Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NEW MEXICO SHOULD REFUND ALMOST $120 MILLION TO THE FEDERAL GOVERNMENT FOR MEDICAID NURSING FACILITY LEVEL-OF-CARE MANAGED CARE CAPITATED PAYMENTS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Christi A. Grimm
Inspector General

May 2024
A-06-20-09001

Office of Inspector General

https://oig.hhs.gov

The mission of the Office of Inspector General (OIG) is to provide objective oversight to promote the economy, efficiency, effectiveness, and integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of the people they serve. Established by Public Law No. 95-452, as amended, OIG carries out its mission through audits, investigations, and evaluations conducted by the following operating components:

Office of Audit Services. OAS provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. The audits examine the performance of HHS programs, funding recipients, and contractors in carrying out their respective responsibilities and provide independent assessments of HHS programs and operations to reduce waste, abuse, and mismanagement.

Office of Evaluation and Inspections. OEI's national evaluations provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. To promote impact, OEI reports also provide practical recommendations for improving program operations.

Office of Investigations. OI's criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs and operations often lead to criminal convictions, administrative sanctions, and civil monetary penalties. OI's nationwide network of investigators collaborates with the Department of Justice and other Federal, State, and local law enforcement authorities. OI works with public health entities to minimize adverse patient impacts following enforcement operations. OI also provides security and protection for the Secretary and other senior HHS officials.

Office of Counsel to the Inspector General. OCIG provides legal advice to OIG on HHS programs and OIG's internal operations. The law office also imposes exclusions and civil monetary penalties, monitors Corporate Integrity Agreements, and represents HHS's interests in False Claims Act cases. In addition, OCIG publishes advisory opinions, compliance program guidance documents, fraud alerts, and other resources regarding compliance considerations, the anti-kickback statute, and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at https://oig.hhs.gov

Section 8M of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG website.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief
Date: May 2024
Report No. A-06-20-09001

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

New Mexico Should Refund Almost $120 Million to the Federal Government for Medicaid Nursing Facility Level-of-Care Managed Care Capitated Payments

Why OIG Did This Audit

In a previous OIG audit, we reviewed recoveries that New Mexico received from its managed care organizations (MCOs) related to payments that New Mexico had made to its MCOs for calendar years 2014 and 2015. For that audit, we reported that New Mexico had not performed reconciliations of capitated payments for Community Benefit (CB) services. This audit followed up on our recommendation that New Mexico perform the required reconciliations and refund the Federal share of any recoveries.

Our objectives were to determine whether New Mexico: (1) performed reconciliations of capitated payments for CB services as required under its contracts with MCOs and refunded the Federal share of any related recoupments to the Federal Government and (2) provided support that enrollees were eligible to receive services at the nursing facility level-of-care (NFLOC) rate.

How OIG Did This Audit

Our audit covered $3.8 billion ($2.7 billion Federal share) in CB services capitated payments and $35.2 million ($24.6 million Federal share) in NFLOC capitated payments for enrollees New Mexico could not support were eligible for the higher NFLOC rate for calendar years 2014 through 2018 (audit period). We determined the accuracy of New Mexico's CB services reconciliations and the overpayment amounts related to our findings and calculated the Federal share impact.

What OIG Found

New Mexico performed reconciliations of capitated payments for CB services as required under its contracts with MCOs. However, it did not recoup from its MCOs any overpayments identified in the CB services reconciliations and did not refund any related Federal share to the Federal Government. Of the $3.8 billion in CB services capitated payments for our audit period, New Mexico did not recoup $139.2 million in overpayments for enrollees who did not use CB services within 90 calendar days of their approval for CB services. As a result, New Mexico did not return the related Federal share of $98.6 million.

Additionally, New Mexico did not provide support that the enrollees on whose behalf MCOs received $35.2 million in capitated payments at the higher NFLOC rate for our audit period were eligible for services at that rate. As a result, New Mexico claimed $29.4 million in overpayments for those enrollees and inappropriately received $20.5 million in Federal share for those overpayments.

What OIG Recommends and New Mexico Comments

We recommend that New Mexico: (1) recoup $139.2 million in CB services capitated payments from its MCOs and refund the $98.6 million in Federal share to the Federal Government, (2) recoup the $29.4 million in NFLOC capitated payments from its MCOs and refund the $20.5 million Federal share to the Federal Government, and (3) establish policies and procedures to recoup the NFLOC capitated payments made to its MCOs based on settings-of-care that are removed after payment and no longer valid.

