DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

MAR 18 2003

TO: Neil Donovan
Director, Audit Liaison Staff
Centers for Medicare and Medicaid Services

FROM: Dennis J. Duquette
Deputy Inspector General
for Audit Services

SUBJECT: Review of Medicaid Payments Made by the New Mexico Human Services Department for Members Enrolled in the State's Medicaid Managed Care Program Entitled, "SALUD!" (A-06-02-00038)

As part of the Office of Inspector General's self-initiated audit work, we are alerting you to the issuance of the subject final audit report within 5 business days from the date of this memorandum. A copy of the report is attached. We suggest you share this report with components of the Centers for Medicare and Medicaid Services involved with program integrity, provider issues, and state Medicaid agency oversight, particularly the Center for Medicaid and State Operations. The objectives of our review were to determine whether:

- managed care payments made under SALUD! were correct and for eligible members; and
- Medicaid payments made under the fee-for-service (FFS) program were for services already covered under SALUD!.

Our review of Medicaid payments showed that the New Mexico Human Services Department (NMHSD) made incorrect managed care and FFS payments totaling about $3.6 million ($2.6 million federal share). The NMHSD made:

- managed care and FFS payments totaling about $1.9 million for deceased individuals for the period of July 1997 through May 2002. Payments were made on behalf of deceased beneficiaries because the date of death information in the Medicaid payment system was not updated properly;

- more than one managed care payment per month for SALUD! members resulting in overpayments of about $961,000 during the period April 1998 through March 2002. These payments occurred because the payment system edit to prevent more than one capitation per member per month was not working; and

- managed care payments for individuals not eligible for SALUD! totaling about $747,000 during the period January 1999 through August 2001. These payments occurred because the eligibility information was not reflected in the payment system timely.

We recommended that NMHSD refund the federal share totaling about $2.6 million related to the overpayments; maintain accurate and complete eligibility information; and consider revising its contracts with Manage Care Organizations (MCO) to allow for recovery of overpayments beyond the 24-month limitation and regardless of whether the MCO provided services. The NMHSD agreed with our findings and are in the process of determining the overpayments and taking corrective action. However, NMHSD does not plan on amending the MCO contracts to allow for recovery of overpayments if the MCO provided services.

Any questions or comments on any aspect of this memorandum are welcome. Please address them to George M. Reeb, Assistant Inspector General for the Centers for Medicare and Medicaid Audits, at (410) 786-7104 or Gordon L. Sato, Regional Inspector General for Audit Services, Region VI, at (214) 767-9206.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services
1100 Commerce, Room 6B6
Dallas, TX 75242

MAR 21 2003

Report Number: A-06-02-00038

Ms. Pamela S. Hyde
Secretary-Designate
New Mexico Human Services Department
Office of the Secretary
2009 South Pacheco Street, Pollen Plaza, Room 310
Santa Fe, New Mexico 87505

Dear Ms. Hyde:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services (OAS) final report entitled, *Medicaid Payments Made by the New Mexico Human Services Department for Members Enrolled in the State's Medicaid Managed Care Program Entitled, "SALUD!"*. A copy of this report will be forwarded to the action official noted below for review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), OIG, OAS reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR part 5.)

To facilitate identification, please refer to report number A-06-02-00038 in all correspondence relating to this report.

Sincerely,

Gordon L. Sato

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Dr. James R. Farris, MD
Regional Administrator
Centers for Medicare and Medicaid Services
1301 Young Street, Room 714
Dallas, Texas 75202

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID PAYMENTS MADE BY THE NEW MEXICO HUMAN SERVICES DEPARTMENT FOR MEMBERS ENROLLED IN THE STATE'S MEDICAID MANAGED CARE PROGRAM ENTITLED, "SALUD!"

JANET REHNQUIST
Inspector General

MARCH 2003
A-06-02-00038

Notices

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

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR Part 5.)

OAS FINDINGS AND OPINIONS

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services
1100 Commerce, Room 6B6
Dallas, TX 75242

MAR 21 2003

Report Number: A-06-02-00038

Ms. Pamela S. Hyde
Secretary-Designate
New Mexico Human Services Department
Office of the Secretary
2009 South Pacheco Street, Pollen Plaza, Room 310
Santa Fe, New Mexico 87505

Dear Ms. Hyde:

This final report provides the results of our review of Medicaid payments made by the New Mexico Human Services Department (NMHSD) for members enrolled in the State's Medicaid managed care program entitled, "SALUD!". The objectives of our review were to determine whether:

- managed care payments made under SALUD! were correct and for eligible members; and

- Medicaid payments made under the fee-for-service (FFS) program were for services already covered under SALUD!.

