CALENDAR YEAR 2015: NEW MEXICO HUMAN SERVICES DEPARTMENT

CENTENNIAL CARE PROGRAM

Claims Adjudication, Prior Authorization, Provider Credentialing, and Contract Loading by Managed Care Organizations

Independent Accountant’s Report on Applying Agreed-Upon Procedures

EXECUTIVE SUMMARY

March 10, 2016
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The following terms are used throughout this document:

- **Adjudicate** – A determination by the MCO of the outcome of a Medicaid claim submitted by a Medicaid provider. Claims may pay, deny, or in some cases have an alternative adjudication outcome.

- **Appeal** – A request by a member or provider for review by the MCO of an MCO action. This may include provider payment, contractual issues and/or Utilization Management decisions.

- **Blue Cross and Blue Shield of New Mexico (BCBS)** – A Medicaid Managed Care Plan contractually engaged with the State of New Mexico Human Services Department.

- **Claim** – A bill for services submitted to the MCO manually or electronically, a line item of service on a bill, or all services for one member within a bill.

- **Claim Adjudication** – the determination of the MCO’s payment or financial responsibility, after the member’s insurance benefits are applied to a claim.

- **Claims Processing System** – A computer system or set of systems that determine the reimbursement amount for services billed by the Medicaid provider and adjudicates claims according to the applicable coverage and payment policies.

- **Claims Universe** – The population parameters for claims to be tested, including the type of claim, the categories of service, and paid dates.

- **Centennial Care** – The State of New Mexico’s Medicaid program operated under section 1115(a) of the Social Security Act waiver authority.

- **Clean Claim** – A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in HSD’s system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

- **Complaint** - Prior to Centennial Care, complaints were defined as any dissatisfaction resolved within 24 hours.

- **Credentialing** – The process of establishing the qualifications of licensed Medicaid providers, which may include the confirmation of their license, confirmation of their education, and determining eligibility to participate in government Medicaid programs.

- **Contract** – The written agreement between the HSD and the MCO or individual provider, clinic, group, association, vendor or facility employed by or contracted with the MCO to furnish medical, behavioral health or long-term care services to the MCO’s members; comprised of the Contract, any addenda, appendices, attachments, or amendments thereto.

- **Denied Claim** – A claim submitted by a Medicaid provider or noncontracted provider for reimbursement that is deemed by the MCO to be ineligible for payment.

- **Diagnosis Related Group (DRG)** - classification system used to derive payment amount for inpatient hospital services.
Encounter - A record of any claim adjudicated by the MCO or any of its subcontractors for a member, including Medicare claims for which there is no Medicaid reimbursement amount and/or a record of any service or administrative activity provided by the MCO or any of its subcontractors for a member that represents a member-specific service or administrative activity, regardless of whether that service was adjudicated as a claim or whether payment for the service was made.

Encounter Data - Information about claims adjudicated by the MCO for services rendered to its members. Such information includes whether claims were paid or denied and any capitated and subcapitated arrangements.

Fraud – An intentional deception or misrepresentation by a person or an entity, with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Grievance – An expression of dissatisfaction about any matter or aspect of the MCO or its operation, other than an MCO action.

I/T/U – The Indian Health Service, Tribal health providers, and Urban Indian providers, including facilities that are operated by a Native American/Alaskan Indian tribe, authorized to provide services as defined in the Indian Health Care Improvement Act, 25 U.S.C. 1601 et seq.

Managed Care Organization (MCO) – An entity that participates in Centennial Care under contract with HSD to assist the State in meeting the requirements established under NMSA1978, § 27-2-12.

Member – A person who has been determined eligible for Centennial Care and who has enrolled in the Contractor's MCO.

Molina Healthcare of New Mexico (Molina or MHC) – A Medicaid Managed Care Plan contractually engaged with the State of New Mexico Human Services Department.

New Mexico Human Services Department (HSD) – The New Mexico State governmental agency responsible for the administration of the State of New Mexico’s Medicaid Program pursuant to Title XIX of the Social Security Act.

National Provider Identifier (NPI) - is a unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS). The NPI has replaced the unique provider identification number (UPIN) as the required identifier for Medicare services, and is used by other payers, including commercial healthcare insurers. The transition to the NPI was mandated as part of the Administrative Simplifications portion of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and CMS began issuing NPIs in October 2006.

Overpayment – Any funds that a person or entity receives in excess of the Medicaid allowable amount of the MCO allowed amount as negotiated with the provider. Overpayments shall not include funds that have been (i) subject to payment suspension; (ii) identified as a third-party liability as set forth in Section 4.18.13; (iii) subject to the MCO’s system-directed mass adjustments, such as due to fee schedule changes; or (iv) for purposes of filing an “Overpayment Report” as required in Section 4.17.4.2.1 of the Medicaid Managed Care Services Agreement, less than fifty dollars ($50.00) or those funds recoverable through existing routine and customary adjustments using HIPAA complaint formats.
• **Paid Claim** – A claim submitted by a Medicaid provider or noncontracted provider for reimbursement that is deemed by the MCO to be eligible for payment.

• **Presbyterian Health Plan (PHP or Presbyterian)** – A Medicaid Managed Care Plan contractually engaged with the State of New Mexico Human Services Department.

• **Prior Authorization** – The process of reviewing a requested medical service or item to determine if it is medically necessary and covered under the member’s plan.