In written comments on our draft report, New Mexico concurred with our third recommendation but did not concur with our first and second recommendations. New Mexico said that, although it did not implement the recoupment process as outlined in its MCO contracts, it developed an alternative method that met the spirit of compliance. New Mexico also said that the alternative method resulted in an immaterial financial impact. After reviewing New Mexico's comments, we maintain that our findings and recommendations are still valid.

The full report can be found on the OIG website.

TABLE OF CONTENTS

INTRODUCTION

WHY WE DID THIS AUDIT

In a previous audit, we reviewed recoveries that the New Mexico Human Services Department (the State agency) received from its managed care organizations (MCOs) related to payments that the State agency had made to its MCOs for calendar years 2014 and 2015.[1] For that audit, we reported that the State agency had not performed reconciliations of capitated payments for Community Benefit (CB) services as required under its contracts with MCOs. As a result, the State agency did not make any recoupments from its MCOs related to CB services or return any related Federal share. This audit followed up on our recommendation that the State agency perform the required CB services reconciliations and refund the Federal share of any recoveries.

OBJECTIVES

Our objectives were to determine whether the State agency: (1) performed reconciliations of capitated payments for CB services as required under its contracts with MCOs and refunded the Federal share of any related recoupments to the Federal Government and (2) provided support that enrollees were eligible to receive services at the nursing facility level-of-care (NFLOC) rate.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. At the State level, the State agency administers the Medicaid program.

Although the State agency has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. The Federal Government pays its share of a State's Medicaid expenditures based on the Federal Medical Assistance Percentage (FMAP). The FMAPs the State agency applied to payments we reviewed ranged from 69.20 percent to 72.71 percent.

[1] *New Mexico Did Not Always Appropriately Refund the Federal Share of Recoveries from Managed Care Organizations* (A-06-18-09001), Feb. 12, 2019.

The State agency contracts with MCOs to make services available to beneficiaries enrolled in New Mexico's Medicaid program, Centennial Care. Centennial Care is a managed care program that began on January 1, 2014. The State agency pays MCOs a monthly capitated payment for each Medicaid enrollee, which comprehensively covers enrollees' medical care for the month. The MCO receives a capitated payment regardless of whether an enrollee uses medical services during the month.

MCOs submit to the State agency encounter data, which is a collection of individual encounters that includes information about the specific services provided to each MCO enrollee, including the first and last date of service provided to an enrollee and how much the MCO paid for the services.[2] The State agency then processes the encounter data using its Medicaid Management Information System.[3]

Community Benefit Services Program in New Mexico

The CB services program helps enrollees with NFLOC needs to remain living in their homes or in the community (e.g., in adult day care or assisted living facilities) rather than in a long-term care facility. Under the CB services program, long-term care services are provided outside of nursing facilities. CB services include adult day health, respite care, personal care services, and assistance with daily tasks (e.g., hygiene, meals, mobility). We observed in the State agency's capitated payments data that MCOs received a higher capitated payment for enrollees with NFLOC needs (NFLOC capitated payment). We also observed that this higher rate was the same whether an enrollee with NFLOC needs resided in a nursing facility or in the community.

According to the State agency's contracts with its MCOs, for the CB services reconciliation, the State agency will review enrollees' needs for CB services by reviewing their service use in the first 90 calendar days of approval for the services (i.e., 90-day requirement). The contracts state that the State agency will recoup the CB capitated payment if an enrollee does not use CB services in that initial 90-day period.[4]

To establish the enrollee's date of approval for CB services in its CB services reconciliations, the State agency's contractor used the first date that an MCO placed each CB enrollee into a setting-of-care, indicating that the enrollee was located in a community-based setting and had NFLOC needs. Therefore, this first date was important to establish, not just to determine the

[2] MCO Contracts, Amendments 5 and 8, section 4.19.2. We refer to an individual encounter as an "encounter."

[3] The Medicaid Management Information System is an integrated group of procedures and computer processing operations designed to meet Medicaid program objectives, such as processing medical claims.

[4] MCO Contracts, Amendments 5 and 8, section 6.11.1. Amendment 8 of the MCO Contracts states that the initial 90-day period begins on the effective date of the setting-of-care and that the State agency will recoup the CB capitated payment for the months in which the CB services were not received.

start of the 90-day period for CB services enrollees but also to determine when an MCO should receive the higher monthly NFLOC capitated payment for an enrollee.