Our review of Medicaid payments showed that NMHSD made incorrect managed care and FFS payments totaling about $3.6 million ($2.6 million federal share). The NMHSD made:

- managed care and FFS payments totaling about $1.9 million for deceased individuals for the period of July 1997 through May 2002. Payments were made on behalf of deceased beneficiaries because the date of death information in the Medicaid payment system was not updated properly;

- more than one managed care payment per month for SALUD! members resulting in overpayments of about $961,000 during the period April 1998 through March 2002. These payments occurred because the payment system edit to prevent more than one capitation per member per month was not working; and

- managed care payments for individuals not eligible for SALUD! totaling about $747,000 during the period January 1999 through August 2001. These payments occurred because the eligibility information was not reflected in the payment system timely.

Under SALUD!, NMHSD contracts with managed care organizations (MCO) to provide the managed care benefit package to eligible individuals. The contracts prohibited collection of overpayments by the state if the MCO provided services to the member for the months in which payment was made, or 12 months had elapsed from the date of payment. Beginning July 2001, the 12-month limitation was changed to 24 months. According to the 42 CFR 433.312, the federal share of an overpayment must be refunded whether or not the state has recovered the overpayment from the provider. The federal share related to the overpayments of about $3.6 million totals about $2.6 million.

We recommended that NMHSD:

- refund the federal share totaling about $2.6 million related to the overpayments of about $3.6 million;

- maintain accurate and complete eligibility information, including the date of death; and correct the edit in place to prevent more than one capitation payment per member per month; and

- consider revising its contracts with MCOs to allow for recovery of overpayments beyond the 24-month limitation and regardless of whether the MCOs provided services.

The NMHSD agreed with our findings and are in the process of refunding the overpayments and taking corrective action. The NMHSD:

- identified about $1.8 million in incorrect payments made to MCOs and about $215,000 in incorrect Medicaid fee-for-service payments. The NMHSD stated that it recovered about $1.5 million from the MCOs and refunded it to the Federal Government. The NMHSD stated that it will refund the remaining amount upon receipt of our final report.

- implemented system edits to ensure that accurate and complete information relating to dates of death and Medicare eligibility are captured correctly. In addition, NMHSD implemented a new duplicate edit processing system to improve the duplicate detection capabilities.

- will be making contract amendments that will allow for recovery of overpayments beyond the 24-month limitation.

Based on discussions with NMHSD officials after their comments were received, NMHSD does not plan on amending the contract to allow for recovery of overpayments if the MCO provided services. The complete text of NMHSD's response is presented as APPENDIX A to this report.

INTRODUCTION

BACKGROUND

The State of New Mexico submitted a proposal under section 1915(b) of the Social Security Act authority to provide comprehensive medical and social services to the state's Medicaid population under a managed care delivery arrangement. On July 1, 1997, the state was awarded an approval to operate a statewide managed care program called SALUD! for children and families receiving Medicaid. The NMHSD's Medical Assistance Division administers the SALUD! program.

Currently, NMHSD contracts with three MCOs to provide all primary care and specialty services to SALUD! members. The contracts are risk based and MCOs may incur a profit or loss for providing managed care benefits to SALUD! members. The MCOs are paid a set amount per member regardless of the amount of services rendered. The MCOs receive an additional payment for Native American members to cover Indian Health Service (IHS) costs. However, if the additional payment is not used then it will be reimbursed to the state. Medicaid services that are not covered by the MCOs are provided and paid for under the Medicaid FFS payment program.

All Medicaid eligible individuals are required to participate in SALUD! except for Native Americans who have the option to enroll and individuals not eligible for SALUD!. The following individuals are not eligible for SALUD! because they are:

- eligible for both Medicaid and Medicare (dual eligible);
- residing in a nursing facility for over 30 days;
- residing in intermediate care facilities for the mentally retarded;
- participating in the Health Insurance Premium Program; or
- in out-of-state foster care or adoption placement.