• **Program Integrity** - Refers to initiatives to monitor fraud, waste, and abuse cases, preliminary investigations, suspicious activities, adverse actions, and financial program integrity activities of the managed care organization.

• **Prospective Payment System (PPS)** – A method of reimbursement in which payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service – for example, diagnosis-related groups for inpatient hospital services.

• **Provider Contract Loading** – The length of time required to load the contractual payment terms for each participating provider into the payment system.

• **Remittance Advice (RA)** – A statement from a MCO to a member and/or Medicaid provider that includes information detailing the pricing and adjudication of a fee-for-service claim and/or claim detail. May also be referred to as the Explanation of Benefits (EOB).

• **Subcontractor** – A vendor who is overseeing or administering the approval, payment, and administration of medical services to the Centennial Care Program population on behalf of a MCO.

• **Subcontractor Oversight** – Policies and procedures to ensure that subcontractors supply the services agreed to under the financial terms and programmatic requirements outlined.

• **Underpayment** – A deficiency in funds received by a person or entity related to the Medicaid allowable amount of the MCO allowed amount as negotiated with the provider.

• **UnitedHealthcare Community Plan of New Mexico (UHC or UnitedHealthcare)** – A Medicaid Managed Care Plan contractually engaged with the State of New Mexico Human Services Department.

• **Utilization Management** - A system for reviewing the appropriate and efficient allocation of healthcare services that are provided, or proposed to be provided, to a member.
In January 2014, Centennial Care replaced previous New Mexico Medicaid Managed Care programs that included: Salud, CoLTS, and Optum. The former New Mexico Medicaid program operated under 12 separate federal waivers. Under the previous system, seven health plans were responsible for delivering healthcare services to one-quarter of New Mexico’s citizens. Centennial Care operates under a single, comprehensive, global 1115(a) demonstration waiver allowing the state to fund its Medicaid Managed Care program under a single budget and allows more effort to be spent on contractor oversight and compliance. New Mexico’s managed care enrollment is projected to reach 670,000 by May 2016.

Centennial Care changed the former Medicaid program by reducing the number of MCOs in the Medicaid program and requiring the MCOs to assume responsibility for the delivery of physical, behavioral and long-term health care services to Medicaid members. The 4 MCOs offering Centennial Care coverage are Blue Cross and Blue Shield of New Mexico, Molina Health Care of New Mexico, Inc., Presbyterian Health Plan, Inc., and UnitedHealthcare Community Plan of New Mexico.

Myers and Stauffer was engaged to assist the New Mexico Human Services Department (HSD), Medical Assistance Division (MAD), with monitoring and reporting of the Managed Care Organizations (MCO). We performed agreed upon procedures on the systems and processes as related to the following areas of the Centennial Care Program: claims adjudication; prior authorization; provider credentialing; and provider contract loading. Additional areas of concern addressed during the on-site were: complaints, appeals, and grievances; health plan compliance; program integrity; and subcontractor/delegated services monitoring.

The following table summarizes the policy assessment and testing results, where applicable, by each MCO. A detailed overview of the findings may be found on pages 8-17.

<table>
<thead>
<tr>
<th>PROFICIENCY AREA</th>
<th>BCBS</th>
<th>Molina</th>
<th>PHP</th>
<th>UHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims Adjudication Policy</td>
<td>Overall, the MCOs' claims adjudication policies are consistent with HSD contract requirements. Any exceptions are noted in the detailed reports for each MCO.</td>
<td>97% of the sample claims paid or denied correctly.</td>
<td>96% of the sample claims paid or denied correctly.</td>
<td>94% of the sample claims paid or denied correctly.</td>
</tr>
<tr>
<td>Inpatient Hospital Claims Testing Results</td>
<td>97% of the sample claims paid or denied correctly.</td>
<td>96% of the sample claims paid or denied correctly.</td>
<td>94% of the sample claims paid or denied correctly.</td>
<td>88% of the sample claims paid or denied correctly.</td>
</tr>
<tr>
<td>Prior Authorization (PA) Policy</td>
<td>Overall, the MCOs' prior authorization policies are consistent with HSD contract requirements. Any exceptions are noted in the detailed reports for each MCO.</td>
<td>- 99.6% of PA requests were approved. - Average number of days between a PA request and PA date for those records with authorization dates was 1.8 calendar days.</td>
<td>- 93.5% of PA requests were approved. - Average number of days between a PA request and PA date for those records with authorization dates was 4.3 calendar days after the removal of outlier requests.1</td>
<td>- 99.2% of PA requests were approved. - Average number of days between a PA request and PA date for those records with authorization dates was 1.6 calendar days.</td>
</tr>
<tr>
<td>PROFICIENCY AREA</td>
<td>BCBS</td>
<td>Molina</td>
<td>PHP</td>
<td>UHC</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Credentialing Policy</td>
<td>Overall, the MCOs' credentialing policies are consistent with HSD contract requirements. Any exceptions are noted in the detailed reports for each MCO.</td>
<td>- 100% of providers for which data was available were credentialed within the required 45 calendar days.</td>
<td>- Approximately 51.3% of providers were credentialed within the required 45 calendar days.</td>
<td>- Approximately 93.17% of providers were credentialed within the required 45 calendar days.</td>
</tr>
<tr>
<td>Credentialing Testing Results ²</td>
<td>- Average number of days to load a new provider contract was 22.16 calendar days.</td>
<td>- Average number of days to load a provider contract was 34.67 calendar days.</td>
<td>- Average number of days to load a long term care contract was 208 calendar days.</td>
<td>- Average number of days to load a hospital contract was 1.32 calendar days.</td>
</tr>
<tr>
<td>Provider Contract Loading Policy</td>
<td>The HSD contract does not contain specific provisions related to provider contract loading.</td>
<td>- Average number of days to load a long term care contract was 28.82 calendar days.</td>
<td>- Average number of days to load a hospital contract was 22.16 calendar days.</td>
<td>- Average number of days to load a hospital contract was 12.47 calendar days.</td>
</tr>
<tr>
<td>Provider Contract Loading Testing Results ³</td>
<td>- Average number of days to load a behavioral health provider contract was 17.45 calendar days.</td>
<td>- Average number of days to load a long term care contract was not available.</td>
<td>- Average number of days to load a hospital contract was 28.82 calendar days.</td>
<td>- Average number of days to load a behavioral health provider contract was 9.18 calendar days.</td>
</tr>
</tbody>
</table>