HOW WE CONDUCTED THIS AUDIT

Our audit covered $3.8 billion ($2.7 billion Federal share) in CB services capitated payments and $35.2 million ($24.6 million Federal share) in NFLOC capitated payments for enrollees the State agency could not support were eligible for the higher NFLOC rate for calendar years 2014 through 2018 (audit period).

To conduct our audit, we: (1) analyzed the State agency's encounter data for CB services, NFLOC capitated payments data, and NFLOC setting-of-care data for completeness and accuracy; (2) validated the accuracy of the State agency's reconciliations of capitated payments for the CB services' 90-day requirement; and (3) determined the overpayment amounts and calculated the Federal share impact.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology.

FINDINGS

The State agency performed reconciliations of capitated payments for CB services as required under its contracts with MCOs. However, it did not recoup from its MCOs any overpayments identified in the CB services reconciliations and did not refund any related Federal share to the Federal Government. Of the $3.8 billion in CB services capitated payments for our audit period, the State agency did not recoup $139.2 million in overpayments for enrollees who did not use CB services within 90 calendar days of their approval for CB services. As a result, the State agency did not return the related Federal share of $98.6 million.[5]

Additionally, the State agency did not provide support that the enrollees on whose behalf MCOs received $35.2 million in capitated payments at the higher NFLOC rate for our audit period were eligible for services at that rate. As a result, the State agency claimed $29.4 million in overpayments for those enrollees and inappropriately received $20.5 million in Federal share for those overpayments.[6]

[5] The exact amount of Federal share that the State agency did not return was $98,582,176.

[6] The exact amount of Federal share that the State agency inappropriately received was $20,536,132.

THE STATE AGENCY MADE PAYMENTS FOR ENROLLEES WHO DID NOT USE COMMUNITY BENEFIT SERVICES WITHIN 90 DAYS

According to the State agency's contracts with its MCOs, the MCOs will provide CB services to enrollees who meet NFLOC. The State agency will review enrollees' needs for CB services by reviewing each enrollee's service use in the first 90 calendar days of approval for the services. The contracts state that the State agency will recoup the CB capitated payment if an enrollee does not use CB services in that initial 90-day period.[7] Generally, a State Medicaid agency must refund the Federal share of overpayments at the end of the 1-year period following the discovery of the overpayments.[8]

The State agency made $171.3 million in CB services capitated payments to its MCOs for our audit period for enrollees who did not use CB services within 90 days of approval for services. The State agency relied on its MCOs to place enrollees into a setting-of-care that qualified enrollees for CB services. The State agency's CB services reconciliations included reclassifying enrollees based on their service needs, which usually resulted in lower capitated payments. The State agency should have paid and claimed capitated payments of only $32.1 million that were not at the higher NFLOC rate for those enrollees. The additional $139.2 million in CB services capitated payments the State agency made and claimed represents overpayments that it did not recoup from its MCOs.[9] The State agency received $121.3 million in Federal share for CB services capitated payments but should have received only $22.7 million in Federal share.

As a result, the State agency inappropriately received $98.6 million in Federal share. The State agency believed that it did not need to recoup overpayments or refund these overpayments by either requesting direct repayment from the MCOs or reducing future monthly capitation payments for enrollees who did not meet the 90-day requirement because it believed such overpayments would be offset in future NFLOC capitated rate-setting calculations. However, the State agency's contracts with its MCOs required the State agency to recoup CB services capitated payments for enrollees who did not use CB services in that initial 90-day period.

THE STATE AGENCY DID NOT PROVIDE SUPPORT SHOWING THAT ENROLLEES WERE ELIGIBLE FOR SERVICES AT THE HIGHER NURSING FACILITY LEVEL-OF-CARE CAPITATED RATE

For costs to be allowable under Federal awards, they must be adequately documented.[10] Federal reimbursement is available only for allowable, actual Medicaid expenditures for which

[7] MCO Contracts, Amendments 5 and 8, sections 4.5.7 and 6.11.1.

[8] 42 CFR § 433.312.

[9] We questioned: (1) capitated payments made for the 90-day period and (2) capitated payments for months after the 90-day period until there was an eligible CB service provided to the enrollee.

