Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NEW MEXICO DID NOT ALWAYS APPROPRIATELY REFUND THE FEDERAL SHARE OF RECOVERIES FROM MANAGED CARE ORGANIZATIONS

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

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Office of Inspector General

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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: February 2019
Report No. A-06-18-09001

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

New Mexico Did Not Always Appropriately Refund the Federal Share of Recoveries from Managed Care Organizations

Why OIG Did This Review

Prior Office of Inspector General work found that another State did not always appropriately refund the Federal share of managed care organization (MCO) recoveries. After that work, we were concerned that other States may not appropriately refund the Federal share of MCO recoveries.

MCO recoveries refer to recoupments of prior payments to MCOs. New Mexico made recoveries when MCO profits exceeded contract-established limits and to reduce certain payments to the MCO's actual cost.

The objective of our audit was to determine whether New Mexico appropriately refunded the Federal share of MCO recoveries.

How OIG Did This Review

Our review covered $374 million ($341.5 million Federal share) in MCO recoveries for calendar years 2014 and 2015.

What OIG Found

Of the $374 million in MCO recoveries, New Mexico appropriately refunded the Federal share for $359 million. However, New Mexico underreported the Federal share for the remaining $15 million by $4.4 million as follows:

- $4.3 million because it incorrectly calculated the Federal share of recoveries related to Affordable Care Act (ACA) expansion population payments, which the Federal Government originally matched at 100 percent using the regular Federal medical assistance percentage (FMAP), and

- $118,584 because it did not consider higher FMAPs, such as for Family Planning and Breast and Cervical Cancer, in its Federal share calculations for MCO recoveries of other beneficiary populations' payments.

Additionally, New Mexico did not perform reconciliations of capitation payments for community based long-term care services as required under its contracts with MCOs. As a result, New Mexico had not made any MCO recoveries related to those long-term care services.

What OIG Recommends and New Mexico's Comments

We recommended that New Mexico refund to the Federal Government the additional $4.4 million Federal share related to ACA expansion MCO recoveries and MCO recoveries originally claimed at higher FMAPs, such as those for Family Planning and Breast and Cervical Cancer.

We also recommended that New Mexico establish policies and procedures to identify MCO recoveries that were originally claimed at higher FMAPs, perform reconciliations in accordance with its contracts with MCOs, and consider conducting its reconciliations in a more timely manner.

In written comments on our draft report, New Mexico concurred with some but not all of our recommendations. New Mexico agreed to work with CMS to refund the recommended $4.4 million to the Federal Government and to develop an appropriate allocation methodology for MCO recovery reporting. After reviewing New Mexico's comments, we maintain that our findings and recommendations are valid.

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INTRODUCTION

WHY WE DID THIS REVIEW

Prior Office of Inspector General work found that another State did not always appropriately refund the Federal share of managed care organization (MCO) recoveries.[1] After that work, we were concerned that other States may not appropriately refund the Federal share of MCO recoveries. The Centers for Medicare & Medicaid Services (CMS) officials informed us that New Mexico had recently recovered approximately $300 million from its MCOs.

OBJECTIVE

The objective of our audit was to determine whether the New Mexico Human Services Department (State agency) appropriately refunded the Federal share of MCO recoveries.

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, CMS administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. The State agency administers the Medicaid program. Contracted MCOs provide medical services to beneficiaries enrolled in 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), which varies depending on the State's relative per capita income.

The State agency's regular FMAP during calendar years (CYs) 2014 and 2015 ranged from 69.20 percent to 70.37 percent. For Family Planning and Breast and Cervical Cancer services, the State agency receives a higher reimbursement rate.[2]

Within 30 days after the end of each quarter, States report expenditures and the associated Federal share on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance

[1] *Texas Inappropriately Claimed Medicaid Balancing Incentive Payments Program and Family Planning Funding* (A-06-14-00059), issued February 2016.

[2] Family Planning services are reimbursed at a fixed 90-percent rate, and Breast and Cervical Cancer services are reimbursed at the enhanced rate, which ranged from 78.44 percent to 79.26 percent.