¹ Molina prior authorization data included 40 requests which were deemed "outliers" because they had an authorization date of 12/31/2078. These 40 cases were removed from the PA calculations.
² Complete and accurate testing of credentialing timeliness could not be performed due to data limitations. For details, see the credentialing section of this document. The percentage of providers credentialed within 45 calendar days includes providers with an application date prior or equal to their credentialing date.
³ BCBS did not include information on provider type with the data submission. Therefore, Myers and Stauffer was not able to distinguish contract load turnaround times specific to LTC, hospital, and behavioral health providers.
**Claims Adjudication.** Each MCO provided Myers and Stauffer with its existing policies and procedures related to adjudicating inpatient hospital claims and the claims processing/reimbursement system. Myers and Stauffer reviewed these policies and procedures to determine if the policies were in accordance with the contract between HSD and the MCO. Additionally, Myers and Stauffer performed an analysis on paid and denied inpatient hospital claims submitted by the MCOs and remittance advices provided by a select group of hospitals. (See Tables 1a and 1b below.)

**Table 1a: Inpatient Hospital Claims Universe and Testing Summary Results**

<table>
<thead>
<tr>
<th>Claims Universe</th>
<th>BCBS</th>
<th>Molina</th>
<th>PHP</th>
<th>UHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Paid Claims</td>
<td>27,917</td>
<td>16,921</td>
<td>30,009</td>
<td>8,854</td>
</tr>
<tr>
<td>Percent of Total Claims</td>
<td>92%</td>
<td>77%</td>
<td>80%</td>
<td>47%</td>
</tr>
<tr>
<td>Number of Denied Claims</td>
<td>2,497</td>
<td>5,062</td>
<td>7,561</td>
<td>10,312</td>
</tr>
<tr>
<td>Percent of Total Claims</td>
<td>8%</td>
<td>23%</td>
<td>20%</td>
<td>53%</td>
</tr>
<tr>
<td>Total Claims</td>
<td>30,414</td>
<td>21,983</td>
<td>37,651</td>
<td>19,166</td>
</tr>
</tbody>
</table>

**Table 1b: Inpatient Hospital Claims Universe and Testing Summary Results**

<table>
<thead>
<tr>
<th>Testing Sample</th>
<th>BCBS</th>
<th>Molina</th>
<th>PHP</th>
<th>UHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims in Sample</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Claims Tested</td>
<td>891</td>
<td>100</td>
<td>96</td>
<td>2</td>
</tr>
<tr>
<td>Sample Underpayments</td>
<td>$53.66</td>
<td>$165,683.32</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Sample Overpayments</td>
<td>$151.65</td>
<td>$0.00</td>
<td>$4,570.83</td>
<td>$86,614.62</td>
</tr>
<tr>
<td>Number of Paid Claims</td>
<td>77</td>
<td>78</td>
<td>69</td>
<td>55</td>
</tr>
<tr>
<td>Number of Denied Claims</td>
<td>12</td>
<td>22</td>
<td>27</td>
<td>40</td>
</tr>
<tr>
<td>Claim Paid/Denied Correctly</td>
<td>86</td>
<td>96</td>
<td>90</td>
<td>84</td>
</tr>
<tr>
<td>Claims with Mispayments</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Claims with Mispayments/Claim has been adjusted</td>
<td>1</td>
<td>2</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Claim Issues Identified</td>
<td>39</td>
<td>45</td>
<td>42</td>
<td>68</td>
</tr>
<tr>
<td>Claim Issues Identified/Later Resolved</td>
<td>37</td>
<td>41</td>
<td>36</td>
<td>57</td>
</tr>
</tbody>
</table>

1. BCBS - 11 Remittance Advice claims were identified as Non Centennial Care.
2. PHP – 4 Remittance Advice claims were identified as Non-Centennial Care.
3. UHC – 5 Remittance Advice claims were identified as Non Centennial Care.
4. Claim has been adjusted, not corrected as an error.
5. Molina adjusted two of the identified mispayments.
6. The volume of denials for UHC appears greater in comparison to the other Centennial Care MCOs. This can be attributed to claims being denied for “Medicaid Approved Amount Paid by Medicare”. It should be noted that UHC has the largest LTSS population of the MCOs and the LTSS population consists largely of dual eligible members.
Findings

1) Overall, Myers and Stauffer found the MCOS’ policies and procedures related to claims adjudication were in accordance with HSD’s contract requirements. Exceptions are noted in each MCO’s report.