[10] 45 CFR § 75.403(g).

there is adequate supporting documentation.[11] According to the MCO contracts, "long-term care" is the overarching term that refers to CB services, services of a nursing facility, and services of an institutional facility. Further, the contracts require that MCOs determine and submit to the State agency accurate settings and levels-of-care for its covered enrollees.[12] To be eligible for the CB services that were paid at the higher NFLOC rate, enrollees must meet an NFLOC and have an assessed need for services.[13]

The data we received from the State agency did not support that the enrollees were eligible for services at the higher NFLOC rate. Specifically, the State agency did not provide settings and levels-of-care data for some enrollees on whose behalf NFLOC capitated payments were made. For other capitated payments, we observed that the NFLOC capitated payments occurred before a qualifying setting-of-care began.

For our audit period, the State agency paid MCOs $35.2 million ($24.6 million Federal share) at the higher NFLOC rate for enrollees for whom the State agency did not support were eligible for services at that rate. The State agency should have paid and claimed capitated payments of only $5.8 million ($4.1 million Federal share) for those enrollees. As a result, the additional $29.4 million ($20.5 million Federal share) in capitated payments the State agency made and claimed represents overpayments.

State agency officials explained that, at the time the State agency paid these NFLOC capitated payments, a qualifying setting-of-care was in place for each enrollee. However, after these payments were made, the MCOs or the State agency retroactively removed the settings-of-care on which authorization of the NFLOC rate was based.[14] The State agency did not have policies and procedures in place to recoup the NFLOC capitated payments it had made based on settings-of-care that were removed and no longer valid.

RECOMMENDATIONS

We recommend that the New Mexico Human Services Department:

- recoup $139,232,902 in CB services capitated payments from its MCOs and refund the $98,582,176 in Federal share to the Federal Government,

[11] CMS, *State Medicaid Manual*, § 2497.1.

[12] MCO Contracts, Amendments 5 and 8, sections 2, 4.1.2, 4.4.5.7, 4.5.7, and 4.20.2.6.

[13] MCO Contracts, Amendments 5 and 8, section 4.4.5.7.1.

[14] The State agency explained that a change in circumstances of the enrollee is one of the reasons a setting-of-care may be removed after payment is made.

- recoup the $29,442,388 in NFLOC capitated payments from its MCOs and refund the $20,536,132 Federal share to the Federal Government, and

- establish policies and procedures to recoup NFLOC capitated payments made to its MCOs based on settings-of-care that are removed after payment and no longer valid.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our third recommendation and explained that it had implemented a recoupment process that identifies NFLOC capitations no longer covered by a long-term care setting-of-care and adjusts those capitations to pay at the lower non-NFLOC rate.

The State agency did not concur with our first or second recommendations. Regarding our first recommendation, the State agency said that it complied with: (1) Special Term and Condition (STC) #98 of the Centennial Care Section 1115 Demonstration Waiver to adjust capitated payments made to MCOs for months in which the MCO did not provide CB encounter data and (2) 42 CFR part 438, which requires capitated payments to be actuarily sound. The State agency said that it did not implement the reconciliation described in the contracts because of unanticipated systems and data challenges with MCOs. It also stated that it had developed an alternative method to demonstrate compliance with the spirit of STC #98. The State agency cited its 1115 Demonstration Waiver renewal application submitted to CMS, in which it requested the renewal of its managed care waiver, claiming it had met STC #98 by adjusting capitated payments to its MCOs through its claims system and that prospective capitation rates reflect the appropriate CB services utilization.[15] The State agency asserted that CMS had accepted these described actions in its application because CMS did not take issue with the State agency's compliance with STC #98.

The State agency also said that the financial impact of its alternative method was immaterial and believed that the Federal share impact we identified reflected only a partial financial impact and missed the appropriate offsetting downstream impact of reclassification on the development of Centennial Care program capitation rates. The State agency conducted its own CB services reconciliation in which it accounted for reductions to prospective capitated payments based on CB services utilization to arrive at its immaterial impact conclusion.

Regarding our second recommendation, the State agency agreed that for a small subset in the NFLOC population, there is a discrepancy between members' current NFLOC status and the

[15] State of New Mexico Human Services Department, *Application for Renewal of Section 1115 Demonstration Waiver Centennial Care Program: Centennial Care 2.0.* Available online at https://www.hsd.state.nm.us/wp-content/uploads/Centennial-Care-2_0-Waiver-Application-NM-Dec-2017-1.pdf. Accessed on Dec. 4, 2023.

