Health Notes

Program Evaluation Unit
Legislative Finance Committee
Date: May 9, 2019

Medicaid Spending on Program and Managed Care Administration

AT A GLANCE

Spending on the administrative side of health care – everything from processing medical claims, collecting payments and maintaining patient records, to building maintenance and utilities, marketing and CEO bonuses – makes up roughly 30 percent of all health care spending in the U.S. Every medical service has some administrative cost component attached, and according to a *Health Affairs* study, U.S. health care administrative costs are among the highest in the world. Spending on administration is a cost driver for all players in the health care system, particularly for individual providers and hospitals where a large portion of administrative spending is devoted to the complexities of billing within a multi-payer system. The Medicaid program faces its own set of challenges to keep administrative spending in line.

Other LFC program evaluations and Health Notes have delved into rising healthcare costs and Medicaid medical expenditures. This Health Note explores the non-medical, administrative costs of the program from 2014 through 2017 at the agency level, the managed care organization (MCO) level, and the hospital level. The medical services covered by Medicaid are delivered almost exclusively within New Mexico, but many HSD contracts and MCO and hospital system corporate headquarters are located outside the state, so the brief also explores what portion of administrative expenditures stay within the state, potentially contributing to economic growth.

The Human Services Department (HSD) is a national leader in keeping its administrative spending low; in 2016, the agency spent 3.5 percent of all Medicaid dollars on program administration. That ratio ticked a little higher as administrative costs increased during the transition to Centennial Care 2.0, but was still just 4 percent at the end of 2018. HSD's administrative spending ratio only reflects the department's spending pattern and is not representative of the total amount spent on administration of the program. All payments to MCOs are categorized by HSD as medical spending, but the MCOs then use a portion of their Medicaid revenue for their own administrative costs.

None of the four New Mexico Medicaid managed care organizations had administrative costs that were as lean as HSD's, but for the first four years of Centennial Care they all achieved the contractual requirement that they spend no more than 15, then 14, percent of capitation payments for administrative purposes. Some were able to do this and still make substantial profits, others were less financially successful. The MCOs spent a combined $410 million on administration in 2017, and the three MCOs that fully cooperated with the LFC on this brief reported that 74 percent of their collective $345 million in administrative spending was spent in New Mexico.

Lastly, because hospitals are such an important component of the Medicaid landscape, this brief also includes a review of hospital operating costs, the non-medical side of running a hospital. Hospitals clearly spend a far larger portion of their revenues on operating costs than MCOs spend on plan administration, primarily because even the smallest hospitals have considerable physical facilities to run and maintain. In 2017, operating costs consumed between 17 percent and 56 percent – for an average of 42 percent – of spending by New Mexico's 34 general and acute hospitals.

Background

As of December, 2018, over 832 thousand New Mexicans were enrolled in the state's Medicaid program, nearly 79 percent, or 660 thousand, of whom received health care services through the Centennial Care managed care program. Centennial Care expenditures accounted for about 77 percent, or $4.32 billion, of the full FY18 Medicaid budget of $5.6 billion.

In the Centennial Care program, the Human Services Department (HSD) contracts with managed care organizations (MCOs) to provide Medicaid services on a prospective at-risk capitated payment basis: the department pays the MCO a flat per member per month (PMPM) payment, and the MCO provides necessary covered services, ideally containing health care costs without compromising quality of care or health outcomes through improved management and coordination of health care services. Until August 31, 2018, there were four Centennial Care MCOs: Blue Cross Blue Shield, Molina Health Care, Presbyterian Health Plan, and United Healthcare.

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In August, 2018, United Healthcare sold its Medicaid business to Presbyterian, and as of January 1, 2019, HSD launched Centennial Care 2.0 with three MCOs: Blue Cross Blue Shield, Presbyterian, and Western Sky Community Care.

As noted above, administrative costs make up a significant portion of overall health care spending, and this Health Note seeks to determine how much of every dollar spent on the New Mexico Medicaid program goes to administrative costs at the agency level, the managed care organization (MCO) level, and, because hospitals account for such a large share of Medicaid spending, at the hospital level. The brief also explores what portion of those administrative expenditures stay within the state, potentially contributing to economic growth.

Table 1: Spending on Health Care Services and Administrative Costs in New Mexico, 2017
in thousands

	Health care	Administrative	Total	Administrative portion
HSD	$4,865,659.	$220,076.	$5,085,737.	4%
MCOs	$3,684,223.	$409,937.	$4,094,160.	10%
Hospitals	$2,912,937.	$2,083,253.	$4,996,190.	42%

Note: MCO spending is a subset of HSD spending; only general and acute care hospitals.
Sources: HSD CY17 CMS 64 reports; MCOs CY17 financial report 14; Hospital FY17 CMS cost reports

HSD Administrative Spending

HSD's administrative costs for the Medicaid program are a very small portion of its total spending and, as with the health care services portion of the program, most of the costs are borne by the federal government.

The Human Services Department (HSD), as the state's Medicaid agency, has responsibility for running a large and complex program as effectively and efficiently as possible. HSD's administrative costs for the Medicaid program are a very small portion of its total spending. In 2014, the department spent $168 million out of a total spend of $4.7 billion – or 3.5 percent – on administration, rising by 2017 to $220 million out of a total spend of $5.1 billion – or 4.3 percent. Most of the costs in both categories are borne by the federal government: in 2017, the federal government paid 78 percent of New Mexico Medicaid's medical costs and 68 percent of the state's administrative costs. Relatively low administrative overhead for HSD may be an indicator that the program is being run efficiently, but it also may be an indicator that the department is not allocating sufficient resources to oversight and quality assurance.

HSD's administrative spending roughly followed enrollment as the program grew after expansion, but then kept rising in 2017 even as enrollment slowed (Chart 1). The process of developing and then implementing the Centennial Care 2.0 waiver renewal, complete with the complex and eventually litigious procurement of the current three MCOs, is likely the cost driver for these increases; review of 2019 administrative costs should validate or disprove this assumption. As noted above, however, HSD's administrative spending ratio only reflects the department's spending pattern and somewhat understates the total amount spent on administration of the program. All payments to MCOs are categorized by HSD as medical spending, but the MCOs then use a portion of their Medicaid revenue for their own administrative costs.

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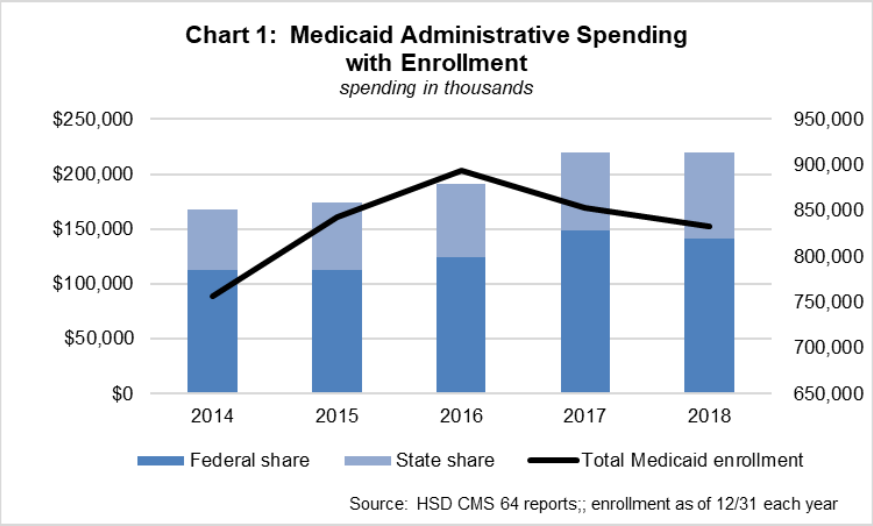

HSD's administrative spending for New Mexico's Medicaid program compares well to other states. The bulk of HSD's administrative costs are found in employee compensation and contracting, and are spread across multiple parts of the agency. The Medical Assistance Division (MAD) is responsible for administering the managed care and fee for service programs, including policy decisions, MCO contracts, rates, reporting and compliance, contracts with other vendors, and handling the department's on-going responsibilities for complying with federal regulations and procedures. The Income Support Division (ISD) handles eligibility determination for Medicaid recipients as well as for individuals who receive other benefits like SNAP or TANF, so some of its costs are also billable to Medicaid. Lastly, many expenditures by HSD's Administrative Services Division, Information Technology Division, and Program Support Division are also Medicaid administrative costs.

In 2016, compared to all other state Medicaid programs New Mexico had the eighth highest proportion of medical spending, 96.4 percent of every dollar.

In order to draw down federal matching funds, state Medicaid programs submit administrative and medical spending reports to the Centers for Medicare and Medicaid (CMS) using the CMS 64 report. The CMS 64 lacks the detailed data necessary for in-depth analysis of program spending, but it does provide a clear and relatively accurate method for state-to-state comparison. According to 2016 reports (the most recent complete year posted on the CMS web site), compared to all other state Medicaid programs New Mexico had the eighth highest proportion of medical spending, at 96.4 percent.