2) The following claim repricing errors were identified:
   a. Prompt Pay Interest was not paid
   b. Claim paid incorrectly per provider contract
   c. Claim paid incorrect rate
   d. Claim denied in error
   e. Claim paid incorrectly - Other Insurance paid more than allowable
   f. Claim paid incorrectly - Medicare paid more than allowable
   g. Claim paid incorrectly - Disallowed amount was not applied
   h. Manual Pricing - pricing details were not provided

3) We reviewed the claims data and identified the most frequent denials for each MCO. We determined that:
   a. For BCBS, 50% of the denials during 3 sample periods were due to the “Late Charge Denial (No EOB Created for this Claim)”.
   b. For Molina, 29% of the denials during 3 sample periods were due to “Our Records Indicate There is Not a Prior Authorization on File for this Service on this Date. Therefore, Benefits are Denied.”
   c. For PHP, 48% of the denials during 3 sample periods were due to “Benefits based on Admission Date”.
   d. For UHC, 21% of the denials during 3 sample periods were due to the “Requires Notification/Plan not Notified”.

Recommendations Applicable to HSD

1) HSD should include a provision in the contract which would require the MCOs to ensure provider contracts are loaded into their systems within a specified timeframe. As an example, the Texas Health and Human Services Commission's Uniform Managed Care Contract requires MCO to complete the credentialing process for a new provider and specifies the MCO's claim system must be able to recognize the provider as a network provider no later than 90 calendar days after receipt of a complete application.

2) HSD should include a provision in the contract which would require the MCOs to pay the prompt pay interest at the same time the claim is adjudicated or within 30 calendar days of the adjudication date. As an example, the Georgia Department of Community Health stipulates that a care management organization shall pay all interest required to be paid under the provision or Code Section 33-24-59.5 automatically and simultaneously whenever payment is made for the claim giving rise to the interest payment.

3) HSD should include a provision in the contract which would require the MCOs to include prompt pay interest in the encounter data.

4) HSD should consider updating this policy to limit clean claim adjudication to 15 calendar days. As an example, the Georgia Department of Community Health's policy states, “Pursuant to O.C.G.A. 33-24-59.5(b) (1) once a clean claim has been received, the CMO(s) will have 15 Business Days within which to process and either transmit funds for payment
electronically for the claim or mail a letter or notice denying it, in whole or in part giving the reasons for such denial.”

5) HSD should clearly address and publish its lesser of logic/COB claims processing guidelines. HSD should require the MCOs to adjudicate all claims which did not pay according to this policy.

6) HSD should review its lesser of logic/COB claims processing guidelines and include a provision in the contract which would ensure Medicaid is the payor of last resort. As an example, the Georgia Department of Community Health contract states, “If the primary plan paid more than the Medicaid maximum allowable amount, no additional payment will be made by Medicaid. If the primary plan paid less, in most cases Medicaid will pay the difference.”

Recommendations Applicable to BCBS

1) BCBS should conduct provider training and education on how to properly submit late charges on inpatient hospital claims.

2) A best practice was identified for this area in the Texas Health and Human Services Commission Uniform Managed Care Manual Version 2.4, Chapter 2.0 which requires that institutional claims and encounter data contain POA indicators. BCBS should adopt a similar best practice in which applicable institutional claims with blank POA indicators are returned to providers for the proper POA indicator.

3) BCBS should review data validation procedures to determine if additional edits are needed to safeguard against the occurrence of double paid and double billed amounts in the claims data.

4) BCBS should review its prompt pay interest policies to ensure claims with interest due are accurately processed.

5) BCBS should properly address the 2 remaining claims with mispayments.

6) BCBS should provide a separate remittance advice (EOP/EOB) or create a rendering provider activity report to distinguish Centennial Care members. BCBS should provide HSD with a timeline for completing this project.

Recommendations Applicable to Molina

1) Molina should review its policies and procedures on notification/prior authorization requests, submissions, and processing. Molina should also conduct provider training and education on how to properly request and submit prior authorizations on inpatient hospital claims.

2) Molina should closely monitor the effectiveness of the newly implemented process to ensure future employee transitions do not disrupt operations.

3) Molina should review its prompt pay interest policies to ensure claims with interest due are accurately processed.
4) Molina should properly address the remaining claims with mispayments.

5) Molina should ensure that contracts between Molina and the Centennial Care providers clearly state the cases when the claim will not price according to the published contract terms.

6) Molina should revise its current processes to ensure proper categorization of grievances in compliance with the contract and also ensure reporting to HSD includes all grievances including those resolved within 24 hours.

7) Molina should closely monitor the effectiveness of the newly implemented corrective action plan to ensure future grievances are properly reported.

8) Molina should review the incident to ensure required HIPAA reporting was conducted and also require a corrective action plan for this vendor, if necessary, to ensure future data transfers go to the intended recipients.

Recommendations Applicable to PHP

1) PHP should determine the source of its denials and, if appropriate, provide benefit verification and claim submission training to providers.

2) In the absence of voids, PHP should ensure proper employee and provider education on its process for recouping money for incorrectly paid claims and properly identify these transactions.

