Mercer

Government Human Services Consulting

Calendar Year 2022 AIDS Healthcare Foundation Mainstream Rate Development Template

Auditor's Report

California Department of Health Care Services

August 8, 2024

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Contents

Section 1: Executive Summary

Pursuant to federal requirements under Title 42 of the Code of Federal Regulations 438.602(e), the State of California Department of Health Care Services (DHCS) must periodically, but no less frequently than once every three years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each managed care organization (MCO). DHCS contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to fulfill this requirement for the financial data submitted in the Medi-Cal rate development template (RDT) for calendar year (CY) 2022 by AIDS Healthcare Foundation (AHF). Mercer designed and DHCS approved procedures to test the accuracy, truthfulness, and completeness of self-reported financial data in the RDT.

The specific financial schedules selected for testing are used by Mercer as a critical part of the base data development process for capitation rate development related to the CY 2024 rating period. The RDT tested was the final version, including any revisions stemming from resubmissions as a result of the RDT Question and Answer discussion guide process with the MCO.

The key schedules subject to testing from the RDT included, but were not limited to:

- Schedule 1 — Utilization and Cost Experience
- Schedule 1-A — Global Subcontracted Health Plan Information
- Schedule 1-B — Incentive Payments Arrangements
- Schedule 1-C — Base Period Enrollment by Month
- Schedule 1-O — Supplemental Financial Report for Provider Overpayments
- Schedule 1-U — UM/QA/CC
- Schedules 6a and 6b — Financial Reports
- Schedule 7 — Lag Payment Information

The data collected in the RDT is reported on a modified accrual (incurred) basis for CY 2022 and does not follow generally accepted accounting principles with regards to retroactivity from prior year activity, including claim or capitation accruals, retroactive enrollment, or termination of enrollment of members from prior years. The data provided is designed to report only financial and enrollment activity incurred for the CY reported.

The procedures and results of the test work are enumerated in the Table(s) of Section 2.

Section 2: Procedures and Results

Mercer has performed the procedures enumerated in the Table(s) below, which were designed by Mercer and were reviewed and agreed to by DHCS, solely to test the completeness, accuracy, and truthfulness of information reported in the Medi-Cal RDT from AHF for CY 2022. AHF's management is responsible for the content of the RDT and has responded in a timely manner to all requests for information.

Table(s): Procedures

Fee-For-Service (FFS) Medical Expense	
Description of Procedures	**Results**
Mercer reviewed all paid claims data for each category of service (COS) to verify control totals, verify eligibility and enrollment in the Mainstream Medi-Cal program, confirm the COS grouping was correct, confirm the year reported was correct, and confirm enrollment with the MCO for date of service.	• Control totals: No variance noted. • Eligibility: 0.02% of claim submissions with no matching eligibility totaling $586 or 0.01% of total medical expense and is included in the variance noted below. • COS Map: Review of all COS showed 97%–100% match for all COS except for LTC COS at 76% and Physician COS at 57%. Per AHF, the mapping misalignment is a result of inconsistent population of the taxonomy code, an optional field in the provider/plan billing guidance. For future submissions, AHF has altered the COS grouping assignment methodology to utilize alternative fields to categorize claims into the COS groupings defined by DHCS. • Service Year: No variance noted. All dates of service fall within CY 2022.
Mercer compared detailed lag tables for each major COS (Inpatient, Outpatient, Physician, Facility — LTC, and All Others) created from the paid claims data files provided by the MCO and compared this	Variance: RDT FFS Expenses are overstated as compared to the support provided: • Inpatient 9.03% • LTC 7.59%

Fee-For-Service (FFS) Medical Expense	
Description of Procedures	**Results**
support to the information reported in Schedule 7. Mercer compared the paid claims amounts from Schedule 7, line 35 and the incurred but not reported (IBNR) amount from Schedule 7, line 40 to total paid claims data as provided by the MCO.	• Outpatient 5.84% • Physician 4.67% • All Other 1.57% In Total 7.32%, or $465,121, which is 5.91% of total medical expense. Per AHF, a portion of the variance is due to a large overpayment reversal of $131,123 collected by AHF after the initial RDT submission. The remaining variance of $333,998 is due to an unusually small runout that occurred between May 2023 and December 2023 for CY 2022. Both events are considered unusual and could not have been predicted at the time of the RDT submission.
Using data files (paid claims files) provided by the MCO, Mercer sampled and tested 60 transactions and traced them through the MCO's claims processing system, the payment remittance advice, and the bank statements.	No variance noted.