Program (CMS-64 report). The amounts that States report must represent actual expenditures. The State agency uses line items on the CMS-64 report to split expenditures based on the type of services provided. When a State agency recovers a prior expenditure, it must refund the Federal share by reporting the recovery to CMS at the FMAP used to calculate the amount it originally received.[3]

Affordable Care Act Expansion

The Affordable Care Act (ACA) expanded Medicaid coverage by creating an opportunity for States to provide Medicaid coverage, effective January 1, 2014, for individuals under 65 years of age with incomes up to 133 percent of the Federal poverty level. The ACA established an enhanced Medicaid FMAP reimbursement rate of 100 percent for medical assistance provided to newly eligible individuals in 2014 through 2016. This new group may also be referred to as the expansion population.[4]

Managed Care Organization Recoveries

MCO recoveries refer to the State agency's recoupments of prior capitated payments to MCOs. The State agency made recoveries when MCO profits exceeded contract-established limits and to reduce certain payments to the MCO's actual cost.

HOW WE CONDUCTED THIS REVIEW

Our review covered $374,094,906 ($341,532,800 Federal share) in MCO recoveries for CYs 2014 and 2015 (January 1, 2014 to December 31, 2015). We determined the FMAPs at which the State agency claimed capitated payments for CYs 2014 and 2015 and traced the MCO recoveries to the CMS-64 reports. We then determined whether the State agency appropriately applied the FMAPs it originally used to claim the associated capitated payments. When the State agency did not appropriately apply all FMAPs to its recoveries, we determined 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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

Appendix A contains the details of our scope and methodology.

[3] The Social Security Act, section 1903(d)(2)); CMS State Medicaid Manual, section 2500.6(B).

[4] The Patient Protection and Affordable Care Act, P.L. No. 111-148 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (Mar. 30, 2010), is known as the Affordable Care Act.

FINDINGS

Of the $374,094,906 in MCO recoveries, the State agency appropriately refunded the Federal share for $359,049,406. However, the State agency underreported the Federal share for the remaining $15,045,500 by $4,421,572 as follows:

- $4,302,988 because it incorrectly calculated the Federal share of recoveries related to ACA expansion population payments, which the Federal Government originally matched at 100 percent using the regular FMAP, and

- $118,584 because it did not consider higher FMAPs, such as for Family Planning and Breast and Cervical Cancer, in its Federal share calculations for MCO recoveries of other beneficiary populations' payments.

Additionally, the State agency did not perform reconciliations of capitation payments for Community Benefit services as required under its contracts with MCOs.[5] As a result, the State agency had not made any MCO recoveries related to Community Benefit services or returned any related Federal share.

THE STATE AGENCY INCORRECTLY CALCULATED THE FEDERAL SHARE OF AFFORDABLE CARE ACT EXPANSION RECOVERIES

The State agency used the lower, regular FMAP to calculate the Federal share for $14,403,110 in MCO recoveries of ACA expansion population payments. The Federal Government matched those payments at the 100 percent FMAP.

The State agency did not reconcile and recover CY 2014 and 2015 MCO capitation payments for the ACA expansion population until midway into CY 2017. However, the New Mexico Office of the Superintendent of Insurance did its reconciliations much earlier in December 2015 and December 2016, and required the State agency to recover the $14,403,110 in Medicaid payments from one MCO. At the time of recovery, the State agency calculated the Federal share using the regular FMAP. When the State agency completed its reconciliations and assigned the recoveries to ACA expansion population payments, it did not correct the Federal share calculation.

As a result of its miscalculation, the State agency only refunded $10,100,122 of the recoveries to the Federal Government, rather than the full amount. Therefore, the State agency did not appropriately refund the difference of $4,302,988 to the Federal Government.

[5] New Mexico's Medicaid Community Benefit covers long-term care services for the elderly that are provided outside of nursing homes. These services are intended to help the elderly remain living in their homes or in the community.

THE STATE AGENCY DID NOT CONSIDER HIGHER FEDERAL MEDICAL ASSISTANCE PERCENTAGES IN ITS FEDERAL SHARE CALCULATIONS

Even though the State agency originally claimed MCO payments for non-expansion beneficiary populations at higher FMAPs, such as the Family Planning and Breast and Cervical Cancer FMAPs, it did not consider those higher FMAPs when it calculated the Federal share of related MCO recoveries because the State agency's policies and procedures for calculating the Federal share of MCO recoveries did not include consideration of the higher FMAPs. Instead, the State agency calculated the Federal share of all such recoveries using the lower, regular FMAP.

Therefore, the State agency did not identify $642,390 in MCO recoveries of payments that it originally claimed at higher FMAPs. As a result, the State agency underreported the Federal share of those recoveries by $118,584.