3) PHP should review the process for manually reviewed claims to identify opportunities for increased efficiency through greater automation and less manual intervention on claims.

4) PHP should implement and maintain a system to proactively notify providers of fee schedule changes.

5) PHP should review its prompt pay interest policies to ensure claims with interest due are accurately processed.

6) PHP should properly address the 6 remaining claims with mispayments.

7) PHP should review HSD’s lesser of logic policy and adjudicate all claims which did not pay according to this policy.

8) PHP should provide a separate remittance advice (EOP/EOB) or create a rendering provider activity report to distinguish Centennial Care members. PHP should provide HSD with a timeline for completing this project.

9) PHP should work with HSD to define complaints and any associated reporting requirements the state may wish to implement.

10) PHP should take steps to increase monitoring and review of the 6 performance measures not being met to identify opportunities to improve performance.
11) PHP should implement and maintain a system to track reporting due dates and timeliness. PHP should also take steps to increase efficiency in the area of meeting health risk assessment targets.

12) PHP should continue monitoring the nurse advice line and make adjustments to consistently meet call standards.

13) PHP should monitor and implement a time threshold for closing cases and/or forward cases to HSD for further resolution.

**Recommendations Applicable to UHC**

1) UHC should review its policies and procedures on notification/prior authorization requests, submissions, and processing. UHC should also conduct provider training and education on how to properly request and submit prior authorizations on inpatient hospital claims.

2) UHC should provide HSD with a copy and publish its policies on manually priced claims.

3) UHC should review and update its manual claim processing policies to increase the threshold. This will ensure claims are processed faster and in a timely manner.

4) UHC should review the inpatient hospital claims process to identify opportunities for increased efficiency through greater automation and less manual intervention on claims and report back to HSD.

5) UHC should add further clarification to claims adjudication policies and procedures during the next round of updates.

6) UHC should implement a process to monitor claims that are manually changed if the claim is kicked out during auto-adjudication and provide a timeline to HSD.

7) UHC should have backup staff for all job functions so performance measures can be met when specific employees are away from the office.

8) UHC should provide education to staff responsible for authorization on the entirety of the authorization function and provide a timeline to HSD in which this education will occur.

9) UHC should ensure monitoring and oversight is being provided in all delegated service areas.

10) UHC should ensure contract loading staff has knowledge of how Indian health providers are to be loaded in the system.

11) UHC should ensure local representatives are familiar with the process for implementing DRG and fee schedule changes applicable to the New Mexico Centennial Care Program.

12) UHC should review its prompt pay interest policies to ensure claims with interest due are accurately processed.
13) UHC should research and address these claims, since incorrect reporting of these dates could affect the prompt pay interest calculation and pay interest accordingly.

14) UHC should properly address the remaining claims with mispayments. UHC stated one of the mispaid claims would be reprocessed.

15) UHC should implement policies and procedures for performing periodic testing to ensure the lesser of logic continues to be applied.

16) UHC should update its provider manual and reference materials on notification/prior authorization requests and submissions. UHC should conduct provider training and education sessions on this topic.

17) UHC should continue to monitor and submit their denials and reports on claims adjudication to HSD.

18) UHC should implement a contingency plan to handle appeals and grievances that come in at the end of the day or near the cut-off. Additionally, there should be back up in the event the medical director is not able to respond within the allotted time frame due to work load.

19) UHC should evaluate the current matrix structure and identify risk areas where the New Mexico Centennial Care Program may require the allocation of additional resources. Ongoing evaluation and process improvement initiatives are necessary to ensure all HSD reporting requirements are consistently met.

20) UHC should coordinate efforts and cross train staff to ensure staff in all areas have a sufficient understanding of work flows, processes and how other departments impact their department.

21) UHC should be more proactive in ensuring on-site representatives are able to explain the program integrity functions specific to the local health plan.

22) UHC should implement a more robust system for monitoring performance of subcontractors and delegated vendors. This system should include, but not be limited to: utilizing standardized audit tools for delegated functions, conducting on-site visits, and performing the annual audits as referenced in UHC policy.

Prior Authorization. Each MCO provided Myers and Stauffer with its existing policies and procedures related to prior authorization processing requirements. Myers and Stauffer reviewed these policies and procedures to determine if the policies were in accordance with the contract between HSD and the MCO. Additionally, Myers and Stauffer performed an analysis on the prior authorization data to determine the number of days between an authorization request and the date the authorization was approved or denied. (See Table 2 below.)

<table>
<thead>
<tr>
<th>MCO</th>
<th>% of Total Prior Authorization Requests Approved</th>
<th>% Approved within 14 day Requirement</th>
<th>Average # of Days Between Authorization Request and Authorization Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCBS</td>
<td>99.6%</td>
<td>96.0%</td>
<td>1.8</td>
</tr>
<tr>
<td>Molina</td>
<td>93.5%</td>
<td>95.2%</td>
<td>4.3*</td>
</tr>
</tbody>
</table>

Table 2: Prior Authorization Data Testing Summary Results
Per the MCO's policy provided to Myers and Stauffer, BCBS, PHP, and UHC have policies in place that address the 14 calendar day turnaround timeframe for standard requests and the 72 hour turnaround for urgent requests as stated in the contract between HSD and the MCO. Molina's provider manual stated 14 business days, which is not in compliance with the contract between HSD and the MCO. During interviews with the MCOs, BCBS and PHP did not discuss the requirements for authorization turnaround timeframes. Both Molina and UHC staff discussed the 14 day and 72 hour timeframe requirements.

