Situation Report from MAD Compliance Officer to Secretary and Director
Issue: Impact of Community Benefit Capitation Payment Audit

Date: March 4, 2024

Situation: Community Benefit Capitation Payment Audit findings totaling $119.1 million in federal share.

Background: The US Department of Health & Human Services, Office of Inspector General (DHHS/OIG) provided MAD with an audit engagement letter on March 3, 2020. The scope of the audit was to determine whether the State had performed reconciliations of capitation payments for community benefit (CB) services as outlined in the MCO contracts **and** returned the federal share of all recoveries to CMS. The period under review was CY2014 through CY2018 (see "Engagement Letter 3.5.2020).

The reconciliation was incorporated into the MCO contracts to satisfy the Centennial Care 1115 Demonstration Waiver Special Terms and Conditions (STCs) which reflected the following:

> "***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.*"

To further define how the state would implement STC #98, the state included the following language into the MCO contracts that were in effective beginning CY2014:

> "*6.10* ***Community Benefit Reconciliation***
>
> *6.10.1 HSD shall review services for Members determined by the CONTRACTOR to need the Community Benefit. If a Member does not utilize Community Benefit services within (90) Calendar Days of the effective date of the Setting of Care (SOC), HSD will recoup the Capitation Payment from the CONTRACTOR for the months in which Community Benefit Services were not received. The ninety (90) Calendar Day period begins on the effective date of the SOC.*
>
> *6.10.2 The CONTRACTOR shall adhere to the NF LOC and Setting of Care timelines outlined in the Systems Manual.*
>
> *6.10.3 HSD will not retroactively adjust payments from physical health or a healthy dual Rate Cohort to a LTC Rate Cohort. It is the CONTRACTOR'S responsibility to ensure timely submission of correct Setting of Care for the Member. Notwithstanding the foregoing, if the CONTRACTOR has made good faith efforts to complete the CNA and the CONTRACTOR demonstrates through Encounter Data that it has continued to provide the LTC benefits after expiration of the NF LOC determination, then the retroactive payment adjustments to the appropriate LTC Cohort may be made."*

In early 2016 the state and its actuary found through a review of encounter data that the MCOs were having difficulties reflecting the accurate setting of care. To further explain, it was observed that the MCOs were not always updating the setting of care in the encounter data before the start of the month in which the capitation payment was made. The MCOs were given a new process for correctly submitting member setting of care spans which included direction to reprocess encounters for CY2014

and CY2015. The MCOs also received technical assistance from the state in order to complete the reprocessing.

Once the encounters were reprocessed by the MCOs, the state performed a reconciliation of CY2014 and CY2015. The state recouped capitation payments from the MCOs (and in some circumstances the state reissued the correct capitation payments) and returned the federal share to CMS on the CMS-64 quarterly expenditure report based on the following observations:

1. A non-NF LOC LTSS capitation payment was made where the member had a valid setting of care and the member was identified as using long-term care services;
2. A NF LOC LTSS capitation payment was made where the member had a valid setting of care but had not used long-term care services; and
3. A NF LOC LTSS capitation payment was made where the member had neither a valid setting of care nor had used long-term care services.

Due to the extensive reprocessing work for CY2014 and CY2015, in CY2016 the state made a business decision to implement a new strategy for more accurately setting CB capitation rates (beginning with the contract period of CY2016 and beyond) which also alleviated the administrative burden of having to recoup inappropriate capitation payments made to the MCOs. Unfortunately, this change was not reflected in the MCO contracts. On August 20, 2020, MAD issued a letter of direction to the MCOs notifying them that the CB reconciliation had been removed from the contract applicable to CY2019 and forward (see LOD_43_Community_Benefit_Reconciliation.pdf).

Additionally, it is important to note that prior to the engagement of the current audit, the DHHS/OIG had finalized an audit of all reconciliations performed in accordance with the terms of the MCO contracts in 2019 (see New Mexico Did Not Always Appropriately Refund the Federal share of the Recoveries from Managed Care Organization). Under this audit the above details were provided within the official state response. The 2019 audit did not result in monetary findings for the CB reconciliation but rather found that the state should establish policies and procedures to ensure that the reconciliations of the CB capitation payments were performed.