THE STATE AGENCY DID NOT PERFORM COMMUNITY BENEFIT SERVICES RECONCILIATIONS

According to the State agency contracts with its MCOs, the State agency will review beneficiaries' needs for the Community Benefit by reviewing each beneficiary's service utilization in the first 90 calendar days of their approval for the services. The contracts state that the State agency will recoup the Community Benefit capitation payment if a beneficiary did not utilize Community Benefit services in that initial 90-day period.[6]

The State agency did not perform reconciliations of capitation payments for Community Benefit services as required under its contracts with MCOs because it did not have policies and procedures in place during our audit period to ensure that it conducted these reconciliations. As a result, the State agency had not made any MCO recoveries related to Community Benefit services or returned any related Federal share.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government the additional $4,421,572 Federal share related to ACA expansion recoveries and recoveries originally claimed at higher FMAPs, such as those for Family Planning and Breast and Cervical Cancer;

- consider conducting its reconciliations of MCO payments in a more timely manner;

- establish policies and procedures to identify MCO recoveries that were originally claimed at higher FMAPs; and

[6] MCO Contracts, Amendment 5, section 6.11.1.

- establish policies and procedures to ensure that it performs reconciliations of capitation payments for Community Benefit services as required under its contracts with MCOs, perform those reconciliations, and refund the Federal share of any MCO recoveries made to the Federal Government.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with two of our four recommendations, did not indicate concurrence or nonconcurrence for one, and did not concur with our final recommendation.

Regarding our first and third recommendations, the State agency agreed that it had incorrectly calculated the Federal share of ACA expansion recoveries and did not consider higher FMAPs in its Federal share calculations and stated that it would work with CMS to refund the related $4,421,572 Federal share. The State agency also agreed to work with CMS to develop an appropriate allocation methodology for MCO recovery reporting.

As for our second recommendation, the State agency stated that it is already following a timeline established under the MCO contracts.

The State agency disagreed with our final recommendation and responded that it had conducted an analysis of long-term services and supports capitation payments that met the requirements of the reconciliation. The State agency provided information about the results of that analysis.

The State Agency's comments are included as Appendix B.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we maintain that our findings and recommendations are valid. Conducting reconciliations in a more timely manner would help to avoid lengthy delays between the New Mexico Office of the Superintendent of Insurance's reconciliations and the State agency's reconciliations. The delay between those two reconciliations resulted in the State agency incorrectly calculating the Federal share of ACA expansion recoveries.

As for our final recommendation, we made multiple requests for the Community Benefit services reconciliations and were told that the reconciliations had not been completed. The document the State agency provided to support its policies and procedures for calculating MCO recoveries included a blank section for the Community Benefit services reconciliation

methodology. The document stated that the Community Benefit services methodology would be completed after the MCO's reviewed it, which indicates that the methodology to conduct the reconciliations had not been finalized.

To explain why the reconciliations were not completed, a State agency official told us that the reconciliations were not required for CYs 2014 and 2015, even though they were required.

During our review, the State agency did not provide the information it included in its comments to our draft report, so we were not given the opportunity to review and validate it.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered $374,094,906 ($341,532,800 Federal share) in MCO recoveries for CYs 2014 and 2015.[7]

Our objective did not require us to assess the State agency's overall control structure. We limited our internal control review to understanding and assessing the State agency's policies and procedures for calculating MCO recoveries. However, we did not validate the accuracy of the State agency's calculations.

We conducted our fieldwork from May through August 2018. Work was conducted at the State agency's offices in Santa Fe, New Mexico.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal regulations and the State agency's contracts with its MCOs;
- reviewed the State agency's policies and procedures for calculating MCO recoveries;
- determined the FMAPs at which the State agency claimed capitated payments for CYs 2014 and 2015;
- traced MCO recoveries to the CMS-64 report and determined if the State agency appropriately applied the FMAPs it originally used to claim the associated capitated payments; and
- determined the Federal share impact when the State agency did not appropriately apply all FMAPs to its recoveries.

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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

[7] After we concluded our fieldwork, the State agency told us that it had conducted reconciliations of Indian Health Services claims and related MCO recoveries claims, so we excluded them from our audit scope.

APPENDIX B: STATE AGENCY COMMENTS

December 28, 2018

HUMAN SERVICES DEPARTMENT

Susana Martinez, Governor
Brent Earnest, Secretary
Nancy Smith-Leslie, Director

Miquel Darcy & Eurika Ramdas
DHHS OIG

Re: NMHSD Response to DHHS OIG draft report on the A-06-18-09001 Application of FMAPs to MLR Rebates audit

After much consideration and additional analyses, here are our responses to the OIG draft report findings:

- As to the finding that the "**the state agency incorrectly calculated the federal share of ACA expansion recoveries**", the state agrees and will work with the Centers for Medicare and Medicaid to return the $4,302,988.