States organize their Medicaid agencies – and their Medicaid programs – quite differently, however, so any comparison across all 50 states is problematic. New Mexico Medicaid is more accurately compared with states that have similar key characteristics: a managed care delivery structure, expanded Medicaid under the ACA, and an enrolled population of between 500 thousand and about one million members. Seven states fall into this group: Iowa, Minnesota, Nevada, Oregon, Virginia, West Virginia, and New Mexico. New Mexico's Medicaid program holds top ranking for this group of peers (Chart 2).

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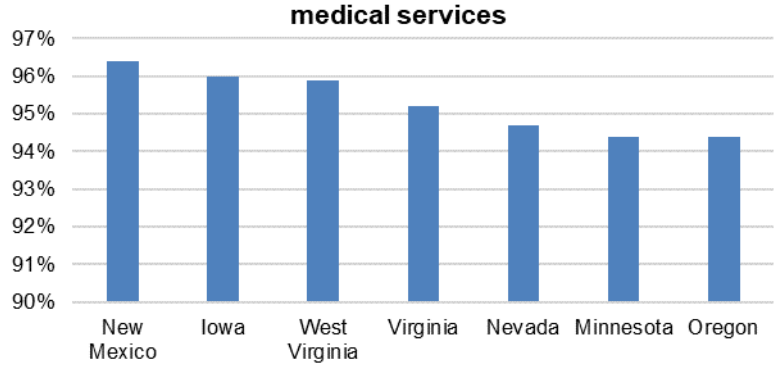
Chart 2: Portion of Medicaid dollars spent on medical services



Source: LFC analysis of CMS 64 data

In FY18, 28 percent of the department's administrative spending, or $62 million, went to contractors. HSD contracts for assistance with administrative services as a way of leveraging its Medicaid staff and compensating for New Mexico's limited pool of professionals and companies with relevant skills and expertise. For FY18, HSD reported 36 contracts of $10,000 or more for administrative services, totaling $62.5 million. The largest single contractor, Conduent State Healthcare, received $19 million for an array of financial management agent (FMA) services. Some of the other major contracts include the administration portion of Medicaid school-based services ($10.2 million distributed across 116 school districts and charter schools), actuarial services ($6 million), utilization review ($4 million), auditing and accounting (three contracts for a total of $6.6 million), and $2.3 million to the University of New Mexico (UNM) for an array of training and support programs. A collection of 12 vendors worked with HSD on systems and information technology projects in FY18, as the department gears up for the 2021 roll-out of its Medicaid Management Information System Replacement; their contracts totaled $10.3 million. Other contracts were for services ranging from outreach to brain injury services to legal representation. (Appendix A has a complete list of FY18 Medicaid administrative services contracts over $10,000.)

HSD reported 36 FY18 administrative services contracts of $10,000 or more, totaling $62.5 million.

At least 29 percent of HSD contract funding went to New Mexico companies and schools. According to HSD, 18 of the FY18 contracts (when all schools are counted as a single entity) are entirely New Mexico companies, schools, or individuals; this group received $18 million – or 29 percent – of HSD's spending on administrative services contracts. Eleven contractors with entirely out of state operations received $10.2 million, or 16 percent of department spending. The last seven contracts, worth $34.2 million or 55 percent of the total, were with businesses primarily located out of state but with some activity in New

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Mexico – a call center, a local office, employees working in state, etc. HSD does not monitor the business models of its administrative services contractors, so it is not possible to get a completely accurate tally of these vendors' in and out of state spending. It may be notable that, whether by design or chance, the three largest contracts fall into different categories: $6 million to out of state Mercer for actuarial services, $10 million to New Mexico schools for administering school-based health services, and $19 million to Conduent, doing business both in and out of the state, for FMA services.

Managed Care Organization Administrative Spending

State and federal regulations include an array of safeguards meant to ensure managed care organizations (MCOs) do not prioritize profit over the health and well-being of their members.

State and federal regulations include an array of safeguards meant to ensure managed care organizations (MCOs) do not prioritize profit over the health and well-being of their members. The most basic of these safeguards is the allowable ratio of medical to administrative spending, referred to as the medical loss ratio or MLR. Centennial Care contracts require an MLR of 86:14, meaning that the MCOs must spend at least 86 percent of their Medicaid revenues on direct medical services and quality improvement activities, and no more than 14 percent on the administrative activities of running the program. (For the first three years of the Centennial Care program, New Mexico's MLR was 85:15; in late 2016, HSD shifted to 86:14.) HSD is required by the federal government to pay rates to the MCOs that are actuarially sound, meaning that while the largest portion of the rates is dedicated to providing actual medical care, rates must also cover all reasonable non-medical costs so that the MCOs can remain economically sound. Profit is considered an allowable MCO administrative cost, so ideally, an MCO can meet the contractual MLR requirements and, by keeping other administrative costs low, still retain a profit. Centennial Care contracts place a 3 percent cap on MCO profits; anything above 3 percent must be shared with HSD.

Centennial Care contracts require that the MCOs spend at least 86 percent of their Medicaid revenues on direct medical services and quality Improvement activities, and no more than 14 percent on administrative activities – including a reasonable profit.

Clear and reasonable rules for defining acceptable administrative costs, as well as accurate MCO reporting and meaningful department oversight, are critical to ensuring that the MLR operates as intended. Centennial Care contract language accomplishes the first part of that equation fairly well. The process for calculating both MCO profit – referred to as underwriting gain – and the MLR are spelled out. The list of 38 valid administrative expenses includes items that would all be commonly accepted as non-medical costs of running a health plan. (See Appendix B for a complete list.) In addition, HSD created a package of financial reports for the MCOs with an even more detailed list of potential administrative expenses: ten major categories with over 68 specific lines, including unspecified lines for MCOs to claim an expense the department may not have thought of. (See Appendix C for the complete list and definitions.)

Meaningful department oversight faces a number of hurdles, however. HSD uses the MCO financial reporting packages to determine each MCO's underwriting gain and MLR performance, and in the rate development process. Review of those documents by LFC staff, followed by discussions with each of the MCOs, found that although the contract language and the report templates and definitions appear clear, the MCOs nonetheless completed the financial reports quite differently from one another.

Part of the differences are based on the different MCO business models, such as

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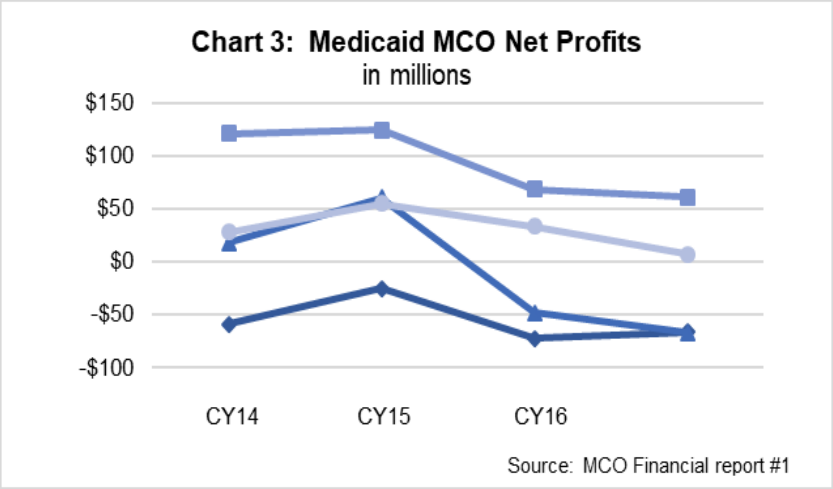
how each company accounts for costs divided between its Medicaid and commercial and/or Medicare lines of business. Depending on how an MCO handles that cost-shifting, Medicaid expenses for some basic business costs can appear minimal or even non-existent. For example, all the Centennial Care MCOs have their own pharmacy benefit managers (PBMs), but their contracts are structured differently. One MCO reported zero administrative costs for its PBM, and then later explained that the administrative costs are built into the price of each prescription in such a way that even the MCO cannot distinguish them. This lack of PBM transparency is a nationwide issue, not unique at all to New Mexico Medicaid, and makes program-wide costs in this area impossible to calculate. It also demonstrates at least one way in which administrative costs can drift into medical costs, artificially assisting an MCO to reach the required MLR.

There are many other examples of notable variations between the MCO reports, but from available information it is not at all clear which of these, if any, might be an indicator of some more significant issue. Without greater transparency and consistency in financial reporting, HSD's ability to exercise meaningful oversight is limited, and neither HSD nor LFC staff can accurately calculate program-wide costs. When the department does determine that an MCO is out of compliance with contractual requirements, HSD has the option to recoup overpayments and retrieve its share of any excess MCO profits; recoupments and sanctions are discussed in detail in a later section.

Medicaid MCO financial reports show the four MCOs made a cumulative profit of about $107 million in CY14, rising to over $214 million in CY15, then dropping to a nearly $19 million loss for CY16 and a $65 million loss for CY17.

That big picture view, however, obscures considerable variation among the MCOs, two of which made a profit every year: Presbyterian Health Plan and United HealthCare.