Medicaid eligibility determinations are made through NMHSD's Income Support Division; Children, Youth, and Families Department; and the Social Security Administration (SSA).

The NMHSD pays a monthly capitated amount to MCOs on behalf of each SALUD! eligible member. The monthly rate for each member is based on 1 of 29 rate groups. Each of the capitation rate groups is based on a combination of several factors that include: the member's age, gender, and Medicaid eligibility category. Payment and eligibility information is maintained by NMHSD on its Omnicaid system.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The objectives of our review were to determine whether:

- managed care payments made under SALUD! were correct and for eligible members, and
- Medicaid payments made under the FFS program were made for services already covered under SALUD!.

Scope and Methodology

To obtain an understanding of the SALUD! program requirements and payment process, we met with NMHSD officials and discussed Medicaid and SALUD! eligibility categories. We also discussed how the state's Omnicaid system generated managed care payments using each member's category of Medicaid eligibility. In addition, we reviewed: (1) contracts between NMHSD and the MCOs; (2) New Mexico's Medicaid managed care regulations pertaining to managed care payments; and (3) SALUD! systems manual used to translate Medicaid eligibility categories to capitation rate groups for payment purposes.

To determine whether capitation payments made under SALUD! were correct and for eligible individuals, we selected a judgmental sample of 30 SALUD! members enrolled during July 2000. The results of our review of the sample of 30 members are shown in APPENDIX B to this report. We reviewed each member's eligibility and payment history during the period July 1, 2000 through June 30, 2001, state fiscal year 2001. We verified that each member met the eligibility requirements for Medicaid and SALUD! and that the capitation payment was accurate.

To determine whether Medicaid payments made under the FFS program were made for services already covered under SALUD! we: (1) interviewed NMHSD officials, and (2) reviewed FFS paid claims for the sample of 30 SALUD! members. For each member under review, we located FFS claims in the Omnicaid system that were paid and determined if the services were already covered under SALUD!.

After preliminary testing, we expanded our scope in the following areas:

Medicaid Payments for Deceased Individuals

We obtained a database from SSA of 7,403 supplemental security income (SSI) recipients in New Mexico who had passed away from July 1997 to March 2002. We obtained SALUD! capitation payments for the SSI recipients for the months of July 1999 through June 2002. We then identified SALUD! capitation payments that were paid after the date of death.

We then asked NMHSD to perform a query to identify SALUD! and FFS payments made on behalf of the 7,403 deceased SSI recipients. The NMHSD identified SALUD! and FFS payments made after the SSI recipients' date of death for the time period July 1997 through May 2002.

Unnecessary Additional SALUD! Payments
We requested that NMHSD perform a query to identify managed care payments paid to MCOs that were paid twice for the same month. The query performed covered the period April 1998 through March 2002.

Payments for Individuals Not Eligible For SALUD!
We obtained from NMHSD, documents supporting payments made to MCOs for individuals who were not eligible for SALUD! that were not recouped during the period January 1999 through August 2001. We quantified the uncollected amounts.

Our audit was performed in accordance with generally accepted government auditing standards. We limited consideration of the internal control structure to those controls concerning Medicaid payments for SALUD! members because the objectives of our review did not require an understanding or assessment of the complete internal control structure at NMHSD. Our audit work was conducted at NMHSD in Santa Fe, New Mexico and our offices in Dallas, Texas and Austin, Texas during the period February 2002 through October 2002.

FINDINGS AND RECOMMENDATIONS

We found that NMHSD made incorrect managed care and FFS payments totaling about $3.6 million. The NMHSD made:

- managed care and FFS payments totaling about $1.9 million for deceased individuals for the period July 1997 through May 2002. Payments were made on behalf of deceased beneficiaries because the date of death information in the Medicaid payment system was not updated properly.

- more than one managed care payment per month for SALUD! members resulting in overpayments of about $961,000 during the period April 1998 through March 2002. This occurred because the payment system edit to prevent more than one capitation per member per month was not working.

- managed care payments for individuals not eligible for SALUD! totaling about $747,000 during the period January 1999 through August 2001. This occurred because the eligibility information was not reflected in the payment system timely.