NFLOC status at the time the capitated payment was made. However, the State agency said that now that it is aware of the issue, it took the NFLOC capitated payments made to its MCOs based on settings-of-care that are removed after payment into account during its own CB services reconciliation, which resulted in an immaterial financial impact.

The State agency's comments are included in their entirety as Appendix B.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we maintain that our findings and recommendations are still valid. According to the Centennial Care Section 1115 Demonstration Waiver referenced in the State agency's comments, MCOs participating in this demonstration must generally meet the requirements under section 1903(m) of the Social Security Act, which require services to be provided in accordance with a contract between the State and the MCO (§ 1903(m)(2)(A)(iii)). Implementing regulations at 42 CFR part 438 state that CMS must review and approve all MCO contracts (42 CFR § 438.3(a)). For our first recommendation, the State agency reaffirmed that the process it used was not performed as outlined in its MCO contracts approved by CMS, which required a recoupment from MCOs for months in which a member did not use CB services within 90 days of approval for services.[16]

In addition, the State agency did not take all of the actions it described in the 1115 Demonstration Waiver renewal application referenced in its comments. Specifically, the State agency indicated to CMS that it had adjusted capitated payments to its MCOs through its claims system, which would be an appropriate action to recoup capitated payments identified through the reconciliation process outlined in its contracts. As stated in the report, the State agency did not recoup from its MCOs any overpayments identified in the CB services reconciliations and did not refund any related Federal share to the Federal Government.

The alternative method the State agency described in its comments was, in essence, to take no action related to the capitated payments in question, but to instead rely on the recalculation of prospective (i.e., future) capitated payments to correct overpayments.

Relying solely on the prospective capitated payment recalculations to account for overpayments, such as those identified in this audit, is problematic because of changes that may occur with the MCOs with which the State agency contracts. For example, two of the four MCOs, which received $74.5 million in overpayments ($52.3 million Federal share) during our

[16] Further, the Department of Health and Human Services, Departmental Appeals Board decision No. 2281 noted that determining whether payments to an MCO constitute overpayments in which the Federal share must be refunded depends on whether the payments were made in accordance with the applicable managed care contract. (Pennsylvania Department of Public Welfare, Decision No. 2281, Nov. 10, 2009. Available online at https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2009/dab2281.pdf. Accessed on Feb. 15, 2024.)

audit period, were not contracted with the State agency from calendar years 2019 through 2023, during which theoretically lower capitated payments would be made, so those MCOs kept their overpaid amounts.

Finally, implementing our first two recommendations is financially advantageous to the State. In addition to the refunding of Federal funds, implementing our first two recommendations, which are supported by the MCO contract requirements, would return almost $50 million in overpaid State funds.

For our second recommendation, the State agency, again, plans to take no action to recoup the capitated payments in question, but to instead rely on the recalculation of prospective (i.e., future) capitated payments to correct overpayments. For all the reasons we listed above for our first recommendation, we maintain that the State agency should recoup the NFLOC capitated payments made to its MCOs based on settings-of-care that are retroactively removed after payment and refund the related Federal share to the Federal Government.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $3.8 billion ($2.7 billion Federal share) in CB services capitated payments and $35.2 million ($24.6 million Federal share) in NFLOC capitated payments for enrollees the State agency could not support were eligible for the higher NFLOC rate for calendar years 2014 through 2018.

Our initial focus was on whether the State agency performed reconciliations of CB services capitated payments, which included determining whether enrollees used CB services within the initial 90-day period.

However, the State agency did not provide settings-of-care data for some enrollees that covered all those enrollees' NFLOC capitated payments. Thus, we added our second objective and expanded the scope of this audit to include those NFLOC capitated payments.

We assessed internal controls necessary to satisfy the audit objectives. In particular, we assessed how the State agency made capitated payments related to CB services and the State agency's policies, procedures, and methodologies related to performing reconciliations of CB services capitated payments to enrollees' actual service use.

We conducted our audit work from April 2020 through June 2023.