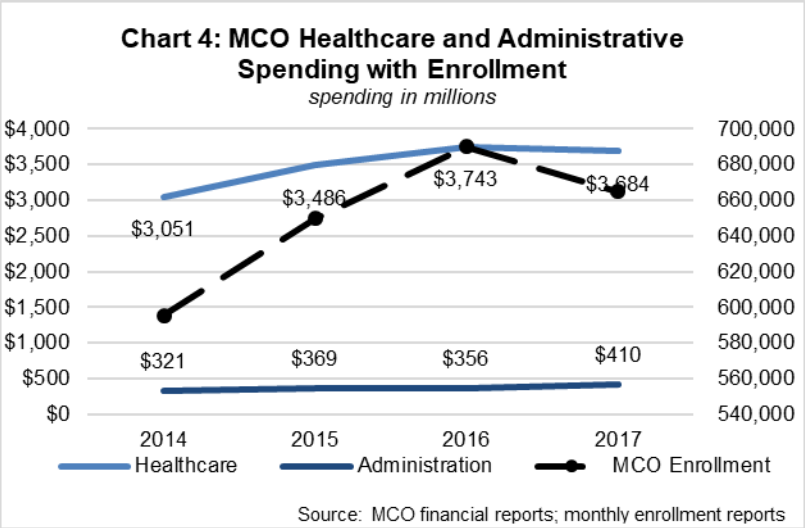
Although some MCOs at times exceeded the contractual cap of 3 percent profit, the Centennial Care MCOs averaged a 2 percent profit rate for 2014 through 2017. Medicaid MCO financial reports show the four MCOs made a cumulative profit of about $107 million in CY14, rising to over $214 million in CY15, then dropping to a nearly $19 million loss for CY16 and a $65 million loss for CY17. New Mexico's experience mirrors the national experience in this instance: according to a 2017 Health Management Associates analysis, Medicaid MCO profits in expansion states more than tripled between 2013 and 2015, and then dropped in 2016 as states – including New Mexico – gained experience and adjusted their rates. That big picture view, however, obscures considerable variation among the MCOs, driven by their unique population mixes, per member per month (PMPM) rates, medical loss ratios (MLRs), and other business decisions. (Chart 3.)



Between 2014 and 2017, administrative spending by Medicaid managed care organizations (MCOs) rose more steeply than spending on health care and more quickly than managed care Medicaid enrollment. In those four years, MCO spending on health care increased by 21 percent, from just over $3 billion to close to $3.7 billion. During the same time, the number of people enrolled in managed care Medicaid grew by 12 percent, from about 595 thousand to nearly 665 thousand, and MCO spending on administration costs increased by 28 percent, from $321 million to $410 million.

MCO administrative costs rose by 15 percent between 2014 and 2015, the first and second years of Centennial Care, while managed care enrollment increased by 9 percent.

Put another way, in 2014 the MCOs spent approximately $540 administrative dollars for each member, and by 2017 that amount had risen to $617 per member.



MCO administrative costs rose by 15 percent, or over $47 million, between 2014 and 2015, the first and second years of Centennial Care, as managed care enrollment increased by 9 percent, or about 54 thousand people. Put another way, in 2014 the MCOs spent approximately $540 administrative dollars for each member, and by 2017 that amount had risen to $617 per member. The increase included close to $39 million in expanded employee and care coordination compensation as the organizations staffed up to meet the demands of the new program. For 2016, enrollment increased by another 6 percent, but MCOs began to improve efficiency and saw a 3 percent drop in administrative spending despite increasing costs for health information technology and pharmacy benefits management. Administrative spending may have continued to drop had it not been for unusually high 2017 costs reported by Molina. By the time the 2017 financial reports were filed, Molina had learned that it was not awarded a CC 2.0 contract. The MCO responded by adding over $60 million to its reported administrative expenses for discontinued operations charges and the remaining costs associated with Molina's purchase of Lovelace Community Health Plan's Medicaid membership in 2013.

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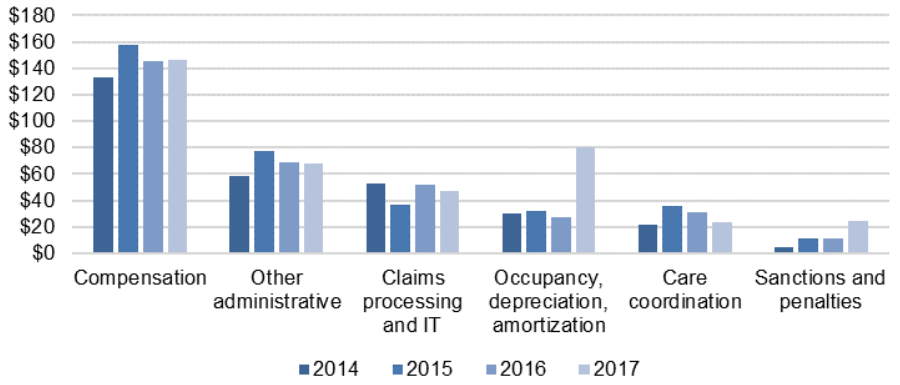
Total compensation for employees, executive officers and board members was the largest set of expenditures for all years for all MCOs. Category-level trend analysis of the financial reports for every MCO showed a lot of year over year volatility. Total compensation, for example, rose from an aggregate total of $133 million in 2014 to nearly $158 million in 2015, dropped to $145.6 million in 2016, and then rose again to $146 million in 2017. Because of the unusually high Molina depreciation expenses for 2017, that category saw a 165 percent increase between 2014 and 2017, from $30.4 million to $80.5 million. Another stand-out category in terms of volatility and growth is the sanctions and penalties line. (Chart 5.)

Sanctions and penalties are frequently assessed up to three years after the year the error or failure occurs, so some increase over time for this category would be expected; actual increases are discussed in more detail in the next section. In addition, Appendix D has detailed total category level spending for each year.

Chart 5: MCO Administrative Spend by Category
in millions



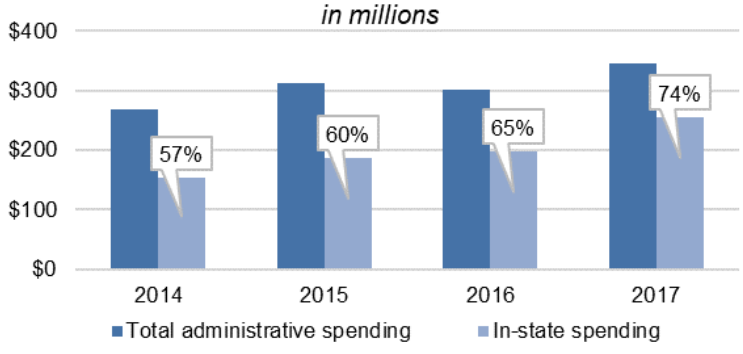
Source: MCO financial reports

Between 48 percent and 92 percent of the administrative spending by BCBSNM, Molina Healthcare, and Presbyterian Health Plan remained in New Mexico.

Between 48 percent and 92 percent of the administrative spending by BCBSNM, Molina Healthcare, and Presbyterian Health Plan remained in New Mexico. United Healthcare did not provide LFC staff with information about its in-state spending. Centennial Care contracts require in-state spending in only two areas: at least 20 specific key MCO staff for the Medicaid program must reside in the state, and each MCO must locate and operate its primary call center within New Mexico. Total administrative spending for these three MCOs increased by 29 percent between 2014 and 2017.

The MCOs showed substantial individual variation. BCBSNM spent the lowest portion of its administrative costs in the state, sending an average of over $40 million dollars per year to its out-of-state corporate partners and contractors. BCBSNM's total administrative spending increased by 8 percent between 2014 and 2017, but its in-state spending declined by 9 percent, from 57 percent in 2014 to 48 percent in 2017. On the other hand, Presbyterian, whose corporate headquarters are located in New Mexico, increased its in-state spending from 84 percent in 2014 to 92 percent – or $69 million – in 2017. Molina's experience falls between these two. From 2014 to 2016, Molina sent an average of $66.1 million annually to its corporate partners and contractors outside of New Mexico, but the proportion of its in-state administrative spending nonetheless increased from 45 percent in 2014 to 59 percent in 2016. In 2017, driven by an array of unusually high administrative costs (discussed above) that were largely categorized as in-state spending, the in-state proportion jumped by $57.5 million to 80 percent of spending. This large increase for Molina is responsible for pushing up the aggregate in-state spending as well. (Chart 6.)

Chart 6: Administrative Spending in New Mexico by BCBS, Molina and Presbyterian
in millions

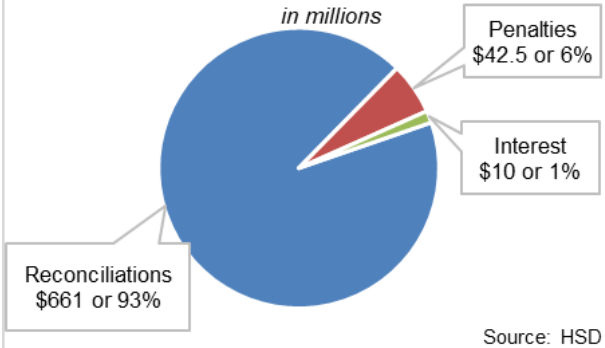


Source: LFC analysis of MCO data

Insights into Other Areas of the Program

Review of Medicaid administrative spending can offer insights into how the program is functioning that are not accessible anywhere else. The LFC receives program information and financial and enrollment data about Medicaid from HSD on a regular basis. However, until work began for this brief LFC staff was unaware of just how substantial an amount of money the department has retrieved from the MCOs since the start of Centennial Care. These funds fall into three broad categories: reconciliations for overpayments and excess MCO profits, financial penalties for poor performance, and interest on late payments to providers. HSD now reports that all these categories combined, from 2014 through 2017, equal over $713 million. (Chart 7.) In context, $713 million is 4.3 percent of the over $16.5 billion in total capitation payments made to the MCOs during those four years. Because of the high federal matching rate for the expansion population and for New Mexico Medicaid overall, much of this money will have flowed back to the federal government; after multiple requests from LFC staff, HSD reports it is still working to provide the LFC with a breakdown of where the dollars went and how much was retained by the department.

