66.0%	83.5%
Percentage of All Cases Open Longer Than 60 Days That Lacked Documentation of Any Supervisory Review	74	6.8%	2.8%	13.7%

Source: OIG analysis of New Mexico Unit case files, 2020.

# APPENDIX E

## Unit Comments

**STATE OF NEW MEXICO**  
OFFICE OF THE ATTORNEY GENERAL



**HECTOR H. BALDERAS**  
**ATTORNEY GENERAL**

August 27, 2021

Ms. Susan Murrin  
Deputy Inspector General for Evaluation and Inspections  
U.S. Department of Health and Human Services  
Sent by email to [Jordan.Clementi@oig.hhs.gov](mailto:Jordan.Clementi@oig.hhs.gov)

*RE: New Mexico MFCU 2020 Onsite Review (OEI-06-20-00550)*

Dear Ms. Murrin:

Thank you for the New Mexico State Medicaid Fraud Control Unit: 2020 Onsite Review, OEI-06-20-00550, and for providing us an opportunity to respond to your team's draft report. We appreciate the opportunity presented by the review and report findings to improve the way in which our Unit functions. We thank your team for the thorough, courteous and professional manner in which the review was conducted.

As reflected in the 2020 Onsite Review report, New Mexico MFCU was selected for enhanced review because statistical data showed the Unit's performance compared negatively with other units of similar size and resources. I want to address this before commenting on the recommendations. New Mexico has certain challenges that are quite unique to this state. The OIG's comparison of the MFCU with other "similarly sized" MFCUs may not be a terribly helpful comparison given these unique challenges. First, the judiciary is most reluctant to impose incarceration on white collar criminals. Second, the managed care organization (MCO) contracts with the single state agency prevent direct referral from the MCO to the MFCU. Additionally, there continues to be confusion about what types of conduct should be referred out as "fraud", and whether the MCO or the Medicaid Single State Agency (HSD), through the MFCU, should recover the funds. It should be noted that a significant number of the referrals received from the single state agency are personal care timesheet fraud cases and not provider agency fraud cases. Further, private citizens account for the majority of fraud referrals to the MFCU and these referrals are not accompanied by a preliminary investigation from a state or federal oversight agency. These referrals require that an investigation be completed by the MFCU from inception and while these investigations require significant resources, many of these matters result in closure for lack of supporting evidence. Third, state law was passed in December 2020 that requires HSD to provide a notice of right to informal conference and an expedited adjudicatory proceeding when it makes a determination of overpayments or credible allegation of fraud. See Section 27-11-7 NMSA. This notice requirement must be met before the matter is referred to the MFCU. This means a significant delay in referral to the MFCU and provides a "heads-up" that the provider is under investigation. With OIG/OEI's support, the MFCU plans to work with CMS Program Integrity to get support in

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MAILING ADDRESS: P.O. BOX 1508 - SANTA FE, NEW MEXICO 87504-1508  
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its efforts to work on the problematic aspects of this new law.

We offer the following in response to the recommendations:

**Recommendation:** Develop an action plan to reduce turnover of management and staff and to ensure continuity of Unit operations should turnover occur.

**Comments:** We concur with this recommendation. The Unit did experience challenges with turnover of management and staff during the audit period. Since the audit period, the Unit has instituted changes meant to improve management and staff retention. These changes have resulted in significant improvement. Director [REDACTED] and Deputy Director [REDACTED], who began their management of the Unit in 2020, developed an action plan to improve on employee retention. This plan includes developing procedures to obtain a better pool of applicants and to personalize the onboarding process with targeted training and mentoring. It also includes cross-training, conducting regularly scheduled weekly, monthly and quarterly in-person and remote meetings with individuals, teams and the entire Unit staff. Employees receive recognition in these meetings, informally and through our "kudos" process. The monthly staff meetings also encourage loyalty building comradery. In-office Medicaid training is now part of the retention plan. They provide reassuring knowledge to employees through examination of complex concepts. Finally, the Office of the Attorney General is now part of the New Mexico state personnel system. This change will assist in the implementation of the employee retention action plan because non-director employees are now classified, meaning they can only be removed for cause. Classified employees are provided increased job security and a sense of long-term career stability.

**Recommendation:** Develop and implement an action plan to ensure that the Unit receives quality referrals of fraud and patient abuse or neglect.

**Comments:** We concur with this recommendation. However, as explained in paragraph two above, the MFCU has unique challenges in this area. Turnover in management and staff during the audit period made it difficult for the Unit to maintain consistent contact with potential sources of quality referrals. Since early 2020, an action plan has been implemented to improve relationships with the New Mexico single state agency's OIG, sister agencies, licensing boards, and federal partners. The plan, which is already in process, includes conducting regularly scheduled meetings with partner agencies and providing a written summary of MFCU jurisdiction. Further, [REDACTED], as intake manager and outreach coordinator, has developed reader-friendly posters and pamphlets to provide to care facilities, agencies and other potential sources of quality referrals. Lastly, as part of the plan, the Unit has implemented a procedure to notify complainants and referring agencies of the reason a matter was not accepted by the Unit. This informs them of the types of cases under the Unit's authority as well as ensures that the referring agencies can pursue other administrative action as appropriate.

**Recommendation:** Ensure that supervisory reviews of case files are conducted periodically and

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documented in accordance with Unit policy.