Global Subcontracted Payments	
Description of Procedures	**Results**
Mercer requested global capitation supporting detail. Mercer compared the support provided to the amounts reported in Schedule 1-A.	Not applicable. AHF does not have global capitation arrangements.

Sub-Capitated Medical Expense	
Description of Procedures	**Results**
Mercer requested overall non-global sub-capitation supporting detail. Mercer compared the support provided to the amounts reported in Schedule 7.	Not applicable. AHF does not have sub-capitated contracts.

Utilization and Cost Experience	
Description of Procedures	**Results**
Mercer compared summarized total net cost data from amounts reported in Schedule 1 to Total Incurred Claims by COS from Schedule 7.	Schedule 1 is overstated by 0.92%, or $58,575, when compared to Schedule 7. This variance is 0.74% of total medical expense.

Member Months	
Description of Procedures	**Results**
Mercer compared the MCO-reported member months from Schedule 1-C to eligibility and enrollment information provided by the State. Mercer's procedures are to request explanations for any member months with greater than 0.5% variance in total or greater than 1.0% variance by major COA.	Variance: RDT member months understated by 0.08% in total.

Provider Incentive Arrangements	
Description of Procedures	**Results**
Mercer requested a listing of all provider incentive arrangements, by provider and by month, and compared the amounts to Schedule 6a, lines 34–36.	Not applicable. No Provider Incentives reported.

Reinsurance	
Description of Procedures	**Results**
Mercer requested reinsurance supporting detail. Mercer compared the support provided to the amount reported in the RDT.	No variance noted.
Mercer recalculated reinsurance premiums, based on CY 2022 membership as of February 2023, to compare to reported amounts.	No variance noted.
Mercer recalculated recoveries for a sample of five members.	No reinsurance recoveries were reported for CY 2022.
Mercer compared the amount of reinsurance recoveries as compared to the information in Schedule 5 for reasonableness.	Not Applicable.

Settlements	
Description of Procedures	**Results**
Mercer inquired of the MCO whether they incurred any settlement amounts with providers related to CY 2022 dates of service. If settlements existed, Mercer noted whether the amounts were actual or estimates based on the status of the settlements and where the amount(s) were reported in the RDT.	Not applicable. No Settlements were paid for CY 2022.

Third-Party Liability (TPL)	
Description of Procedures	**Results**
Mercer reviewed information submitted by the MCO as to how TPL is identified and reported. Per DHCS All Plan Letter (APL) 21-007, the MCO is not required to collect TPL; however, they are required to report to DHCS service and utilization information for covered services related to TPL.	Per review of the support provided and confirmation with DHCS, AHF is submitting TPL information as required by APL 21-007. No further testing necessary.

Administrative Expenses	
Description of Procedures	**Results**
Mercer reviewed administrative expenses as a percentage of revenue and on a PMPM basis, taking into consideration the dynamics of the plan and the membership size when reviewing the results.	AHF reported Administrative expenses of $214.54 PMPM, 17.97% of Net Revenue. Due to enrollment size and population acuity results are in line with expected results.
Mercer compared detailed line items from the plan's trial balance for reasonableness when mapped to line items in Schedule 6a and/or Schedule 6b. If applicable, Mercer reviewed allocation methodologies and recalculated for reasonableness.	No variance noted.

Taxes	
Description of Procedures	**Results**
Mercer reviewed to ensure proper reporting of federal, State, and local taxes on line 59 of Schedule 6a. If no taxes were reported on Schedule 6a, we confirmed the organization is not subject to taxes.	AHF is exempt from income taxes; therefore, taxes were appropriately not reported on the RDT.

Related Party Transactions	
Description of Procedures	**Results**
Mercer obtained related party agreements for medical services and reviewed to determine whether the terms are at fair market value. Mercer compared the terms (e.g., PMPM or other payment rate amounts) to other similar non-related party terms for reasonableness.	Not applicable. No Related Party Transactions reported.