Chart 7: Total HSD Recoupments of $713.3 million 2014 - 2017
in millions



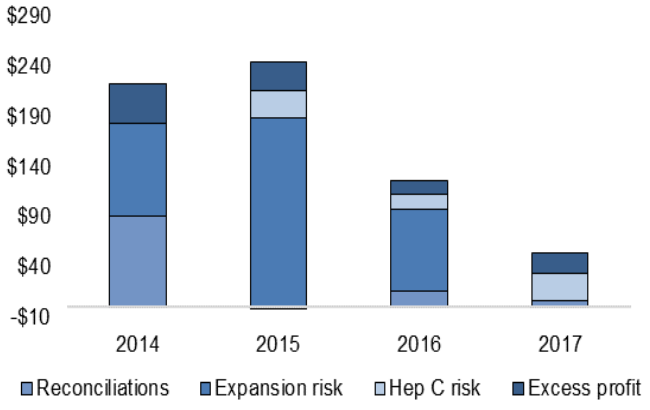
Source: HSD

Review of Medicaid administrative spending can offer insights into how the program is functioning that are not accessible anywhere else.

Between 2014 and 2017, HSD recouped over $660 million in overpayments from the four MCOs. Recoupments are not administrative costs, but rather corrections - or reconciliations - to the total amount of capitation revenue received by the MCOs. These amounts are deducted before HSD makes its final calculation of MLR which it then uses to determine whether the MCOs have been compliant with contractual requirements. Despite being a very small portion of total capitation payments, all recoupments have the effect of pushing up an MCO's final MLR because they reduce the denominator of the equation – revenues – while holding the nominator – medical spending – constant. In addition, tracking, calculating and recouping these overpayments adds to HSD's own administrative costs.

During the first four years of Centennial Care, reconciliations fell into five possible categories. Retroactive reconciliations review whether an individual was, in fact, eligible to receive Medicaid services at the time those services were provided; a very simple example of this would be if one MCO was paid a per member per month (PMPM) capitation fee for a member who was actually enrolled with a different MCO, then HSD would recoup that PMPM. Between 2014 and 2017, HSD recouped $119 million for these types of reconciliations. Under some circumstances, reconciliations may lead the department to pay an MCO more; for example, to cover actual expenses incurred during the retro-eligibility period or for individual liability amounts for nursing home patients. Between 2014 and 2017, HSD returned $6.7 million in patient liability payments to the MCOs. (Chart 8.)

Chart 8: HSD Recoupments
in millions



Note: Expansion risk corridor active 2014 - 2016, Hep C risk corridor active 2015 - 2017
Source: HSD

A risk corridor is a mechanism that cushions both HSD and the MCOs from extreme gains or losses: if MCO actual costs are higher than projected, HSD pays a portion of the higher costs; if MCO actual costs are lower than projected, HSD is able to recover the majority of its overpayment.

Centennial Care contracts have included two risk corridors for areas that had largely unknown potential costs when the program began: the new Medicaid expansion population and treatment with the new and very expensive drugs for hepatitis C. A risk corridor is a mechanism that cushions both HSD and the MCOs from extreme gains or losses: if MCO actual costs are higher than projected, HSD pays a portion of the higher costs; if MCO actual costs are lower than projected, HSD is able to recover the majority of its overpayment.

The combination of the risk corridor structure and HSD's choice to pay MCOs at the top of the rate range has had the result of leaving millions of extra dollars with the MCOs.

The expansion cohort was made up mostly of people who had not had any health insurance, and it was difficult to set accurate rates without having a utilization or cost history. HSD and its actuary based rates on the financial data available from the repealed State Coverage Initiative, but that was not a precise match for the expansion population. Because of the financial risk, HSD put a risk corridor into place for this cohort from 2014 through 2016, by which time enough credible historical data existed to enable the development of more accurate rates. Similarly, the department created a risk corridor in 2015 for hepatitis C expenditures; that risk corridor is still in place, even though the cost per course of treatment has dropped from over $92 thousand in 2014 to a projected $26 thousand for 2019.

Bolstered by the security of the risk corridors, HSD's actuary developed relatively higher MCO rates for the expansion population, particularly for 2014 and 2015, and included substantial anticipated costs across all physical health cohorts for hepatitis C treatment. The result: when the projected high costs for the expansion population did not appear, and as the cost of hepatitis C drugs dropped steadily, HSD was in the position of recouping substantial overpayments from the MCOs. Between 2014 and 2016, the department recouped over $362.3 million from the expansion risk corridor, and between 2015 and 2017, recouped $69.3 million from the hepatitis C risk corridor.

In the context of MCO administrative costs, MLRs, and profits, it is important to recall that the risk corridors are meant to protect both parties, but also to reward the MCOs for taking what appears to be additional risk. For the first two and a half years of Centennial Care, HSD elected to pay inflated rates upfront, preferring to overpay and then recoup to the alternative – underpay and then owe large sums. HSD consistently awarded MCO payment rates set at or near the top of an actuarially sound rate range even though the middle or lower end of the rate range would also have been a sound option. The LFC's 2015 program evaluation of Centennial Care estimated HSD could have saved as much as $28 million in general fund dollars in 2014 if it had paid at the lower end of the rate range. The consequence of this approach has been to leave millions of extra dollars with the MCOs. The risk corridors allow an MCO to keep 100 percent of the first 3 percent of any overpayment, 25 percent of the next 3 percent, and 10 percent of any gain over 6 percent. HSD provided data to the LFC showing how much the department recouped, but it did not provide the amounts the MCOs were able to keep.

HSD recouped over $102 million in excess profits between 2014 and 2017 from two MCOs, Presbyterian Health Plan and United Healthcare.

The last major area of reconciliations leading to recoupments is excess profits. As long as they stay within the required MLR, Medicaid MCOs are free to make as much profit as they can. However, in an effort to ensure that they are as focused on providing quality health care as on turning a profit, Centennial Care contracts direct that any profit over 3 percent must be split equally with HSD. Referred to as the underwriting gain limit, HSD recouped over $102 million in excess profits between 2014 and 2017 from just two MCOs, Presbyterian Health Plan and United Healthcare.

Between 2014 and 2017, HSD levied $42.5 million in performance-related financial penalties against the four MCOs. Financial penalties are allowable administrative costs. Centennial Care contracts authorize financial penalties for two areas related to MCO performance: failure to comply with process and business requirements like accurate and timely claims payment, health risk assessments, and reporting, and failure to meet performance measure targets. In addition, the contracts require each MCO to hold back 1.5 percent of its net capitation payments in a delivery system improvement fund. At the end of the year, these funds can be released to the MCO if it accomplishes delivery system improvement performance targets (DSIPT) set by the department; if goals are not met, HSD can recoup the associated money, or allow the MCO to use it for approved delivery system improvement projects.

Penalties related to failure to meet basic contract business requirements would, ideally, decline with each year of Centennial Care, as MCOs became more adept at meeting the requirements of their contracts, building their delivery systems, and addressing the health issues of their members. There were no material changes to this type of MCO responsibilities during the first four years of Centennial Care, and HSD and MCO reports show the program penalties dropped from a high of $3.3 million in 2015 to zero for 2017. The 2017 figure may merit further investigation, however, as perfect MCO compliance in this one area would be an outlier.

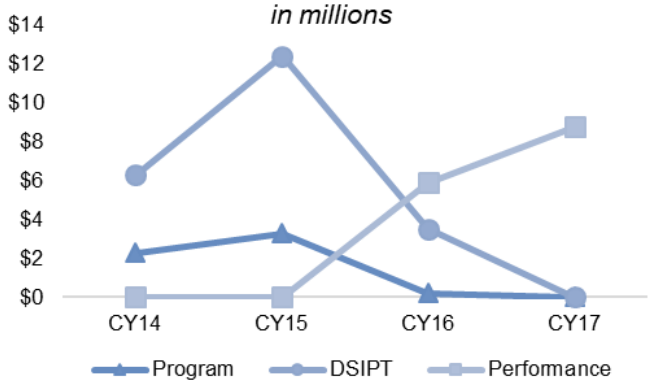
Performance measure penalties increased by 48 percent between 2016 and 2017, a troubling indicator of poor performance.

Performance measures and their respective targets were established at the beginning of the Centennial Care contracts to ensure the MCOs had meaningful advance knowledge of expectations and could develop systems to capture data correctly. Most of these are National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measures, used across the nation by Medicare, Medicaid, commercial insurance, and others; the Centennial Care MCOs were all very familiar with HEDIS measures. But because targets are based, in part, on year-over-year improvements in MCO performance, and because the initial health condition of the expanded Medicaid population was largely unknown, the first two years of the program were devoted to establishing baseline performance, and the first penalties were not issued until 2016. (Appendix D has performance measure penalties for 2017.)