**Findings**

1) Myers and Stauffer identified the following issues when testing the timeliness of the MCO's prior authorization processes:
   a. BCBS did not provide authorization decision dates for the denied or pending requests.
   b. Molina - 40 requests in the sample had an authorization date of 12/31/2078, which resulted in 20,000+ calendar days between request date and authorization date.
   c. PHP reported 31.3% of PA's approved prior to date of receipt.
   d. UHC did not provide decision dates for pended or denied prior authorizations.

2) BCBS should review the 31 prior authorizations that were approved prior to the date of receipt and provide an explanation to HSD. Any remediation should occur within the timeframe specified by HSD thereafter. BCBS should continue monitoring the prior authorization process to remain within compliance.

3) Molina should review the 111 prior authorizations that were approved prior to the date of receipt and provide an explanation to HSD. Any remediation should occur within the timeframe specified by HSD. Molina should continue monitoring the prior authorization process to remain within compliance.

4) PHP should review the 3,729 prior authorizations that were approved prior to the date of receipt and provide an explanation to HSD. Any remediation should occur within the timeframe specified by HSD. PHP should continue monitoring the prior authorization process to ensure compliance.

5) UHC should evaluate and modify the prior authorization process to ensure compliance with HSD's 14 calendar day requirement and provide a timeline to HSD.

**Provider Credentialing.** Each MCO provided Myers and Stauffer with its existing policies and procedures related to credentialing Centennial Care providers. Myers and Stauffer reviewed these policies and procedures to determine if the policies were in accordance with the contract between HSD and the MCO. Additionally, Myers and Stauffer performed an analysis on the
credentialing data to determine the number of days required to complete the credentialing process. (See Table 3 below.)

Table 3: Credentialing Data Testing Summary Results

<table>
<thead>
<tr>
<th>MCO</th>
<th>Percentage of Provider Credentialed within 45 Calendar Days*</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCBS</td>
<td>100%</td>
</tr>
<tr>
<td>Molina</td>
<td>51.3%</td>
</tr>
<tr>
<td>PHP</td>
<td>93.2%</td>
</tr>
<tr>
<td>UHC</td>
<td>13.0%</td>
</tr>
</tbody>
</table>

* These percentages include providers with an application date prior or equal to their credentialing date.

**Findings**

1) The MCOs have policies and procedures in place related to the credentialing and recredentialing providers. However, complete data was not readily available to accurately test the timeliness of the credentialing process. Issues identified include:
   a. In some cases, credentialing is a delegated function, so information was not stored in the MCOs system.
   b. BCBS noted some provider types are not credentialed (e.g., I/T/Us).
   c. In other cases, the MCO system only contained information for the current credentialing cycle.
   d. There were duplicates contained in the data.
   e. The MCOs reported credentialing dates which preceded application dates.
   f. Based on available data, Myers and Stauffer could not differentiate the date when all required primary source information was received from providers. The data fields we requested from the MCOs included: the application submission date to become a MCO credentialed provider; and the MCO provider credentialing date.

**Recommendations**

1) As indicated by the supporting details in Exhibit B, more reliable data on application dates and credentialed dates is needed to perform an accurate analysis of credentialing timeliness. Complete and accurate data is necessary in order to monitor BCBS and delegated vendor compliance with HSD credentialing requirements. BCBS should review the 125 application dates where the credential date is prior to the application date and provide justification to HSD along with a timeframe for remediation.

2) BCBS should take steps to capture complete and accurate credentialing data in its system and provide a timeline to HSD for implementing this change.

3) Molina should take steps to improve the quality and completeness of credentialing data retained in the Molina system. Additionally, Molina should provide an explanation to HSD for the 4 cases where the credentialing date is prior to the application date.

4) Molina should outline a plan to capture complete and accurate credentialing data. Such data is needed to effectively calculate and monitor credentialing timeliness.

5) PHP should review the 137 application dates where the credential date is prior to the application date and provide justification to HSD along with a timeframe for remediation.
6) PHP should take steps to capture complete and accurate credentialing data in its system and provide a timeline to HSD for implementing this change.

7) UHC should outline a plan to capture complete and accurate credentialing data in its system and provide a timeline to HSD for implementing this change. Such data is needed to effectively calculate and monitor credentialing timeliness.

8) UHC should take the necessary steps to capture the date of provider application and credentialing. UHC should be able to demonstrate compliance with HSD’s 45-calendar day requirement related to the timely credentialing of providers.

9) UHC should improve the quality and completeness of credentialing data retained in the UHC system. As indicated by the supporting details in Exhibit B, more reliable data on application dates and credentialed dates is needed to perform an accurate analysis of credentialing timeliness. Complete and accurate data is necessary in order to monitor UHC and delegated vendor compliance with HSD credentialing requirements. UHC should review the 114 application dates where the credential date is prior to the application date and provide justification to HSD of this discrepancy and provide a timeline for remediation.