Under SALUD!, NMHSD contracts with MCOs to provide the managed care benefit package to eligible individuals. The contracts prohibited collection if the MCO provided services to the member for the months in which payment was made, or 12 months had elapsed. Beginning

July 2001, the 12-month limitation was changed to 24 months. According to 42 CFR 433.312, the federal share of an overpayment must be refunded whether or not the state recovered the overpayment from the provider. The federal share related to the overpayments of about $3.6 million totals about $2.6 million.

Medicaid Payments for Deceased Individuals

The NMHSD made managed care and FFS payments totaling about $1.9 million during the period July 1997 through May 2002 for deceased individuals previously qualified for SSI. These payments include:

- Medicaid FFS payments totaling $516,061 for 237 deceased individuals who were formerly eligible for Medicaid under SSI; and

- managed care payments under SALUD! totaling $1,367,595 for 293 deceased individuals who were previously enrolled in SALUD!.

Of the $516,061 in FFS payments, NMHSD paid six providers over $29,000 each on behalf of members who had passed away totaling $199,276. (See Figure 1.)

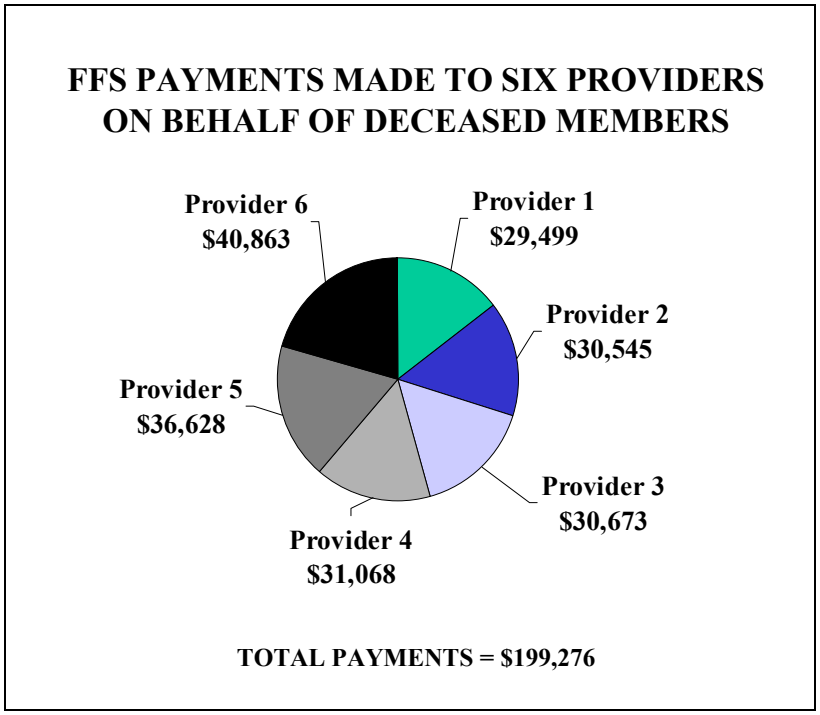

Figure 1

Of the $1.37 million in managed care payments, NMHSD paid MCOs for over 40 months after the date of death for six former members resulting in an overpayment of $152,466. (See Figure 2.)

