Mercer

Government Human Services Consulting

State Fiscal Year 2021 CalOptima Health Coordinated Care Initiative Rate Development Template

Auditor's Report

California Department of Health Care Services

July 10, 2024

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Contents

Section 1: Introduction

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 state fiscal year (SFY) 2021 by CalOptima (CAL). 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 calendar year 2023 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 include, but were not limited to:

- Schedule 1.1–1.3 — 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 1.1U–1.3U — UM/QA/CC
- Schedule 5 — Large Claims Report
- Schedules 6.1a-b and 6.2.3a-b — Financial Reports
- Schedule 7.1–7.3 — Lag Payment Information

The data collected in the RDT is reported on a modified accrual (incurred) basis for SFY 2021 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 SFY 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 CalOptima for the SFY 2021. CalOptima's management is responsible for the content of the RDT and responded timely to all requests for information.

Table(s): Procedures

Fee-For-Service (FFS) Medical Expense		
Description of Procedures	**Results CMC**	**Results Non-CMC**
Mercer reviewed all paid claims data for each category of service (COS) to verify control totals, verify eligibility and enrollment in the Coordinated Care Initiative 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: Verified for all members. • COS Map: Review of each COS showed a 75.75%–99.94 % match rate. Per CalOptima, updated data structures and improvements to COS logic will increase these match rates in future reporting. • Service Year: No variance noted. All dates fall within SFY 2021.	
Mercer compared detailed lag tables for each major COS (Inpatient, Outpatient, Physician, Facility — Long-Term Care [LTC], and All Others) created from the paid claims data files provided by the MCO and compared the 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)	Variance: RDT FFS Expenses are over/(understated): • Inpatient 2.16% • Outpatient 1.35% • LTC 3.48% • Physician 1.79% • All Other (2.79%) In total, 1.58% or $1,238,871, which is 0.46% of the total medical expense. Per CalOptima, the plan has enhanced the COS logic as of June 2023 which should improve COS mapping in future	Variance: RDT FFS Expenses are over/(understated): • Inpatient (5.60%) • Outpatient 10.01% • LTC (0.36%) • Physician (2.74%) • All Other (0.51%) In total, 0.02% or $68,964, which is 0.02% of the total medical expense. Per CalOptima, the plan has enhance the COS logic as of June 2023 which should improve COS mapping in future reporting.

Fee-For-Service (FFS) Medical Expense		
Description of Procedures	**Results CMC**	**Results Non-CMC**
amount from Schedule 7, line 40 to total paid claims data as provided by the MCO.	reporting.	
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 observed.	

Global Subcontacted Payments		
Description of Procedures	**Results CMC**	**Results Non-CMC**
Mercer requested overall global capitation supporting detail. Mercer compared the support provided to the amounts reported in Schedule 1-A.	CalOptima did not have any Global Sub-contractor arrangements.	

Sub-Capitated Medical Expense		
Description of Procedures	**Results CMC**	**Results Non-CMC**
Mercer requested overall non-global sub-capitation supporting detail. Mercer compared the support provided to the amounts reported in Schedule 7.	Variance: RDT Sub-capitated Medical Expense is understated by 0.08% or $107,380, which is 0.04% of total medical expense. The total of the detail provided was more to the amounts reported in the RDT.	Not applicable. CalOptima does not have Non-CMC sub-capitated arrangements for SFY 2021.
Mercer reviewed a sample	Variance: Detailed support	Not applicable.

Sub-Capitated Medical Expense		
Description of Procedures	**Results CMC**	**Results Non-CMC**
of the five highest provider payments, 10 random payments, reviewed the related contractual arrangements, and recalculated the total payment amounts by sub-capitated provider using roster information provided by MCO.	for sub-capitated amounts is understated by 0.49% or $202,109. The recalculated amounts were less than the sub-capitation amount reported in the supporting detail provided.	
Mercer observed proof of payments via relevant bank statements, clearinghouse documentation or other online financial institution support for the sampled sub-capitated provider payments in the previous step.	Variance: Detailed support for the sampled sub-capitated providers is overstated by 0.00% or $98. The proof of payment information was more than the supporting detail provided for the sampled sub-capitated providers.	Not applicable.
Mercer obtained roster information for the sampled provider payments and verified eligibility of members, confirmed enrollment with the MCO, and validated PMPM amounts paid by member.	Eligibility was verified for 99.44% of rostered members in the sample. The amount of non-global sub-capitation paid for the ineligible members is $222,403 and is included in the variance noted above.	Not applicable.
If applicable, Mercer reviewed Full Dual COA subcontracted PMPM payment rates to determine if the amount(s) are at a reduced rate as compared to the non-Full Dual COAs.	Confirmed reduced rates as compared to the non-Full Dual COA groups.	Not applicable.
For sub-capitated arrangements 5% or more of total medical expense or	CalOptima had two sub-capitated arrangements that exceeded the 5% or	Not applicable.

Sub-Capitated Medical Expense		
Description of Procedures	**Results CMC**	**Results Non-CMC**
major COS, Mercer reviewed the sampled sub-capitated contracts to determine delegated administrative duties. Using this information, Mercer then reviewed the amount of administrative dollars reported in the RDT as compared to the delegated administrative functions. If applicable, see Appendix A for detail.	more of total medical expense threshold. There were four administrative functions delegated to the two sub-capitated providers and the plan did not report administrative dollars in the RDT. However, the plan estimated an overall amount of $13,599,081 of administrative expense that was not reported on CCI Schedule 6a and 6.1b. This amounts to 10.00% of total sub-capitated medical expense. Therefore, this is an understatement of administrative expenses and an equal overstatement of medical expenses.	