METHODOLOGY

To accomplish our objectives, we:

- reviewed applicable Federal regulations and the State agency's contracts with its MCOs;
- reviewed the State agency's documented policies, procedures, and methodologies related to performing reconciliations of capitated payments for CB services;
- interviewed State agency officials to gain a better understanding of the State agency's applicable policies, procedures, and methodologies;
- obtained the State agency's encounter data for CB services, NFLOC capitated payments data, and settings-of-care data and analyzed the data for completeness and accuracy;
- obtained the State agency's reconciliations of capitated payments for the CB services' 90-day requirement and validated their accuracy by independently performing our own CB services reconciliations and comparing our results with the State agency's results;

- determined the overpayment amounts for any capitated payments the State agency should have recouped based on the 90-day requirement (i.e., the difference between the NFLOC capitated payment and the lower, correct capitated payment) and calculated the Federal share impact;

- identified capitated payments for enrollees who did not qualify for services at the NFLOC capitated payment rate, determined the related overpayment amounts, and calculated the Federal share impact; and

- discussed the results of our audit with State agency officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: STATE AGENCY COMMENTS

December 1, 2023

Patricia Wheeler
Regional Inspector General for Audit Services
Office of Inspector General
Department of Health and Human Services
Via email: Trish.Wheeler@oig.hhs.gov

Re: Office of Inspector General (OIG) Report A-06-20-09001

Dear Ms. Wheeler:

Thank you for the opportunity to review and respond to U.S. Department of Health and Human Services, Office of Inspector General (DHHS/OIG) draft report entitled "*New Mexico Should Refund Almost $120 Million to the Federal Government for Medicaid Nursing Facility Level-of-Care Capitated Payments*." The DHHS/OIG's findings reflect only a partial understanding of the process of Centennial Care Long-Term Services and Supports (LTSS) capitation rate development. The New Mexico Human Services Department (HSD) firmly asserts that we have complied with the governing authority in the Centennial Care 1115 Demonstration and the managed care regulations at 42 C.F.R. Part 438, and provided robust oversight and accurate community benefit (CB) capitation payments to our managed care organizations (MCOs). The HSD's detailed responses to the findings and recommendations are outlined below.

DHHS/OIG Finding & Recommendation: *The State Agency made payments for enrollees who did not use Community Benefit services within 90 days. The State should recoup $139,232,902 in CB services capitated payments from its MCOs and refund the $98,582,176 in Federal share to the Federal Government.*

State Response: HSD does not concur with the DHHS/OIG's finding and recommendation for the following reasons:

1. **HSD complied with Special Terms and Condition (STC) #98 of the Centennial Care Section 1115 Demonstration Waiver to adjust MCO PMPMs**. (See *New Mexico Centennial Care Waiver Approval Letter 7.12.13* and *New Mexico Centennial Care Waiver Approval Letter and Conditions STCs Revision 11.18.14.)*

The Centennial Care Section 1115 Demonstration Waiver is the governing authority for the Centennial Care managed care program, including the LTSS portion of Centennial Care. When the Centennial Care 1115 Waiver was approved in 2013, states and CMS had far less experience with

Office of the Secretary | PO Box 2348 – Santa Fe, NM 87504 | Phone: (505) 827-7750 Fax: (505) 827-6286

managed long-term services and supports (MLTSS) programs than today. In the STCs, CMS required HSD to "adjust the MCO's PMPM accordingly" for any month in which HSD did not receive CB encounter data. This requirement is described in STC #98.

> *"STC #98. Post Cap Reconciliation Process. For any given month the state does not receive Community Benefit encounter data from an MCO for each member assessed to need the Community Benefit, the state will adjust the MCO's PMPM accordingly."*

HSD developed the MCO contract CB reconciliation and recoupment language cited by the DHHS/OIG as one way to implement STC #98. Ultimately, this approach described in the MCO contract was not implemented in full because of the unanticipated systems and data challenges with the contractors that HSD has described to CMS and to the DHHS/OIG. Although the recoupment was not performed as intended in the contract, HSD understood the intent of the STC and the flexibility permitted in the "adjust MCO PMPMs accordingly" language of the STC. HSD and its actuary developed an alternative approach to demonstrate compliance with STC #98. (See: *2017 Centennial Care 2.0 Waiver Renewal Request*).

This approach to compliance with STC #98 is well-documented with CMS. When HSD submitted the Centennial Care 1115 demonstration renewal application for Centennial Care 2.0, HSD was required to describe the status of our compliance with the demonstration STCs. In this application, HSD described the steps taken to comply with STC #98 and adjust the capitation rates to reflect member months in which no CB encounter data was reported.