UM/QA/CC	
Description of Procedures	**Results**
Mercer reviewed UM/QA/CC expenses as a percentage of medical expense and on a PMPM basis, taking into consideration the plan dynamics and membership size when reviewing the results.	AHF reported UM/QA/CC expenses of $150.63 PMPM and 18.07% of total medical expense and is in line with expected results.
Mercer compared detailed line items from the plan mapped to line items in Schedule 1-U for reasonableness. Mercer reviewed allocation methodologies and recalculated for reasonableness.	No variance noted.
Mercer interviewed financial management to determine how healthcare quality improvement activities such as care coordination are isolated from general administrative expenses in the general ledger. Mercer confirmed with MCO that UM/QA/CC costs were not also included in general administrative expenses.	Confirmed.

Capitation Revenue	
Description of Procedures	**Results**
Mercer compared capitation amounts reported in Schedule 6a for calendar year 2022 with the Capitation Management System (CAPMAN) file received from DHCS for the same period. The CAPMAN file contains all amounts paid to the health plan by DHCS.	Variance: RDT is understated by 0.21%, or $21,021.

Interest and Investment Income	
Description of Procedures	**Results**
Mercer requested interest and investment income for the MCO entity as a whole and information regarding how the income provided in Schedule 6a was allocated to the Medi-Cal line of business.	AHF did not report any interest or investment income in the RDT. Per their consolidated audited financial statements, a net investment loss was reported.

Other Information	
Description of Procedures	**Results**
Mercer reviewed the plan's audited financial statements for CY 2022 for a clean audit opinion or identification of significant deficiencies or material weaknesses.	Mercer confirmed a clean audit report.
Mercer compared reported expenses, including IBNR and administrative expenses, to audited financial statements for consistency.	No material variances notes.
Mercer requested information on the efforts to identify and recover provider overpayments and on how the recoveries are recorded in the RDT.	AHF provided the written policy for the identification and recovery of overpayments. Based on a review of that policy, typically AHF does not report any provider overpayments in the RDT medical expenses. However, due to timing issues noted in the FFS section above, overpayments were reported before AHF's claims audit procedures were appropriately able to identify the overpayment.

Section 3: Summary of Findings

Based on the procedures performed, the total amount of gross medical expenditures in the RDT was overstated by $523,696, or 6.65%, of total medical expenditures in the CY 2022 RDT. As detailed in Table 1, the majority of the medical expense variance is due to an unusual and unpredictable adjustment to the FFS medical expense that could not have been known at the time of submission.

Based on the defined variance threshold, the results of the audit of gross medical expenditures are determined to be material, however, do not warrant corrective action.

Based on the procedures performed, the total amount of capitation revenue for the CY 2022 RDT was understated by $21,021 or 0.21%.

Based on the procedures performed, administrative expenditures in the CY 2022 RDT showed no variance.

Based on the defined variance threshold, the results of the audit of administrative expense and capitation revenue are determined to be immaterial and do not warrant corrective action.

AHF reviewed this report and had the following comments:

1) Based on the procedures performed, the total amount of capitation revenue for the CY 2022 RDT was understated by $21,021 or 0.21%

    a) The plan believes the revenue variance of $21,021 between CAPMAN and the financials Schedule 6a is related to member retroactivity and the timing of the MCP's accounting financial close period. Overall, we understand the potential for minimal differences as a result of accounting accruals between the timing of payments that often arises from member retroactivity.

2) Based on the procedures performed, the total amount of gross medical expenditures in the RDT was overstated by $523,696, or 6.65% of the total medical expenditures in the CY 2022 RDT.

    a) The plan recognizes that the gross medical expenditures in the CY 2022 RDT was higher when initially reported. Since the plan has a relatively small non-dual population of 485 average monthly members that are medically high-risk, the plan can experience volatile swings in claim expense due to a small number of catastrophic members. During the May 2023 and September 2023 runout periods a couple of factors caused the overstatement in gross medical expenditures. One factor that impacted the plan was a significant claim reversal that was readjudicated subsequently to the May 2023 runout. In addition, the plan experienced a total reserve based on the actuarial calculations derived from the plans past claims experience that had not materialized. Given the historical completion patterns for both CA-Medicaid and other AHF managed care lines of business, the plan actuaries found it would have been unreasonable to set the expected future claims runout well below past claim experience.

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