The DSIPT goals are revised each year to respond to issues or areas needing more attention; the department only reported the amount of DSIPT money it recouped, so it is not clear whether the reduction in this amount from a high of $12.4 million in 2015 to zero in 2017 is the result of MCO success at meeting targets or HSD allowing the MCOs to retain more of the funds, or both.

Performance measure penalties increased by 48 percent between 2016 and 2017, from $5.9 million to $8.7 million, a troubling indicator of poor performance. (Chart 9.) The steep increase in performance measure penalties is worrisome for several reasons. The performance measure penalties are based on a percent of MCO capitation payments, which declined by about 3 percent from 2016 to 2017 as a result of declining

Chart 9: Centennial Care Performance-Related Financial Penalties



Source: HSD

Rising penalty amounts in the face of declining revenue point to a significant drop in performance.

Medicaid enrollment. Rising penalty amounts in the face of declining revenue point to a significant drop in performance. In addition, HSD reported that it made numerous adjustments to how it handled performance measures for 2017, and these adjustments effectively relieved some of the pressure on MCOs. All four of the behavioral health measures were dropped as targets, two because three of the four MCOs could not reach the target and two because of data collection problems. But the points associated with these measures were kept in the pool so as to hold MCOs harmless, regardless of their performance. According to HSD, setting unattainable targets is discouraged by the federal Centers for Medicare and Medicaid Services (CMS); the department established a working group to focus on how to improve performance and data collection for these measures. HSD adopted a collaborative approach to working with the MCOs to adjust performance measures and data collection and to improve performance from the very beginning of Centennial Care; the LFC's 2015 program evaluation found measures for health homes were removed from MCO contracts when it became clear the initial timeline for implementing health homes would not be met.

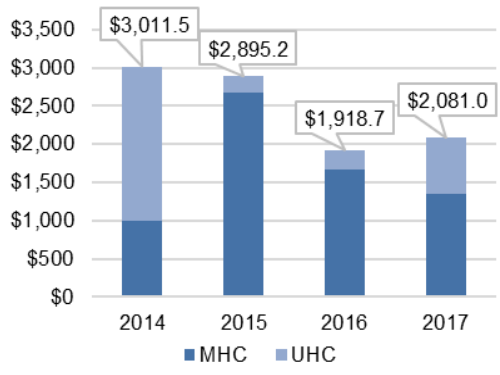
If the MCOs were held to all the performance measures as written in contract, as well as the original dollar value of those penalties, the 2017 penalties would have been upwards of $17 million, instead of the $8.7 million HSD ended up imposing.

The other major adjustment HSD has made regarding calculation of performance measure penalties was to change the dollar value. Centennial Care contracts state that performance measure penalties are "based on 2 percent of total capitation … divided by the total number of performance measures." According to HSD, when the 2016 performance measure penalties were under consideration, department leadership was concerned by the high amount, reportedly higher than average among peer states and likely to draw CMS attention to possibly unattainable goals. The department decided to interpret that section of the contract as allowing penalties based on *up to* 2 percent of capitation, and use 1 percent instead. LFC analysis of the data indicate that if the MCOs were held to all the performance measures as written in contract, as well as the original dollar value of those penalties, the 2017 penalties would have been upwards of $17 million, instead of the $8.7 million HSD ended up imposing. This higher amount would have increased allowable administrative costs and skewed calculations of MLR, but would also quite possibly have provided greater incentive for MCO performance improvements.

The sanctions and financial penalties category includes over $9.9 million in MCO interest expenses for late payment of claims. Managed care reimbursement rules specify that MCOs must pay 1.5 percent per month for clean claims not paid within 30 days of receipt of an electronic claim or 45 days of receipt of a paper claim. The total amount of nearly $10 million indicates high numbers and/or high amounts of late payments, long time frames for resolution, or both. Also notable is that all of these interest expenses were incurred by just two MCOs, Molina and United Healthcare. Across all four years, Molina's late payments involved mostly providers in the physical health and expansion – physical health programs, while United's late payments were mostly to long term services and supports (LTSS) providers. (Chart 10.)

Chart 10: MCO Interest on Late Provider Payments

in thousands



Source: MCO financial reports

Medicaid providers have made their dissatisfaction with late payments rather widely known, including during discussions at the quarterly Medicaid Advisory Committee meetings. HSD has generally responded that the complaints are provider-specific and not indicative of any major systemic problems, but the volume and persistence of payments found in

MCO financial reports suggests otherwise. It appears that the MCOs make interest payments directly to providers without any HSD oversight; the department has not responded to repeated requests from LFC staff to explain whether it tracks or verifies MCO-reported amounts or whether it uses this information when assessing MCO contract compliance.

It appears that the MCOs pay interest for late payment of claims directly to providers without any HSD oversight.

Hospital Non-Medical Operating Expenses

New Mexico's 34 general and acute care hospitals provide some of the most costly and complex acute care health services and serve as a safety net throughout the state for Medicaid recipients unable to access care anywhere else. Spending on hospital-based services is a large portion of the Medicaid program: in 2017, the hospitals reported receiving over $1.2 billion in net Medicaid revenues, which accounts for about 22 percent of the FY17 Medicaid budget. In turn, Medicaid is a critical source of revenue for the state's hospitals, bringing in 25 percent or more of the total net patient revenues for 13 hospitals in 2017; two-thirds of the state's hospitals draw at least 15 percent of their total net patient revenues from Medicaid services. The financial benefits of Medicaid expansion for the state's hospitals are clear: on average, hospitals have seen their Medicaid revenues as a percent of patient revenues increase by 7 percent, accompanied initially by a corresponding decrease in uncompensated care. For these reasons, no study of Medicaid administrative costs would be complete without a review of the hospital equivalent of administrative spending, operating costs.

Spending on hospital-based services is a large portion of the Medicaid program: in 2017, the hospitals reported receiving over $1.2 billion in net Medicaid revenues, which accounts for about 22 percent of the FY17 Medicaid budget.

The financial benefits of Medicaid expansion for the state's hospitals are clear: on average, hospital Medicaid revenues as a percent of patient revenues have increased by 7 percent, accompanied initially by a corresponding decrease in uncompensated care.

As hospital Medicaid revenues have increased, so too have hospital Medicaid profit margins, which are one indicator of how efficiently many hospitals are managing their Medicaid patients. Hospital profit margins for Medicaid rose from 10 percent in 2014 to nearly 15 percent in 2017. Any hospital that receives Medicare reimbursements is required to file an annual cost report with the Center for Medicare and Medicaid Services (CMS), and this discussion of hospital finances is based on LFC staff analysis of those reports. Hospital cost reports do not separate operational costs by line of business, and it is possible that some hospitals have lower administrative costs for their Medicaid patients than for the hospital as a whole.

This aggregate trend of greater financial strength, however, masks significant differences among the state's hospitals. New Mexico's hospitals are a widely varied group, in terms of everything from size and location, to patient and provider mix, to business structure and ownership type, and it is impossible to make generalizations that fully capture the range of their unique experiences. UNM Hospital (UNMH) is an outlier for many reasons; but even excluding UNMH, 16 hospitals

Table 2: New Mexico Hospital Medicaid Profit Margins

	2014	2015	2016	2017	2014—2017 change
Net revenue from Medicaid	$758,498,933	$1,162,039,209	$1,128,798,746	$1,209,835,306	59.5%
Medicaid costs	$742,366,255	$945,242,389	$1,038,756,313	$1,104,734,424	48.8%
Net Medicaid revenue (plus DSH) minus costs	$75,533,327	$265,106,887	$139,912,206	$178,312,951	136%
Medicaid margin	10%	22.8%	12.4%	14.7%	48%

Note: DSH, or disproportionate share hospital, payments are federal payments to hospitals that serve a large number of Medicaid and uninsured individuals.
Source: LFC analysis of CMS Hospital Cost Reports, worksheet S-10

made a total of over $75 million in profits in 2017 on their Medicaid line of business, and 13 hospitals had positive margins over 14 percent. On the other hand, 17 hospitals reported they lost a total of nearly $34 million caring for Medicaid patients. Why some hospitals do well with Medicaid rates and patients while others do not is not easy to discern. There are no clear patterns revealed by factors such as Medicaid revenues as a proportion of total revenues, the overall profitability of the hospital, or increases or decreases in Medicaid revenues from one year to the next.

Excluding UNMH, 16 hospitals made a total of over $75 million in profits in 2017 on their Medicaid line of business. On the other hand, 17 hospitals reported they lost a total of nearly $34 million caring for Medicaid patients.

In 2017, operating costs overall (not just Medicaid) consumed an average of 42 percent of spending by New Mexico's general and acute care hospitals. Hospitals clearly spend a far larger portion of their revenues on operating costs than MCOs spend on plan administration, primarily because even the smallest hospitals have considerable physical facilities to run and maintain, in addition to all of the necessary administrative staffing and other non-medical costs. Hospitals also have a more challenging time cleanly dividing costs between administrative and medical, given that almost every aspect of a hospital eventually connects to health care delivery and many hospital employees may perform both medical and administrative functions. For this discussion, salaries for administrative personnel – the people who work in the human resources department, for example – are counted as operational costs, while the salaries for people who provide direct medical services are considered medical costs (as per worksheet A of hospital cost reports).