Provider Contract Loading. Each MCO provided Myers and Stauffer with its existing policies and procedures related to loading provider contracts into the MCO’s system. Myers and Stauffer reviewed these policies and procedures to determine if the policies were in accordance with the contract between HSD and the MCO. Additionally, Myers and Stauffer performed an analysis on the provider contracting data to determine the number of days required to load provider contracts. We requested contract loads for Behavioral Health providers, LTC providers, and hospitals during Quarter 1 of 2015 (January 1, 2015 - March 31, 2015). We requested the following information: date the request was made to add the provider's contract; date the contract was loaded; and date the provider was made effective in MCO system. (See Table 4 below.)

Table 4: Provider Contract Loading Data Testing Summary Results (Long Term Care, Hospital and Behavioral Health)

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>BCBS*</th>
<th>Molina</th>
<th>PHP</th>
<th>UHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long Term Care</td>
<td>-</td>
<td>28.82</td>
<td>208</td>
<td>1.32</td>
</tr>
<tr>
<td>Hospital</td>
<td>-</td>
<td>Not available</td>
<td>38.50</td>
<td>12.47</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>-</td>
<td>17.45</td>
<td>9.18</td>
<td>9.32</td>
</tr>
<tr>
<td>All Providers*</td>
<td>34.67 days</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

* BCBS data did not specify provider type

Additionally, BCBS, Molina, and PHP provided Myers and Stauffer with a contract loading process workflow document. UHC provided a contract loading process workflow for long term care only. Requirements for provider contract loading were not addressed in the contract between HSD and the MCOs. It appeared the four MCOs have internal policies in place for contract loading. PHP was the only MCO to provide Myers and Stauffer with a policy with specific turnaround timeframes for
provider contract loading. Per the interview with BCBS staff, there is a 60 day turnaround timeframe for rate changes. A timeframe for provider contracts was not discussed. The staff at Molina indicated there is a 10 day turnaround timeframe for provider contract loading. PHP staff indicated the contract loading process is a 30 day process. UHC staff stated there is a goal of 5 days for provider contract loading.

**Finding**

1) We noted that the contract between HSD and the MCO does not contain any requirements specifically related to loading provider contracts into the MCO’s system. This is a potential area for contract improvement.

**Recommendations**

1) HSD should include a provision in the contract which would require the MCOs to ensure provider contracts are loaded and the claim system recognizes all providers within a specified period of time. In Texas, the Health and Human Services Commission’s Uniform Managed Care Contract requires the MCO to complete the credentialing process for a new provider and specifies the MCO’s claim system must be able to recognize the provider as a network provider no later than 90 calendar days after receipt of a complete application. HSD should also consider defining contract load requirements by provider type if certain contracts (e.g., hospitals) are known to historically take a longer length of time to negotiate/finalize.

2) The MCOs should define standards and outline a plan to routinely monitor contract loading timeliness. They should provide HSD with a timeline for completing this project.
Complaints, Appeals and Grievances. Each MCO provided Myers and Stauffer with its existing policies and procedures related to the reporting, investigation, and resolution of complaints, appeals and grievances. Myers and Stauffer reviewed these policies and procedures to determine if the policies were in accordance with the contract between HSD and the MCO. An analysis of data was not performed.

Findings and Recommendations Applicable to HSD
Complaints are not specifically defined or addressed in the HSD contract. During discussions with the HSD, Myers and Stauffer was informed that prior to Centennial Care, complaints were defined as any dissatisfaction resolved within 24 hours. HSD should add a definition of a complaint to the contracts and specify tracking and reporting expectations related to matters resolved within 24 hours.

Findings and Recommendations Applicable to BCBS
BCBS's policies do not indicate that an oral appeal must be followed by a written appeal that is signed by the member within 13 calendar days or that failure to file the written appeal within 13 calendar days shall constitute withdrawal of the appeal as required by section 4.16.3.6 of the contract between HSD and the MCO. BCBS agreed with our assessment and indicated the policy will be updated. BCBS should update its policies and procedures to address this contract requirement. The remaining appeals and grievances policies and procedures provided by BCBS are in accordance with the contract between HSD and BCBS.

Findings and Recommendations Applicable to Molina
The complaints, appeals and grievances policies and procedures provided by Molina are in accordance with the contract with HSD and Molina with two exceptions.

1) Molina’s policy as well as the process described in our interview with Molina staff does not properly categorize grievances. The contract defines a grievance as “an expression of dissatisfaction about any matter or aspect of the MCO or its operation, other than an MCO Action.” Molina treats any dissatisfaction resolved within 24 hours as a complaint and not a grievance; however, the contract does not allow for this deviation. We were also informed that complaints, as described, are not reported to HSD. Molina agreed with these exceptions. Molina should revise its current processes to ensure proper categorization of grievances in compliance with the contract and also ensure reporting to HSD includes all grievances including those resolved within 24 hours.

2) We also found that, for a period of time, not all departments were reporting grievances. We were informed that Molina developed a corrective action plan where other departments receiving grievances will forward them to the Appeals and Grievances Department for investigation. Molina should closely monitor the effectiveness of the newly implemented corrective action plan to ensure future grievances are properly reported.

Findings and Recommendations Applicable to PHP
The appeals and grievances policies and procedures provided by PHP are in accordance with the contract between HSD and PHP.

Findings and Recommendations Applicable to UHC
The complaints, appeals and grievances policies and procedures provided by UnitedHealthcare are in accordance with the contract between HSD and UnitedHealthcare.
**Health Plan Compliance.** Each MCO provided Myers and Stauffer with its existing policies and procedures related to health plan compliance. Myers and Stauffer reviewed these policies and procedures to determine if the policies were in accordance with the contract between HSD and the MCO. Data testing was not performed.