- As to the finding that the "**the state agency did not consider higher FMAPs in its federal share calculations**", the state agrees and will work with the Centers for Medicare and Medicaid to return the $118,584. In addition, the state will work with CMS to develop an allocation methodology for recovery reporting that align with FFP claiming.

- As for the recommendation that state should "**consider conducting its reconciliations of MCO payments in a more timely manner**", the state is following timeline as established under the contracts with the MCO. Since there are multiple reconciliations of capitation payments for each calendar year, the state performs the Medicaid medical loss ratio (MLR) reconciliation as the final reconciliation.

- The state disputes the draft finding that the state did not perform the community benefit reconciliation because it did not have policies and procedures.
  The state did conduct an analysis of long-term services and supports (LTSS) capitation payments made to Centennial Care managed care organizations (MCOs) that met the requirements for the reconciliation. In late 2015 through early 2016, the state evaluated the following three data sources from the state's Medicaid Management Information System (Omnicaid) for calendar year 2014 (CY2014) and CY2015:
  - Historical capitation payments by rating cohort made to MCOs;
  - Nursing facility level of care (NF LOC) and setting of care spans, and
  - Encounter data submitted by the Centennial Care MCOs.

  Table 1 below summarizes the three observations, which were mutually exclusive of each other, the actions taken by the state and their impact (recoupment/payment).

Table 1 — CY2014 and CY2015 Analysis of Capitation Payments, NF LOC and Encounter Data

Analysis Observations	Action/Impact
1. A non-NF LOC LTSS capitation payment was made by the state to the MCO where the member had a valid setting of care in Omnicaid **and** encounter data identified that the member was using long-term care services. ** refer to definitions for non-NF LOC and non-NF LOC LTSS capitation payment.*	**Action:** Recouped the non-NF LOC LTSS or other non-LTSS capitation payment and paid the appropriate NF LOC LTSS capitation payment. **Impact:** Increased payment to MCOs.

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2. A NF LOC LTSS capitation payment was made by the state to the MCO where the member had a valid setting of care in Omnicaid **and** encounter data identified that the member **had not** used long-term care services. ** refer to definitions for non-NF LOC and non-NF LOC LTSS capitation payment.*	**Action:** Recouped the NF LOC LTSS capitation payment and paid the appropriate non-NF LOC capitation payment. **Impact:** Decreased payment to MCOs.
3. A NF LOC LTSS capitation payment was made by the state to the MCO where the member **did not have** a valid setting of care in Omnicaid **and** encounter data identified that the member **had not** used long-term care services. ** refer to definitions for non-NF LOC and non-NF LOC LTSS capitation payment.*	**Action:** Recouped the NF LOC LTSS capitation payment and paid the appropriate non-NF LOC capitation payment. **Impact:** Decreased payment to MCOs.

Definitions:

- NF LOC means nursing facility level of care. Members classified as NF LOC meet the state's requirements for meeting a minimum number of activities of daily living and are eligible to receive long-term care services including custodial nursing facility care as well as community benefit services. MCOs receive LTSS capitation payments for members who have a NF LOC.
- Non-NF LOC LTSS capitation payments means the MCO is paid a capitation payment for non-LTSS rate cohorts (TANF, aged, blind, disabled without Medicare coverage) or LTSS members who were dually eligible but did not meet the criteria for NF LOC.

In 2016, the state reprocessed historical capitation payments for CY2014 and CY2015 through Omnicaid in order to process the payments and recoupments. Since the payments and recoupments were done through the Omnicaid system, the quarterly CMS-64 filings reflected monies recouped from the MCOs as reductions in quarterly expenditures and were claimed appropriately.

Other Actions

As part of the analysis process discussed above, the state identified that the primary reason to recoup and/or make additional payment was associated with the entry of NF LOC segments by the MCOs. MCOs were not always updating NF LOC segments before the start of the month that a capitation payment was made. The state found that many times MCOs were submitting NF LOC segments retrospectively, resulting in an incorrect capitation payment. These incorrect capitation payments were addressed in the reconciliation.

In addition to the payment and recoupment process in CY2016, the state implemented additional training for the MCOs related to NF LOC submissions and also provided ongoing technical assistance to the MCOs throughout 2016.

For contract periods CY2016 and beyond, HSD analyzed the historical community benefit utilization, the basis for prospective LTSS capitation rates, and actual encounter experience by the MCOs. This evaluation identified that the LTSS capitation payments and MCO encounter experience was comparable and that no community benefit reconciliation was necessary.

Feel free to contact me with any additional questions or comments.

Thank you.

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