Hospital cost reports identify up to 29 general service cost centers as purely operational costs, and these include things like general administration, plant operation, laundry, housekeeping, and medical records. In 2017, the proportion of hospital operational spending as a share of total hospital spending ranged from a low of 17 percent to a high of 56 percent; 25 out of 34 hospitals spent 40 percent or more on operating costs. No clear trends emerge, although it is notable that the state's largest hospital, UNMH, had one of the lowest operational ratios, while six of the eight hospitals with the highest ratios are for-profit hospitals. Several of the hospitals in this last group also have the highest proportion of salaries categorized as administrative, likely indicating large non-medical workforces or high salaries for executive officers.

Relatively high administrative costs could be indicative of hospital priorities or management inefficiencies, but they could also reflect substantial profits being transferred to out-of-state ownership.

Relatively high administrative costs, whether categorized as operational or salaries, could be indicative of hospital priorities or management inefficiencies, but they could also reflect substantial profits being transferred to out-of-state ownership. As the state considers how best to spend funds appropriated and earmarked for hospital rate increases during the last legislative session, some deliberation about how Medicaid funds are being utilized by hospitals may be valuable.

Conclusions and Concerns for the Future

For the first four years of Centennial Care, the Human Services Department was successful at keeping agency administrative costs for the Medicaid program lower than peer states, and Medicaid MCOs met the contractual requirements regarding their administrative expenditures, including their profits. When contractual requirements and program performance standards were not met, the department appears to have used its authority to recoup monies and impose sanctions effective-

ly, although it has not provided the LFC with full information about where those recouped monies have gone. Total recoupments have declined year over year since 2014, a measure of improved eligibility determinations and better balance between rates and actual costs. Lastly, much of the administrative spending of both the department and the MCOs has occurred in New Mexico, keeping both general fund and federal dollars circulating within the state economy. These are all positive indicators of a financially well-managed Medicaid program.

There are numerous positive indicators that New Mexico has a financially well-managed Medicaid program.

At the same time, relatively low administrative expenditures for HSD may be an indicator that the department is not allocating sufficient resources to oversight and quality assurance. The persistent failure by the MCOs to meet all performance standards and HSD's decision not to fully implement performance standards and penalties as written in the Centennial Care contracts is concerning. One of the highest priorities of the new HSD leadership team is to develop a strategic approach to raising provider and MCO reimbursements; a sustainable strategy must include a plan for reversing the downward trend in performance outcomes.

At the same time, there are indications that HSD may not be allocating sufficient resources to oversight and quality assurance.

There are other areas where HSD needs to maintain strong oversight as the program moves forward into Centennial Care 2.0. Just as the expansion risk corridor was no longer needed once the department gained sufficient data to right-size MCO rates for that population, the hepatitis C risk corridor is likely no longer justifiable now that the program has years of utilization data and medications to treat the disease have dropped to a fraction of their original cost. Centennial Care 2.0 contracts include requirements for the MCOs to provide treatment to their members with hepatitis C, and effective contract management should ensure that the MCOs are paid for the people they do treat and not for those they do not.

Appendix A: HSD Administrative Services Contracts

Contractor	Contract Purpose	Amount	Location
New Mexico schools	School based health services	$10,193,694	In state
University of New Mexico	FASD ID/training, FOCUS outreach/training, ASD support/training, medically fragile case mgmt support/training, early childhood eval/training, treatment foster care support/training; SW Center for Health Innovations	$2,312,846	In state
NM Medical Review Association	External auditor (EQRO) review performance improvement program	$1,574,456	In state
NM Primary Care Association	Increase persons enrolled in MAD Programs; advocacy group ensuring Medicaid access	$1,059,192	In state
Help Net LLC	Brain injury services	$611,383	In state
Developmental Disabilities Planning Council	Administrative claiming guardianship services	$454,183	In state
Goodwill Industries of New Mexico	Brain injury services	$429,756	In state
Clover Leaf Solutions	Organizational change management; data management services	$421,033	In state
Falling Colors	Mental health crisis and access line (BHSD)	$350,000	In state
RE/SPEC	Medicaid business operations support services	$291,755	In state
Advanced Network Management	Network and systems administration support services	$59,837	In state
ARCA	Brain injury services	$59,579	In state
Nardone, Robyn Lee	Centennial Care oversight-independent consumer support system	$49,166	In state
New Mexico Alliance for School-Based Health Care	Provide Medicaid outreach activities related to school based health centers; provide SBHC Advisory Committee with technical assistance and support	$49,000	In state
Scrase, David Lee, MD	Assist Director with quality improvement and review	$19,957	In state
Department of Education	PED staff - Medicaid school based services (MSBS), IEP special education services	$18,810	In state
Whitehead, Carole S.	RN review and audits	$14,224	In state
Caldwell, Debbie	Conduct reviews of NF LOC ratings assigned by Medicaid MCOs and TPAs to recipients to ensure that NF LOC criteria is applied consistently	$50,000	In state
	In state subtotal	**$18,018,870**	**29%**
Mercer Health and Benefits, LLC	Actuarial services (50/50), federal reporting (75/25) and MMIS (90/10)	$6,034,614	Out of state
CSG Government Solutions, Inc	Independent Validation and Verification Services	$1,546,577	Out of state
Netlogx LLC	Medicaid Business Operations Support Services; and Financial Management Support Services	$865,299	Out of state
Turning Point Global Solutions	System Integration Services	$819,667	Out of state
Fairbanks, LLC	Schools administrative claiming (revenue is collected on the program side and then transferred to admin)	$425,000	Out of state
Berry Dunn McNeill & Parker LLC	Solution Architecture Services; IT project management, planning and analysis; business process consultation services	$283,651	Out of state
Prometric, Inc.	Nurse aid training & competency evaluations	$111,764	Out of state
Covington and Burling	Legal representation for MAD (50/50)	$20,000	Out of state
TriGyn	Business analysis support services	$66,120	Out of state
Accenture	Unified portal user experience consulting services	$51,864	Out of state
En Point Technologies	Blackboard software	$17,363	Out of state
	Out of state subtotal	**$10,241,919**	**16%**
Conduent State Healthcare, LLC	FMA; fiscal agent for Mi Via (pass through at 50/50 and 50/75)	$19,015,936	Mixed
Deloitte Consulting, LLP	Eligibility and enrollment services (IT); 1115 Demonstration Waiver evaluation	$5,196,146	Mixed
Qualis Health	Utilization review	$4,038,251	Mixed
Myers and Stauffer, LC	Hospital audit, accounting, and consulting services (50/50), audit electronic health record credits (90/10), MCO audits (50/50), nursing facilities Medicaid audit agent	$2,810,050	Mixed
HMS - Health Management Systems	Recovery audits and third party liability recovery services	$2,187,371	Mixed
Cognosante, LLC	Project administration/security support/technical support and management	$621,349	Mixed
TEKsystems	Web applications development support services; and business analysis support services	$349,924	Mixed
	Mixed subtotal	**$34,219,027**	**55%**
	TOTAL	**$62,479,815**	

Note: parentheses indicate federal/state funding split
Source: HSD

Appendix B: Centennial Care Contract Valid Administrative Expenses

Contract section	Expense/Cost
7.2.8.3.1	Network development and contracting
7.2.8.3.2	Direct provider contracting
7.2.8.3.3	Credentialing and re-credentialing
7.2.8.3.4	Information systems
7.2.8.3.5	Health Information Technology
7.2.8.3.6	Health Information Exchange
7.2.8.3.7	Encounter data collections and submission
7.2.8.3.8	Claims processing for select contractors
7.2.8.3.9	Member Advisory Board and Native American Advisory Board meetings
7.2.8.3.10	Member services
7.2.8.3.11	Training and education for providers and members
7.2.8.3.12	Financial reporting
7.2.8.3.13	Licenses
7.2.8.3.14	Taxes, excluding premium tax, NMMIP and HIX assessments, and PPACA-related insurer fees
7.2.8.3.15	Plant expenses
7.2.8.3.16	Staff travel
7.2.8.3.17	Legal and risk management
7.2.8.3.18	Recruitment and staff training
7.2.8.3.19	Salaries and benefits to MCO staff
7.2.8.3.20	Non-medical supplies
7.2.8.3.21	Purchased service, non-medical, excluding member and attendant travel, meals and lodging costs, reinsurance expense and risks delegated to third parties with HSD's approval
7.2.8.3.22	Depreciation and amortization
7.2.8.3.23	Audits
7.2.8.3.24	Grievances and appeal system
7.2.8.3.25	Capital outlay
7.2.8.3.26	Reporting and data requirements
7.2.8.3.27	Compliance
7.2.8.3.28	Surveys
7.2.8.3.29	Quality assurance
7.2.8.3.30	Quality improvement/quality management
7.2.8.3.31	Marketing
7.2.8.3.32	Damages/penalties
7.2.8.3.33	Project ECHO multi-disciplinary team (added in 5th amendment)
7.2.8.3.34	Electronic visit verification (EVV) (added in 6th amendment)
7.2.9.6.1	Care coordination – health risk assessments (HRAs)
7.2.9.6.2	Care coordination – data runs
7.2.9.6.3	Care coordination – referrals
7.2.9.6.4	Care coordination – case assignment and scheduling