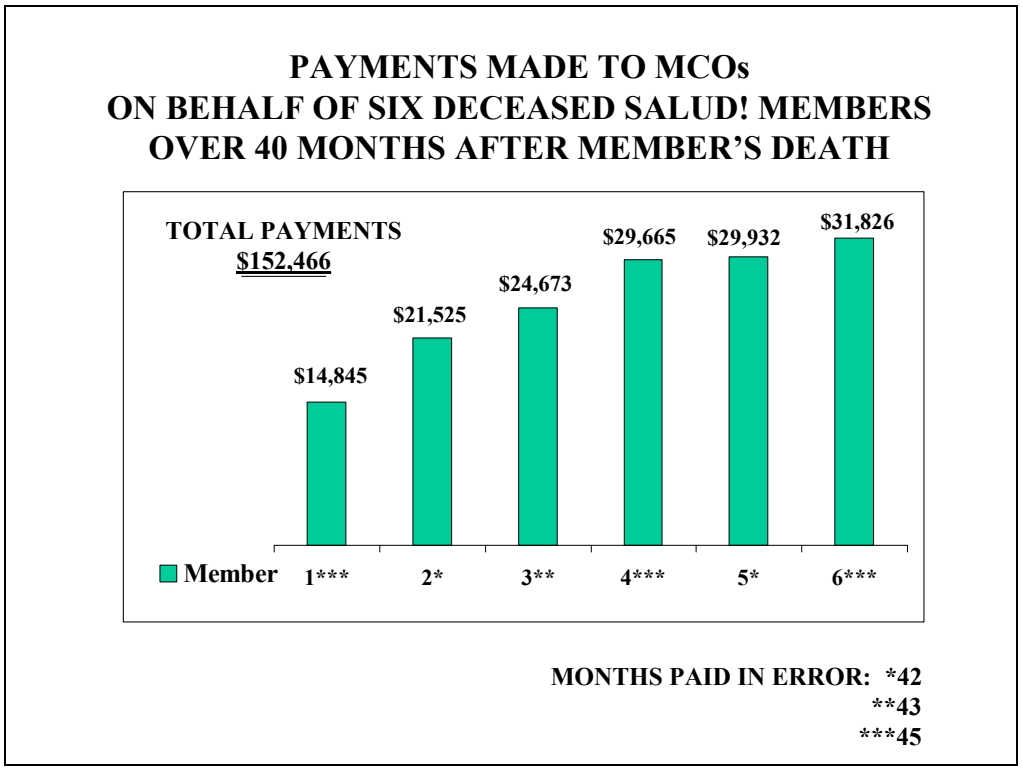

Figure 2

Deceased individuals are not eligible for SALUD! benefits and no capitation payments should have been made. The MCO contracts require the state to recoup capitation payments for ineligible individuals. Based on our audit findings, NMHSD requested MCOs to refund $729,484 of the $1.9 million of overpayments. The NMHSD is still in the process of verifying the date of death for the remaining $1.2 million and had not requested a refund from the MCOs at the time of our review.

For SSI recipients in SALUD!, the Omnicaid system relies on system interfaces between the SSA and State Data Exchange (SDX) systems for obtaining date of death information. Omnicaid is updated with SDX information on a daily basis, Monday through Friday. However, due to a programming logic error in transmitting the data, the date of death located in the SDX system did not always transfer to the Omnicaid system.

Unnecessary Additional Payments

The NMHSD made more than one managed care payment per month for SALUD! members resulting in overpayments of about $961,000 during the period April 1998 through March 2002.[1] This occurred because the payment system edit to prevent more than one capitation per member per month was not working. The MCOs filed manually for payments, and the NMHSD generated automatic payments as well for the same individuals and months. The additional payment was either an exact duplicate payment or based on another capitation rate group. According to the MCO contracts, only one capitation per member should be paid to MCOs each month, except MCOs receive an additional payment for Native American members to cover IHS costs. Based upon our audit findings, NMHSD requested that the MCOs refund the overpayments totaling about $961,000.

Payments for Individuals Not Eligible

The NMHSD identified managed care overpayments totaling $746,647 for dual eligible individuals for the period January 1999 through August 2001. Dual eligible individuals were not eligible for SALUD! according to the MCO contracts. Because NMHSD did not update eligibility information on the Omnicaid system timely, payments were made for dual eligible beneficiaries.

The NMHSD did not recover the $746,647 in overpayments because the MCO contracts prohibit recovery of payment made to the MCO for any given month if: (1) the MCO provided any health care services to the member during the month, or (2) 12 months had elapsed since a payment was made to the MCO on behalf of a SALUD! member.

MCO Contract Recoupment Provisions

The MCO contracts for SALUD! prohibited collection of overpayments if the MCO provided services to the member for the months in which payment was made, or 12 months had elapsed. Beginning July 2001, the 12-month limitation was changed to 24 months. According to 42 CFR 433.312, the federal share of an overpayment must be refunded whether or not the state has recovered the overpayment from the provider. The federal share related to the overpayments of about $3.6 million totals about $2.6 million.

Services Provided by MCO

A payment was not retroactively recouped if the MCO provided any service to the individual for a particular month. For example, SALUD! payments were made for an individual who was dual eligible for the months of January and February 2001 and the MCO provided a service for this individual in January, but not February. In this case, the state collected only the February

[1] The NMHSD identified payments totaling about $4 million for 2,706 individuals in which more than 1 payment was made in a month during the period April 1998 through March 2002. The $4 million included the correct and incorrect payments. Of this amount, the NMHSD quantified overpayments of about $961,000.

payment. Beginning in July of 2001, the recoupment process changed slightly. The state recouped on a quarterly basis instead of monthly. If the MCO provided services during any of the 3 months in the quarter, then the state will not recoup any overpayments made during the quarter.