> *SECTION 4: COMPLIANCE WITH SPECIAL TERMS AND CONDITIONS,*
> *Page 50*
> *"Post Capitation Reconciliation Process (STC 98) HSD evaluated MCO encounter data and capitation payments for members assigned to CB settings and, through the Medicaid Management Information System, adjusted capitation payments to the MCOs. In addition, prospective capitation rates reflect the appropriate utilization of CB services by Centennial Care members, which is at a lower rate than previously used by members in the predecessor program, Coordination of Long Term Services and Supports."*

These steps were accepted by CMS in the demonstration renewal negotiations (i.e., CMS did not take issue with HSD's compliance). Furthermore, CMS removed the language from STC #98 in

the approval of Centennial Care 2.0 (See *New Mexico Centennial Care 2.0 Waiver and Expenditure Authorities and Standard Terms and Conditions (STCs) 01.01.2019*.)

2. HSD Complied with the Requirements for Risk-Based Contracts at 42 CFR Part 438.

The managed care regulations in place during Centennial Care and Centennial Care 2.0 do not provide for reconciliation of retrospective utilization and expenditures in risk-based payments outside of approved risk-mitigation methodologies. CMS views reconciliation as antithetical to risk-based contracts. Furthermore, the requirement to set actuarially sound capitation rates in accordance with the requirements at 42 C.F.R. Part 438 was not waived in the Centennial Care waiver and expenditure authorities for STC #98. While HSD did not implement the reconciliation described in the contracts due to the data and systems challenges that have been described to the DHHS/OIG, our actuaries did adjust the MCO capitation rates in a manner wholly consistent with 42 C.F.R. Part 438 requirements, and with both the letter of STC #98 ("adjust MCO's PMPMs accordingly") and the spirit of STC #98. HSD provided documentation of this adjustment to the DHHS/OIG under this audit.

3. HSD Demonstrated a Commitment to Program Integrity.

The HSD has demonstrated continuous commitment to program integrity. At the outset of the Centennial Care LTSS program, HSD introduced additional training for MCOs related to nursing facility level of care (NF LOC) submissions and provided ongoing technical assistance throughout 2016 to the MCOs. Additionally, the HSD engaged in a comprehensive review of the HSD and the MCOs' policies, procedures, and data related to assessment of member NFLOC assignments, setting of care spans, and encounter service utilization. This review resulted in retrospective payment adjustments to align CY2014-CY2015 CB capitation payments with appropriate CB utilizers, in a manner that deviated from the initial plan (as described in the MCO contract language) but was consistent with STC #98. This revised approach considered both the administrative burden for the MCO contractors and the HSD of complying with the original approach as well as the ability of the HSD to make more timely adjustments of MCO PMPMs under the revised approach. Thereafter, the HSD sustained its monitoring of CB service utilization rates of CB members compared to the CY2014-CY2015 levels, to ensure ongoing integrity of the program's NFLOC assignments, policies, and procedures. These measures were essential to ensuring that the capitation payments accurately reflect a CB risk profile for the members for which the MCOs received CB capitation payments.

While the reconciliation and recoupment process in the contract described a specific method, the HSD's actions were aligned with the broader goal of program integrity. We collaborated extensively with MCOs and conducted retrospective reviews of capitation payments to rectify any

Office of the Secretary | PO Box 2348 – Santa Fe, NM 87504 | Phone: (505) 827-7750 Fax: (505) 827-6286

discrepancies. The capitation approach prospectively accounted for the appropriate CB utilization and allowed us to achieve the same objective – accurate payments to MCOs based on member risk, within the context of a risk-based managed care program and the rule at 42 C.F.R. Part 438.

The contract language in question has been removed from the program effective CY2019 because CMS removed STC #98 from Centennial Care and the contract language was inconsistent with risk-based managed care.

4. <u>The Financial Impact of HSD's Revised Approach is Immaterial.</u>

The HSD strongly disputes the amount of the financial impact calculated by the auditor. It is crucial to understand that the financial impact of the HSD's deviation from the contract language in question is immaterial when HSD's additional actions are taken into consideration. The approximately $98.6 million in federal share indicated in the DHHS/OIG's finding reflects a partial financial impact. However, the DHHS/OIG's finding misses the appropriate offsetting downstream impact of reclassification on the development of Centennial Care program capitation payment rates.

The HSD's rate development process reflects the activities of the managed care program. For example, to reflect the retroactive eligibility period reconciliation process, the capitation payment rates are explicitly adjusted to remove the experience of members during the retroactive eligibility period, and the acuity impact is reflected in the rate development process. Similarly, if the HSD had performed the retrospective reconciliation process, the capitation payment rates would have been adjusted to reflect the increased average member costs for the CB population as a result of reconciliation and cohort reclassification to align rates with actual experience, risk, and the practical aspects of program implementation.