Note: Premium taxes and the NMMIP assessments are not considered either medical or administrative expenses and are removed from the equation by deducting them from total premiums to reach net premiums, which are then used to calculate the MLR.
Source: Centennial Care Contract, Amendment 8 (last amendment before CC 2.0)

Appendix C: MCO Report 14 Administrative Expense Categories and Descriptions

Category	Descriptions
Compensation (excluding care coordination)	
Compensation and Benefits	All forms of compensation, including employee benefits and taxes for administrative personnel who support the MCOs Centennial Care operations. Medical director compensation, whether on salary or contract, should be included as well. Do not include compensation related to care coordination activities. Compensation related to care coordination services deemed administrative per the Centennial Care contract should be reported below on Line 22. Compensation related to care coordination services deemed medical per the Centennial Care contract should be reported in the care coordination medical line within Report 1 and not included in this report.
Compensation - Executive Officers - Board of Directors' Fees	Corporate executive officers' salaries and board of director's fees charged or allocated to the Centennial Care line of business.
Commissions	Compensation expenses related to commissions.
Compensation - Other	To the extent not included elsewhere within this report, all other compensation expenses.
Occupancy/Depreciation/Amortization	
Rent	Expenses incurred for rent on facilities used to support the MCO's Centennial Care operations and not used to deliver health care services to the MCO's members.
Utilities, Security, Facilities Management Costs	Occupancy expenses incurred (e.g., utilities, security, facility management, etc.) for facilities used to support the MCO's Centennial Care operations and not used to deliver health care services to the MCO's members.
Occupancy – Other	All other occupancy expenses supporting the MCO's Centennial Care operations not included in Line 6 and Line 7 and not used to deliver health care services to the MCO's members.
Depreciation - New Mexico Locations	Depreciation expenses for those assets based in New Mexico that directly support the MCO's Centennial Care operations and are not used to deliver health care services to the MCO's members.
Depreciation/Occupancy - Locations Outside New Mexico	Depreciation and/or occupancy expenses for those assets not physically located in New Mexico that directly support the MCO's Centennial Care operations and are not used to deliver health care services to the MCO's members.
Amortization - Goodwill and Other Intangibles	The amortization expense or impairment charges related to goodwill and intangible assets including goodwill related to any business acquisitions.
Amortization - Other	Amortization expense of certain assets that support the MCO's Centennial Care operations and that are not used to deliver health care services to the MCO's members: i.e., leasehold improvements.
Start-Up, Restructuring and Discontinued Operations	All expenses, including amortization or depreciation, associated with business start up, business restructuring and reorganization, and discontinuance of operation costs.
Provider Support	
Provider Networks	Expenses related to activities in support of the MCO's Centennial Care provider network. Such activities include network development and contracting, direct provider contracting, and credentialing and re-credentialing.
Extension for Community Healthcare Outcomes (ECHO) Multidisciplinary Team	Administrative expenses as negotiated between the Centennial Care MCO and Project ECHO and approved by HSD to support Project ECHO.
Provider Services	Expenses related to MCO's provider services such as provider handbook, provider services call center, and provider education, training and technical assistance.
Medicaid Member Support	
Member Materials, Training and Education	Expenses related to the MCO's member education program for the production of member materials and conducting member training and education in accordance with the Centennial Care contract. Member materials include, but are not limited to, member handbooks, provider directories, member newsletters, member identification cards and any other additional, but not required, materials and information provided to members designed to promote health and/or educate members. Exclude any expenses related to health education provided as a direct service to the MCO's Centennial Care members as part of the MCO's care coordination activities.
Member Services	Expenses related to call center operations in support of the member services information line, interpreter and translation services, and electronic health records access for the MCO's members.
Care Coordination	
Compensation - Care Coordination Administrative	All forms of compensation, including employee benefits and taxes, for care coordination activities deemed to be an administrative service per the Centennial Care contract. Such activities include Health Risk Assessments (HRAs), data runs, referrals, and case assignation and scheduling. Do not include compensation related to care coordination services deemed medical per the Centennial Care contract. Compensation related to care coordination services deemed medical per the Centennial Care contract should be reported in the care coordination medical line within Report 1 and not included in this report. For employees of the MCO who are engaged in a range of activities that support both care coordination services deemed administrative and care coordination services deemed medical per the Centennial Care contract, include only the portion of the compensation expenses that are associated with the care coordination activities deemed administrative. The MCO must provide an explanation in the notes that describes the MCO's methodology for determination of care coordination compensation expenses related to administrative activities and care coordination compensation expenses related to medical activities.

Category	Descriptions
Care Coordination Agency (administrative services portion)	Expenses for any care coordination agencies contracting with the MCO to perform care coordination functions required by the Centennial Care contract. Include only the portion of expenses attributable to care coordination activities performed by the agency that are deemed administrative services per the Centennial Care contract. Such activities include HRAs, data runs, referrals, and case assignation and scheduling. Do not include agency expenses related to care coordination services deemed medical per the Centennial Care contract. Agency expenses related to care coordination services deemed medical per the Centennial Care contract should be reported in the care coordination medical line within Report 1 and not included in this report. For care coordination agencies contracting with the MCO that are engaged in a range of activities that support both care coordination services deemed administrative and care coordination services deemed medical per the Centennial Care contract, include only the portion of agency expenses that are associated with the care coordination activities deemed administrative. The MCO must provide an explanation in the notes that describes the MCO's methodology for determination of care coordination agency expenses related to administrative activities and care coordination agency expenses related to medical activities.
Care Coordination Administrative - Other	All other expenses related to administrative care coordination activities that are not included in the care coordination categories listed above in Lines 22 through 23. For example, any non-compensation expenses and/or any non-care coordination agency expenses related to HRAs, data runs, referrals, and case assignation and scheduling.
Quality Assurance	
Quality Management and Quality Improvement (QM/QI)	Expenses related to activities in support of the MCO's QM/QI program.
Surveys	Expenses for provider satisfaction surveys and the annual member satisfaction survey.
Utilization Management	Expenses related to the MCO's utilization management programs. Exclude any expenses related to utilization management provided as a direct service to the MCO's Centennial Care members as part of the MCO's care coordination activities.
Other Quality Assurance Activities	All other expenses related to the MCO's quality assurance activities not included in Lines 26 through 28.
Marketing/Outreach	
Marketing	Expenses for marketing activities directly related to the MCO's Centennial Care operations and permitted by the Centennial Care contract. Per the Centennial Care contract, marketing means any communication from an MCO to individuals who are not enrolled with the MCO that can reasonably be interpreted as intended to influence a recipient or potential member to enroll in the respective MCO and not to enroll in (or to disenroll from) another MCO. Also include expenses for HSD approved marketing materials. Per the Centennial Care contract, marketing materials include materials that are produced in any medium, by or on behalf of the MCO that can reasonably be interpreted as intended to market to a recipient or potential member.
Marketing - Other	All other expenses for marketing activities not included in Line 31.
Promotion and Giveaways	Expenses related to promotion and giveaways including expenses for promotional items, memorabilia, gifts and souvenirs.
Community Relations	Expenses related to activities in support of establishing and maintaining relationships with the communities in which the Centennial Care MCO operates.
Sponsorships	Expenses related to sponsorship of events, properties, groups, activities or employee and/or local athletic programs.
Contributions & Donations to Affiliated Parties of the MCO or its Board Members	Expenses related to donations or gifts to charitable, civic, educational, medical or political entities that are affiliated with the MCO or any of the MCO's board members.
Contributions & Donations - Other	All other expenses related to contributions & donations not included in Line 36.
Claims/IT/Systems Support	
Claims Processing	Direct or vendor-related expenses related to the processing of provider claims.
Encounter Data Collection and Submission	Expenses related to activities in support of encounter data requirements of the Centennial Care contract.
Pharmacy - PBM	Administrative portion of delegated administrative expenses for Pharmacy Benefits Manager (PBM) that cover costs such as claims processing and medical management of the PBM.
Dental	Administrative portion of delegated administrative expenses such as Third Party Administrator (TPA) payments that cover costs such as claims processing and medical management of the TPA. An example of TPA expenses includes dental subcontractors.
Other Category, as Needed - (Specify)	The MCO should enter a line item description for any applicable TPA category other than pharmacy and dental.
Other Category, as Needed - (Specify)	The MCO should enter a line item description for any applicable TPA category other than pharmacy and dental.
Other Category, as Needed - (Specify)	The MCO should enter a line item description for any applicable TPA category other than pharmacy and dental.
Fiscal Management Agency (FMA)	Expenses incurred through the MCO's contract with the FMA specified by HSD to provide assistance to members who choose the self-directed community benefit. Applies only to the LTSS program.
Electronic Visit Verification (EVV) System	Expenses related to the electronic visit verification system.