Time for Recoupment Lapsed

A payment was not recouped if 12 months had passed before NMHSD could collect from the MCO. Prior to July 1, 2001, the MCO contracts stated that NMHSD shall not have a right to recoup a payment paid to MCOs if more than 12 months had elapsed since that payment was made. Beginning on July 1, 2001, the contract between NMHSD and the MCOs changed. This contract states that the MCO shall not recoup payments if more than 24 months have elapsed since payments were made.

RECOMMENDATIONS

We recommended that NMHSD:

- refund the federal share totaling about $2.6 million related to the overpayments of about $3.6 million;

- maintain accurate and complete eligibility information, including the date of death; and correct the edit in place to prevent more than one capitation payment per member per month; and

- consider revising its contracts with MCOs to allow for recovery of overpayments beyond the 24-month limitation and regardless of whether the MCO provided services.

AUDITEE'S COMMENTS

The NMHSD agreed with our findings and are in the process of refunding the overpayments and taking corrective action. The NMHSD:

- identified about $1.8 million in incorrect payments made to MCOs and about $215,000 in incorrect Medicaid fee-for-service payments. The NMHSD stated that it recovered about $1.5 million from the MCOs and refunded it to the Federal Government. The NMHSD stated that it will refund the remaining amount for incorrect payments upon receipt of our final report.

- implemented system edits to ensure that accurate and complete information relating to dates of death and Medicare eligibility are captured correctly. In addition, NMHSD implemented a new duplicate edit processing system to improve the duplicate detection capabilities.

- will be making contract amendments that will allow for recovery of overpayments beyond the 24-month limitation.

Based on discussions with NMHSD officials after their comments were received, NMHSD does not plan on amending the contract to allow for recovery of overpayments if the MCO provided services. The complete text of NMHSD's response is presented as APPENDIX A to this report.

Sincerely,

Gordon L. Sato

Gordon L. Sato
Regional Inspector General
for Audit Services

APPENDICES

NEW MEXICO HUMAN SERVICES DEPARTMENT
P.O Box 2348 Santa Fe, NM 87504-2348
Medical Assistance Division • PO Box 2348 • Santa Fe, New Mexico 87504
Phone: 505-827-3100

Gary E. Johnson
Governor

Robin Dozier Otten
Secretary-Designate

December 31, 2002

Common Identification Number: A-06-02-00038.

Mr. Gordon L. Sato
Regional Inspector General
Department of Health & Human Services
Office of Audit Services
1100 Commerce, Room 632
Dallas, TX 75242

Dear Mr. Sato;

This letter is in response to the U.S. Department of Health and Human Services, Office of the Inspector General (OIG), Office of Audit Services (OAS) draft report of December 6, 2002 entitled "Medicaid payments made by the New Mexico Human Services Department (NMHSD) for beneficiaries enrolled in the state's Medicaid managed care program entitled SALUD!".

Audit findings by the U.S. OIG have estimated $3.6 million was paid incorrectly to the Medicaid managed care organizations (MCOs) and the Fee For Service (FFS) program. Of the $3.6 million it is estimated that $1.9 million was paid incorrectly for deceased beneficiaries, $961,000 in double capitation payments, and $747,000 was paid for individuals not eligible for SALUD! Per the draft report, the federal share totaling about $2.6 million is refundable to the U.S. OIG by the NMHSD.

To date NMHSD has identified $1,820,019.37 as being paid incorrectly to the Medicaid managed care organizations (MCOs). Incorrect double capitation payments amount to $960,920.17 and incorrect payments to deceased beneficiaries amounts to $859,099.20 Incorrect Medicaid FFS payments are $214,593.56.

NMHSD has recovered $1,542,828.66 from the MCOs, which has been refunded to the U.S. OIG. The current amount recovered for deceased beneficiaries is $677,134.27. Efforts to recoup an additional $129,614.83 for deceased beneficiaries are underway. NMHSD has recovered $865,694.39 in duplicate capitation payments from the MCOs.