On April 7, 2020 the state and its actuary met with the DHHS/OIG and provided a detailed presentation of the CY2014-2015 reprocessing and the rate development beginning in CY2016. After that date, there were several follow-up meetings and correspondence with the DHHS/OIG from which it was apparent that the DHHS/OIG was not accepting of the state's shift in business procedures.

In October, 2020 the State's actuary provided the state with a reconciliation of the CB capitation payments as compared to the encounters for CY2016 through CY2018 (see CY2016-CY2018 Community Benefit Reconciliation 10.15.20.pdf). The results of the reconciliation indicate that for CY2016, there was a net impact of .1% on the CB capitation payments made to the MCOs, while in CY2017 and CY2018, there was no impact. **Important note: Had the state conducted a reconciliation in CY2016, it would have had to account for the shift in enrollment of each cohort that was impacted (i.e. moving CB members who had not utilized services from a CB cohort into a non-CB cohort) resulting in revisions to the capitation rates for CY2017 and each year thereafter for which a reconciliation was performed (revisions include adjustments to the acuity of the impacted cohorts).** These results were presented to the DHHS/OIG on October 27, 2020.

Through continued discussions with the DHHS/OIG in CY2021 and a re-evaluation of the encounters for CY2016 through CY2018, a systemic issue was discovered where the long-term care span had either been voided after the CB capitation payment had been made, or had been adjusted for a period not covered by the month in which the CB capitation payment was made. In December of 2023, the State

rectified this problem by incorporating a quarterly recoupment process in Omnicaid that will identify any CB capitation payments for which the long-term care span has been voided or adjusted and does not apply to the month of the CB capitation payment.

On October 10, 2023 the State received the DHHS/OIG's draft findings report (see Draft Report A-06-20-09001). In this report, the OIG found the following:

1) The state did not recoup $139.2M from MCOs for CB members who did not utilize CB services within the first 90 days and should return the federal share of $98.6M; and
2) The state made $35.2M in capitation payments at a higher NFLOC rate to the MCOs in instances where the member did not qualify and should return the federal share of $20.5M.
3) The State should 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.

On December 4, 2023, the state provided its official response to the DHHS/OIG (see HSD Response to Audit A-06-20-09001). In its response, the state did not agree with the first finding, and in support thereof, noted that the state's approach was compliant with the CC 1115 Waiver STC #98 (as accepted by CMS), capitation rates were developed in accordance with federal regulations, and the state's actions were aligned with the federal goal of program integrity ensuring that federal and state taxpayer dollars are spent appropriately.

The state also did not agree with the second finding to return $20.5M in federal funding. The OIG's recommendation would have resulted in a "de minimus" impact on the capitation rates.

The state did agree with the third finding, which did not have an associated monetary value.

To date, the DHHS/OIG has not notified the state that it has issued its final findings report.

Assessment: Based upon the draft findings report, CMS will issue a deferral and the state will be asked to return $119.1M in federal funding.

The state may pay the deferral of $119.1M or the state may choose to file an appeal with the U.S. DHHS Departmental Appeals Board (DAB).

Options	Pros	Cons
Option 1: The state will return the federal share of $119.1M upon issuance of the deferral.	The state maintains relationships with 2 of the 4 MCOs operating under Centennial Care 2.0 and an assessment of financial liability as well as recovery for each of the remaining MCOs could result in the state recovering a portion of the amount due. The state would avoid resources spent on the appeal.	An assessment of MCO financial liability could result in the state returning the entire deferral from state general funds.
Option 2: The state will file an appeal with DAB	The standard practices of capitation rate setting supported by the reconciliation performed by the state's actuary would be an acceptable defense and the DAB board	The standard practices of capitation rate setting would not be an acceptable defense and the DAB board would uphold the CMS deferral.

	would overturn the CMS deferral.	