Category	Descriptions
Health Information Technology (HIT)	Expenses related to HIT activities required by the Centennial Care contract. Per the Centennial Care contract, HIT means the area of information technology involving the design, development, creation, use and maintenance of information systems for the health care industry.
Health Information Exchange (HIE)	Expenses related to HIE activities required by the Centennial Care contract. Per the Centennial Care contract, HIE means the transmission of health-care-related data among facilities, health information organizations and government agencies according to national standards. HIE is also an entity that provides services to enable the electronic sharing of health information.
Information Systems	Expenses related to information systems supporting the MCO's Centennial Care operations that are not included in the expenses reported in the HIT (Line 48) and/or HIE (Line 49) categories. This includes applicable maintenance, upgrades and/or non-capitalized software.
Fraud and Abuse Detection and Prevention	Expenses related to the MCO's Centennial Care internal fraud, waste and abuse program(s).
One-Time Charges for Systems Upgrades and/or Conversions	Expenses for one-time charges for systems upgrades and/or conversions as they relate to equipment and systems required for the administration of the Centennial Care Program.
Claims Adjustment Expense	The expense associated with processing and paying the future claims that are included in the MCO's IBNP estimates.
Sanctions/Fines/ Penalties	
Sanctions/Fines/Penalties - Imposed by HSD	Expenses related to HSD imposed sanctions, fines, penalties, damages and settlements resulting from violations (or alleged violations) of, or failure of the MCO to comply with the program standards, performance standards, or the terms and conditions of the Centennial Care contract.
Sanctions/Fines/Penalties - Other	Expenses related to any other sanctions, fines, penalties, damages and settlements resulting from violations (or alleged violations) of, or failure of the MCO to comply with Federal, State, or local laws and regulations not otherwise reported in Line 55.
Delivery System Improvement Performance Penalties	Expenses for Delivery System Improvement performance penalties imposed by HSD.
Interest Expense for Late Payment of Claims	Interest expense or penalties on late payment of claims.
Other Administration	
Cost Plus Administrative Charges	The portion of all cost plus corporate allocation expenses and management services agreement expenses that are above the actual cost of the services performed. This includes any amounts related to risk margin fees that are included within corporate allocations or that are added to management fees paid to the applicable entity. Note that the actual cost portion for services performed as part of any corporate allocation and/or MSA is to be reported within each of the applicable categories listed in this table. Only amounts above the actual cost of the services performed is to be reported in this line.
Printing, Postage & Direct Mailings	Expenses for printing, postage, express mail and courier service not included in other categories within this report.
Travel, Conferences, Conventions, etc.	All expenses for transportation, lodging, subsistence and conferences in direct support of the MCO's Centennial Care operations and its New Mexico Medicaid members.
Travel - Other	All expenses for transportation, lodging, subsistence, conferences and entertainment not required by the Centennial Care contract. Such costs might include the following: - Tickets to sporting or other events, golf outings, ski trips, cruises or professional entertainers. - Airfare costs in excess of the standard commercial airfare (coach or equivalent) rate. - All costs associated with the purchase and expense of alcoholic beverages. - All costs associated with the purchase, expense (direct or depreciation) or allocation of corporate jets or aircraft.
Employee Recruitment, Training and Retention	Expenses incurred for the purpose of employee recruitment and employee morale such as an employee picnic, holiday party, or employee awards.
Contract Labor	All expenses not otherwise reported in other administrative categories that are associated with contract labor who perform administrative functions where the contracted persons are not employees of the MCO.
Lobbying Expenses	The cost of influencing activities associated with obtaining grants, contracts, cooperative agreements, loans and the cost to influence (directly or indirectly) governmental employees, elected officials and/or political parties. Include portion of any health plan association fees attributable to lobbying activities performed by the particular health plan association.
Dues/Fees (excluding lobbying portion in Line 66)	Expenses related to boards, bureaus and association fees. This should include all dues and assessments of organizations of which the Centennial Care MCO is a member, as well as all dues for employees' and agents' memberships on the MCO's behalf.
Licensing	Expenses related to all licensing necessary for the Centennial Care Program.
Professional Fees (Audit, Tax, Actuarial, Consulting, etc.)	Expenses incurred for professional services rendered by persons who are members of a particular profession or possess a special skill and who are not employees of the MCO. For example, professional services in support of the accounting functions of the MCO (including financial reporting and rate setting) and IT consulting services.
Legal - Litigation & Settlements	Expenses incurred in defense or settlement of any civil or criminal proceeding where the MCO is found liable or has settled out of court. In addition, all legal, litigation and settlement expenses, charges or allocations (even if not found liable) not associated with the MCO's Centennial Care line of business.

Category	Descriptions
Legal - Risk Management, Compliance and Other	Legal expenses related to risk management and compliance. Also includes all other legal expenses not reported in Line 70, including legal costs incurred in defense or settlement of any civil or criminal proceeding where the MCO was not found liable.
Royalties	Royalties on a patent, copyright or amortization of the costs of acquiring by purchase a patent or copyright.
Bad Debt and Allowance for Uncollected Premiums	Bad debts and allowance for uncollected premiums, including losses (actual or estimated) arising from uncollectible accounts and other claims.
Long Term Borrowing and Debt Costs	Interest expense, debt financing and issuance costs, debt restructuring and cancellation costs, and amortization of any such costs when the cost is incurred on borrowed capital that is a specific requirement of the Centennial Care contract.
Long Term Borrowing and Debt Costs - Other	Interest expense, debt financing and issuance costs, debt restructuring and cancellation costs, and amortization of any such costs when the cost is incurred on borrowed capital that is not a specific requirement of the Centennial Care contract.
Payments to State-Mandated Solvency Funds	Expenses incurred for the purpose of meeting the solvency requirements of the Centennial Care contract. For example, expenses related to surety bonds.
State and Federal income taxes not included in Report 1	Any state and federal income taxes, current or deferred, expensed, charged or allocated to the Centennial Care line of business that were not reported as income tax in Report 1.
Other Assessments not included in Report 1	Any assessments expensed, charged or allocated to the Centennial Care line of business that were not reported as assessments in Report 1.
All Other Administrative Expenses	Those administrative expenses not specifically identified in the categories above. Note: Material amounts (greater than 5% of total administrative expenses) should be disclosed and fully explained in the MCO notes.

Appendix D: Total MCO Administrative Spending by Major Category, 2014—2017

	2014	2015	2016	2017	2014 - 2017 change	Percent change
Total compensation	$133,046,561	$157,836,672	$145,691,124	$146,064,237	$13,017,676	10%
Total occupancy/depreciation/ amortization	$30,368,215	$31,604,519	$27,031,467	$80,522,928	$50,154,713	165%
Total provider support	n/a	n/a	$2,844,604	$3,124,900		
Total Medicaid member support	$14,009,403	$13,254,023	$11,560,996	$11,782,090	-$2,227,313	-16%
Total care coordination	$22,019,866	$35,989,738	$31,065,486	$23,114,111	$1,094,245	5%
Total quality assurance	$3,702,660	$4,006,124	$4,978,228	$5,710,788	$2,008,128	54%
Total marketing/ outreach	$1,672,761	$1,494,720	$969,806	$766,783	-$905,978	-54%
Total claims/IT/systems support	$52,902,057	$36,721,914	$52,048,252	$46,771,604	-$6,130,453	-12%
Total sanctions/fines/penalties	$4,784,894	$11,009,550	$11,087,837	$24,092,834	$19,307,940	404%
Total other administrative	$58,860,160	$76,897,986	$68,667,099	$67,986,417	$9,126,257	16%
Total administrative costs	$321,366,577	$368,815,246	$355,944,899	$409,936,692	$88,570,115	28%

*Note: occupancy/depreciation/amortization includes the $60.9 million in one-time Molina costs
Source: MCO financial reports

Appendix E: MCO Performance Measure Penalties, 2017

MCO	Penalty amount	Missed measures
BCBS	$2,075,548	Asthma management: Percentage of members 5 - 64 years of age who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for at least 50% of their treatment period.
		Blood pressure management: Percentage of members 18 - 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled.
		Diabetes management: Percentage of members 18 - 75 years of age with diabetes who had a nephrology screening test for kidney disease.
Molina	$1,998,489	Prenatal care: Percentage of member deliveries of live births that received a prenatal care visit in the first trimester or within 42 calendar days of enrollment in the MCO.
		Postpartum care: Percentage of member deliveries that had a postpartum visit on or between 21 and 56 calendar days after delivery.
PHP	$2,790,607	Diabetes management: Percentage of members 18 - 75 years of age with diabetes who had a nephrology screening test for kidney disease.
		Prenatal care: Percentage of member deliveries of live births that received a prenatal care visit as a member of their MCO in the first trimester or within 42 calendar days of enrollment in the MCO.
		Postpartum care: Percentage of member deliveries that had a postpartum visit on or between 21 and 56 calendar days after delivery.
UHC	$1,874,404	Asthma management: Percentage of members 5 - 64 years of age who were identified as having persistent asthma and were dispensed appropriate medications that they remain in at least 50% of their treatment period.
		Prenatal care: Percentage of member deliveries of live births that received a prenatal care visit as a member of their MCO in the first trimester or within 42 calendar days of enrollment in the MCO.
		Postpartum care: Percentage of member deliveries that had a postpartum visit on or between 21 and 56 calendar days after delivery.
Total	**$8,739,048**	

Note: Three of four MCOs also missed the targets - and indeed, performed worse in 2017 than in 2016 – for two behavioral health measures that were not assessed penalties:
Antidepressant medication management: Number of members 18 years and older, diagnosed with a new episode of major depression, who received continuous treatment with an antidepressant medication for at least 84 calendar days (acute phase) or at least 180 calendar days (continuous phase).

Source: HSD; MCO HEDIS reports