Recovery of the overpayments from the MCOs is conditional under the current contractual agreement. As noted in the draft audit report, the NMHSD contract prohibits recoupment of capitation payments if either the MCO (and/or its subcontractors) provided any health care services to the member during the relevant period of time or more than twenty-four months have elapsed since the payments were made. As recommended NMHSD will be implementing contract amendments that will allow for recovery of overpayments beyond the 24-month limitation regardless of whether the MCO provided services.

As noted in the U.S. OIG draft report incorrect eligibility assignments and incorrect duplicate payments were a result of system problems. As recommended, NMHSD is in the process of correcting the system. To date, NMHSD has revised two interfaces that come into the Medicaid Management Information System (MMIS) to improve the capture of eligibility information related to dates of death and Medicare eligibility. NMHSD found that dates of death were not being reported to the MMIS in certain circumstances. The agency responsible for transmitting this information to NMHSD has been advised to revise their program logic. Program revisions were complete and updates to the MMIS were made on December 5, 2002, resulting in 2,053 date of death updates to NM Medicaid beneficiaries. It was also discovered that the program accepting Medicare updates from the Bendex and Buyin interfaces was inappropriately excluding certain updates, resulting in an increase in the number of Medicare dual eligibles for which the Department had to pursue recoupment. Changes to this program logic have also been made and tested and should be implemented by December 31, 2002. This change will result in Medicare updates to approximately 1,100 Medicaid beneficiaries.

Duplicate payments were made under the old MMIS due to a failure in the duplicate edit processing of that system. That system was replaced in February 2002 with a new system, which has improved NMHSD's duplicate editing capabilities. Initially, upon conversion to the new system, a small number of duplicate claims where identified as a result of a procedural coding error. That procedure code has been terminated so that duplication between it and other capitation procedure code will no longer duplicate. As a further precaution periodic queries to the system are being performed to determine if any duplicate payments are occurring.

To date NMHSD has refunded $1,542,828.66 to the U.S. OIG. Contract amendments regarding duplicate capitation payments and erroneous payments made to deceased beneficiaries are currently underway. System edits have been implemented to correct double capitation payments and to ensure accurate and complete eligibility information. Upon receipt of the final U.S. OIG report NMHSD will refund the remaining amount for incorrect payments, which have been identified by the U.S. OIG and NMHSD.

Sincerely,

Robin Dozier Otten,
Secretary-Designate

Cc: Robert Maruca, Director, Medical Assistance Division
Roger Gillespie, Deputy Director, Medical Assistance Division

Results of Review of Probe Sample of 30

Our review of 30 SALUD! members showed that NMHSD made correct payments on behalf of 23 members, and incorrect payments for 3 members resulting in an overpayment of $6,053.

- For one member, NMHSD made two capitation payments for 1 month. According to the MCO contracts, only one capitation payment should be made per month per member, except an additional payment is made for Native Americans to cover IHS services. The capitation payment of $7,418 was the correct capitation payment based on the members correct risk group category for the month of July 2000. The additional payment of $431 was an incorrect capitation payment and was based on a different capitation rate group.

- For one member, NMHSD made capitation payments totaling $7,016 for a member who passed away. Deceased individuals are not eligible for SALUD! and a capitation payment should not have been made. This member died in May 2000 yet NMHSD made payments for this individual for 8 months, from July 2000 to February 2001. No recoupments were made for these payments at the time of our audit. This member had originally become eligible for Medicaid by receiving SSI. Individuals on SSI are automatically eligible for Medicaid. The date of death was recorded on SSA's SDX system, but did not get transmitted to the Omnicaid system properly.

- One member was assigned to an incorrect capitation risk group that resulted in an underpayment of $1,394. The Omnicaid system had an incorrect birth date for this member. Based on the birth date in the Omnicaid system, the member was assigned to an incorrect capitation rate group. In accordance with the MCO contracts, NMHSD maintains set capitation rates for each Medicaid eligibility group that are used for payment purposes.

The NMHSD did not maintain adequate eligibility information for the remaining four members reviewed. The NMHSD was unable to provide either Medicaid eligibility applications for two members, or complete income verifications for the other two members. The NMHSD did not make FFS payments for any of the 30 SALUD! members for services already covered under SALUD!.