The capitation rates for subsequent years (CY2016 and beyond) were developed based on a baseline level of acceptable CB utilization, which was consistently above 88% throughout the CY2014-CY2018 period, established from our retrospective efforts in CY2014-CY2015. This prudent approach ensured consistency with the HSD's program integrity goals and addressed the limitations around the feasibility of achieving 100% CB utilization within the specified period as part of risk-based prospective capitation rate development.

Our actuarial analysis further indicates that the net financial costs from the corresponding changes made to capitation payments, effectively increasing underlying CB utilization levels from the baseline level up to 100%, would have been virtually equal in magnitude to the net recoupment resulting from CB capitation payment adjustments over the CY2014-CY2018 period. The

adjustments made to align payment rates with utilization and risk, as demonstrated in our detailed financial analysis, largely mitigate the potential adverse financial impact.

The report states that "The State agency believed that it did not need to recoup overpayments or refund these overpayments by either requesting direct repayment from the MCOs or reducing future monthly capitation payments for enrollees who did not meet the 90-day requirement because it believed such overpayments would be offset in future NFLOC capitated rate-setting calculations." This statement is inaccurate. The methodology used to set capitation payments already factored in a reduction for enrollees who did not meet the 90-day requirement. Simply put, the capitation rates developed prospectively paid to the MCOs was lower to account for the reconciliation period and any retrospective recoupment would be double counting the impact. If the recoupment occurs, our actuaries would need to re-evaluate the capitation rates paid over the CY2016-CY2018 period to ensure that the rates would still be reasonable, attainable, and appropriate for the time period given this new information, and likely result in a capitation rate increase.

The impact of performing the CB reconciliation and revising the cohort acuity results in a net 0.038% impact on total non-Expansion capitation payments made for all cohorts. This magnitude falls within what CMS typically considers a "de minimis" impact within at-risk managed care capitation rate variation.

DHHS/OIG Finding & Recommendation: *The State Agency did not provide support showing that enrollees were eligible for services at the higher nursing facility level-of-care capitated rate. The State should recoup the $29,442,388 in NFLOC capitated payments from its MCOs and refund the $20,536,132 Federal share to the Federal Government.*

State Response: HSD does not concur with the DHHS/OIG's recommendation. HSD recognizes that, for a small subset of the NFLOC population, there is a disconnect between what the system now reports as the member's NFLOC status and what status the member actually had at the time. Now that we are aware of the issue, we have implemented a change in approach, consistent with Recommendation described below. Our actuaries accounted for this subset of the population in the impact of performing the CB reconciliation and revising the cohort acuity results which resulted in the "de minimus" impact.

DHHS/OIG Recommendation: *Establish policies and procedures to recoup NFLOC capitated payments made to its MCOs based on settings-of-care that are removed after payment and no longer valid.*

HUMAN SERVICES
DEPARTMENT

Michelle Lujan Grisham, Governor
Kari Armijo, Acting Secretary
Alex Castillo Smith, Deputy Secretary
Kathy Slater Huff, Acting Deputy Secretary
Lorelei Kellogg, Acting Medicaid Director

State Response: HSD concurs with the OIG's recommendation. HSD has implemented a recoupment process which will identify any long term care capitations paid for which the long term care span no longer covers and adjust those capitations to pay at the lower non-long term care cohort. This recoupment process will be set to run quarterly to allow for any lag in the entry of the LTC span.

In conclusion, HSD respectfully requests your reconsideration of findings and that the DHHS/OIG make appropriate revisions to the draft report. We feel that the draft as written does not tell the full story of the HSD's efforts to comply with the CMS requirements. Centennial Care LTSS has maintained program integrity while minimizing unnecessary administrative burdens. We believe our actions, although not strictly following the contract in certain instances, have been guided by the principles of transparency, accuracy, and fiscal responsibility, as well as compliance and program integrity. We do not believe that the DHHS/OIG should be making a recommendation for recovery.

We welcome the chance to discuss or meet with you or your management team to discuss this matter further, should that be necessary.

Sincerely,

Lorelei Kellogg
Acting Director, Medical Assistance Division (MAD)

cc: Julie Lovato, MAD Compliance Officer

Office of the Secretary | PO Box 2348 – Santa Fe, NM 87504 | Phone: (505) 827-7750 Fax: (505) 827-6286