**Findings and Recommendations Applicable to BCBS**
BCBS has a compliance plan in place to ensure contractual requirements with HSD are met. No concerns or areas for improvement were noted in this area.

**Findings and Recommendations Applicable to Molina**
Molina has a compliance plan in place to ensure contractual requirements with HSD are met. Aside from the opportunity for additional cross training of staff responsible for producing the reports, no other concerns or areas for improvement were noted in this area.

**Findings and Recommendations Applicable to PHP**
PHP has a compliance plan in place to ensure contractual requirements with HSD are met. No concerns or areas for improvement were noted in this area.

**Findings and Recommendations Applicable to UHC**
We recommend UHC evaluate the current matrix structure and identify risk areas where the New Mexico Centennial Care Program may require the allocation of additional resources. On-going evaluation and process improvement initiatives are necessary to ensure all HSD reporting requirements are consistently met.

**Program Integrity.** Each MCO provided Myers and Stauffer with its existing policies and procedures related to program integrity. Myers and Stauffer reviewed these policies and procedures to determine if the policies were in accordance with the contract between HSD and the MCO. Data testing was not performed.

**Findings and Recommendations Applicable to BCBS**
The program integrity policies and procedures provided by Blue Cross Blue Shield are in accordance with the contract between HSD and Blue Cross Blue Shield.

**Findings and Recommendations Applicable to Molina**
The program integrity policies and procedures provided by Molina are in accordance with the contract between HSD and Molina.

**Findings and Recommendations Applicable to PHP**
Myers and Stauffer found the Program Integrity policies and procedures provided by PHP are in accordance with the contract between HSD and PHP.

**Findings and Recommendations Applicable to UHC**
The program integrity policies and procedures provided by UnitedHealthcare are in accordance with the contract between HSD and UnitedHealthcare.

**Subcontractor/Delegated Services Monitoring.** Each MCO provided Myers and Stauffer with its existing policies and procedures related to subcontractor oversight, if applicable to claims adjudication, prior authorization, and provider credentialing and contract loading. Myers and
Stauffer reviewed these policies and procedures to determine if the policies were in accordance with the contract between HSD and the MCO. Data testing was not performed.

**Findings and Recommendations Applicable to BCBS**
Policy review and interviews with BCBS personnel support that BCBS is conducting ongoing monitoring of subcontractors as required by the contract. However, we determined there is opportunity for improvement in these processes to monitor the quality of subcontractor data. Subcontractor reports that flow through to the state are reviewed for completeness and reasonableness only. The MCO does not have a process in place to validate subcontractor data reported to the state. BCBS agreed with our assessment. BCBS should routinely verify the accuracy of HSD deliverables based on information from subcontractors. The verification procedures should include all subcontractors and should be based on the level of risk the subcontractors present to BCBS and HSD. BCBS should provide HSD with a timeline for developing policies and procedures for subcontractor data verification.

**Findings and Recommendations Applicable to Molina**
The subcontractor oversight and delegated services monitoring policies and procedures provided by Molina are in accordance with the contract between HSD and Molina. We noted two areas for improvement for Molina’s consideration. We found that Molina’s processes, as documented and described in our interview, as sufficient to constitute ongoing monitoring of subcontractors as required by the contract; however, we concluded these processes are not sufficient to monitor the quality of subcontractor data. Generally, Molina assumes the data provided by the subcontractors is accurate and does not perform validation procedures. Molina agreed and indicated that some validation procedures were implemented in the second quarter of 2015. Molina should routinely verify the accuracy of HSD deliverables based on information from subcontractors. The verification procedures should include all subcontractors and should be based on the level of risk the subcontractors present to Molina and HSD. Molina should provide HSD with a timeline for developing policies and procedures for subcontractor data verification.

Also, we noted in our interview with Molina employees that there was one instance in which Molina’s dental subcontractor, DentaQuest, sent Molina’s dental claims data to another MCO, which appears to be a violation of HIPAA regulations. Molina should review the instance to ensure required HIPAA reporting was conducted and also require a corrective action plan for this subcontractor, if necessary, to ensure future data transfers go to the intended recipients.

**Findings and Recommendations Applicable to PHP**
Myers and Stauffer’s review of PHP policies and on-site interviews with PHP personnel support that PHP is conducting ongoing monitoring of subcontractors as required by the contract.

**Findings and Recommendations Applicable to UHC**
While the written policy and procedure documents were in accordance with the contract between HSD and UnitedHealthcare, we determined the MCO processes, as documented and described in our interviews, are insufficient to constitute ongoing monitoring of subcontractors as required by the contract. UHC should implement a more robust system for monitoring performance of subcontractors and delegated vendors. This system should include, but not be limited to: utilizing standardized audit tools for delegated functions, conducting on-site visits, and performing the annual audits as referenced in UHC policy. Additionally, there is no process in place to validate the accuracy of data submitted by subcontractors. UHC should routinely verify the accuracy of information from subcontracts to ensure accurate reporting to HSD. The verification procedures should include all subcontractors and should be based on the level of risk the subcontractors present to UHC and
HSD. UHC should provide HSD with a timeline for developing policies and procedures for subcontractor data verification.