**Comments:** We concur with this recommendation. With the incorporation of our new data management system, IMS, we are now able to ensure the Unit is consistently and efficiently document supervisory reviews. Director [REDACTED] and Deputy Director [REDACTED] notate all supervisory activities including meeting on cases and reviewing and signing of CROCs and closure reports. Special Agents in Charge [REDACTED] and [REDACTED] routinely add notations on matters when they are reviewed with the investigation teams or when reports are reviewed. [REDACTED], as intake supervisor, notates all matter opening and closing supervisory activities. Unit policy will be amended to mirror our current practice of documenting case review at least every 90 days and ensure the target dates and deadlines are being met. A 180-day review management meeting is held to keep managers aware of pending deadlines.

**Recommendation:** Ensure that investigations are completed within the appropriate timeframes and that delays are documented in the case files.

**Comments:** We concur with this recommendation. We incorporate our comments made to the immediately above quoted recommendation on IMS documenting into these recommendation comments. In addition, since the beginning of 2020 the Unit has successfully ensured referrals and complaints are reviewed and documented by management within one week of receipt. During referral review, the management team considers the resources available and specialized knowledge necessary to complete the referred investigation in order to make efficient assignments. Further, the Unit is working with the single state agency, managed care organizations, and other referring partner agencies to improve the quality of referrals, including ensuring referrals are within the Unit's authority, contain sufficient information to aide in conducting an investigation, and that requisite support is provided throughout the course of the investigation. Accepted matters are reviewed and documented by the SAiCs in weekly team meetings, and by management in quarterly team meetings and before the 180-day Legislative Finance Committee reporting deadline, in order to track progression, assign additional resources if necessary, and address delays timely.

**Recommendation:** Improve communication and seek more opportunities to investigate joint cases with Federal partners.

**Comments:** We concur with this recommendation. The Unit acknowledges it has and continues to have challenges investigating joint cases with our Federal partners. Past inconsistent management has been one issue. Lack of interest from our Federal partners has been another issue. Steps taken since the onsite review have been to set up regular meetings with the AUSA in Albuquerque, working with FBI's healthcare fraud unit, and working with the DEA on overprescribing and COVID-19 testing cases. The Unit has offered investigation and special agent assistance and will continue to do so. Additional steps include the Unit's newly implemented deconfliction/parallel proceedings process. Through deconfliction and data mining, the Unit will identify matters on

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STREET ADDRESS: 408 GALISTEO STREET - SANTA FE, NEW MEXICO 87501



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which we can reach out to our Federal partners to propose joint investigations.

**Recommendation:** Ensure that all convictions and adverse actions are reported to Federal partners within the appropriate timeframes.

**Comments:** We concur with this recommendation. To ensure that reports to the OIG and NPDB are timely made, the Unit has instituted regularly scheduled monthly meetings to go over status. In 2020 Unit staff attended a training on the proper reporting protocol for OIG and have cross trained to ensure consistency in reporting in the event of staff changes.

**Recommendation:** Revise the Unit's MOU with the state Medicaid agency to establish procedures by which the Unit will receive referrals of potential fraud from MCOs.

**Comments:** We concur with this recommendation. Director [REDACTED] has reviewed the MCO contract with HSD, and the MOU between the MFCU and HSD-OIG. She is working with HSD on amendments to establish procedures by which the Unit will receive referrals of potential fraud from the MCOs given the unique challenges explained in paragraph two above.

**Recommendation:** Ensure that costs associated with non-MFCU activities are removed from the Unit's Federal reimbursement request.

**Comments:** We concur with this recommendation. To ensure that costs associated with non MFCU activities are not included in the Unit's Federal reimbursement request, Director [REDACTED] in a recent monthly meeting, went over the proper procedure for conducting work outside the Unit. To ensure compliance, she will repeat the information and procedure on a quarterly basis in the Unit's monthly meeting. The procedure includes obtaining management approval ahead of time and then management reporting all time devoted to non-Unit work to the MFCU budget manager to ensure federal funds are not expended on non-MFCU activities. To future ensure compliance, non-MFCU directors have also been made aware of these requirements.

The New Mexico MFCU appreciates the efforts of HHS/OIG to ensure the quality and standards of each MFCU, and welcomes the opportunity for improvement. We have made efforts to address each recommendation, and will continue to strive to meet all performance standards. Thank you for your time and effort spent on this review.

Sincerely,

Constance  
Tatham

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Constance Tatham  
Date: 2021.08.27 11:11:40  
-06'00'

Constance G. Tatham  
Director

New Mexico Medicaid Fraud Control Unit

TELEPHONE: (505)490-4060 FAX: (505)490-4883 [www.nmaq.gov](http://www.nmaq.gov)  
MAILING ADDRESS: P.O. BOX 1508 - SANTA FE, NEW MEXICO 87504-1508  
STREET ADDRESS: 408 GALISTEO STREET - SANTA FE, NEW MEXICO 87501

# ACKNOWLEDGMENTS AND CONTACT

## Acknowledgments

Jordan Clementi served as the team leader for this study, and Anna Brown and Kristen Calille served as the lead analysts. Office of Evaluation and Inspections staff who provided support include Kevin Farber, Anthony Soto McGrath, and Sara Swisher.

We would also like to acknowledge the contributions of other Office of Inspector General staff, including special agents from the Office of Investigations.

This report was prepared under the direction of Ruth Ann Dorrill, Regional Inspector General for Evaluation and Inspections in the Dallas regional office, and Petra Nealy, Deputy Regional Inspector General, as well as in consultation with Richard Stern, Director of the Medicaid Fraud Control Policy and Oversight Division.

## Contact

To obtain additional information concerning this report, contact the Office of Public Affairs at [Public.Affairs@oig.hhs.gov](mailto:Public.Affairs@oig.hhs.gov). OIG reports and other information can be found on the OIG website at [oig.hhs.gov](http://oig.hhs.gov).

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U.S. Department of Health and Human Services  
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