Utilization and Cost Experience		
Description of Procedures	**Results CMC**	**Results Non-CMC**
Mercer compared summarized total net cost data from amounts reported in Schedule 1 to Total Incurred Claims by COS for Schedule 7.	Schedule 1 is overstated by 0.00% or $5,461 when compared to Schedule 7. This variance is 0.00% of total medical expense.	No variance noted.

Member Months		
Description of Procedures	**Results CMC**	**Results Non-CMC**
Mercer compared 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 overstated by 0.34% in total.	Variance: RDT Member Months understated by 0.57% in total.

Provider Incentive Arrangements		
Description of Procedures	**Results CMC**	**Results Non-CMC**
Mercer requested a listing of all provider incentive arrangements, by provider, by month and compared the amounts to Schedule 1.	Variance: RDT Provider Incentive Expense is overstated by 7.32% or $518,388 which is 0.12% of total medical expense. Per CalOptima, this variance is due to timing of payments versus timing of the RDT submission.	Not applicable. CalOptima does not have Non-CMC provider incentive arrangements for SFY 2021.
From the listing of provider incentive payments, Mercer sampled the highest two payment amounts and one random payment. Mercer observed proof of payments for the sampled provider incentive payments.	No variance noted. The proof of payment information validated the supporting detail provided for the sampled provider incentive payments.	Not applicable.
Mercer reviewed the listing of provider incentive payments for any payments to related parties. If the	Not applicable. There were no provider incentive payments made	Not applicable.

Provider Incentive Arrangements		
Description of Procedures	**Results CMC**	**Results Non-CMC**
review of the provider incentive payment listing showed payments to related parties, and the sample selection in the previous step did not include related party arrangements, Mercer selected the two highest related party provider incentive payments. Mercer observed proof of payments for the sampled related party provider incentive payments.	to related parties.	
If related party provider incentive payments were noted, Mercer reviewed the incentive terms to determine if the terms align with similar arrangements for non-related parties.	Not applicable.	Not applicable.

Reinsurance		
Description of Procedures	**Results CMC**	**Results Non-CMC**
Mercer reviewed the reinsurance contract and compared the amount on the RDT to the requested supporting schedule.	CalOptima did not have any reinsurance contracts during SFY 2021.	

Settlements		
Description of Procedures	**Results CMC**	**Results Non-CMC**
Mercer inquired of the MCO whether they incurred any settlement amounts with providers related to SFY 2021 dates of service. If settlements existed, Mercer noted whether the amounts are actual, or estimates based on the status of the settlements and where the amount(s) are reported in the RDT.	No settlements were paid for SFY 2021.	

Third-Party Liability (TPL)		
Description of Procedures	**Results CMC**	**Results Non-CMC**
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, CalOptima is submitting TPL information as required by APL 21-007. No further testing necessary.	

Administrative Expenses		
Description of Procedures	**Results CMC**	**Results Non-CMC**
Mercer benchmarked administrative expenses as a percentage of net revenue across all COHSCCI plans and compared to the amount reported in the RDT, taking into consideration the	The administrative percentage reported by CalOptima was within an acceptable range as compared to industry standards.	

Administrative Expenses		
Description of Procedures	**Results CMC**	**Results Non-CMC**
membership size of the plan when reviewing the 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.	Variance: RDT reported Administrative Expense is understated by 1.61% or $213,798, which is 0.05% of total medical expense.

Taxes		
Description of Procedures	**Results CMC**	**Results Non-CMC**
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.	CalOptima is exempt from income taxes; therefore, no taxes were reported on the RDT.	

Related Party Transactions		
Description of Procedures	**Results CMC**	**Results Non-CMC**
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	CalOptima had no related parties as defined by the Financial Accounting Standard Board. However, CalOptima had two members who held executive positions at hospitals or provider organizations that provided services to CalOptima's	Not applicable. CalOptima does not have Non-CMC related party transactions for SFY 2021.

Related Party Transactions		
Description of Procedures	**Results CMC**	**Results Non-CMC**
terms for reasonableness.	Medi-Cal members. One of the members is related to three hospitals which represent approximately 23% of the total reported CMC inpatient expense. Per review of related party contracts, payment terms appear reasonable as compared to similar non-related party terms.	
If related party contracts are a material portion of the related medical COS, Mercer also reviewed any allocation methodologies for reasonableness.	CalOptima's related party transactions were not a material portion of the related COS expense.	Not applicable.
Mercer reviews that all services included in the related party agreements are allowable for Medicaid rate setting.	All services included in the related party agreements are allowable for Medicaid rate setting.	Not applicable.
When applicable, Mercer obtained related party corporate allocation methodologies for administrative services. Where significant, Mercer recalculated the amounts for reasonableness.	Per CalOptima, there were no administrative services provided by related parties.	Per CalOptima, there were no administrative services provided by related parties.

UM/QA/CC		
Description of Procedures	**Results CMC**	**Results Non-CMC**
Mercer benchmarked UM/QA/CC expenses as a percentage of total medical expense across all COHS plans and compared to the	The UM/QA/CC percentage reported by CalOptima was within an acceptable range as compared to industry standards.	

UM/QA/CC		
Description of Procedures	**Results CMC**	**Results Non-CMC**
amount reported on Schedule 1-U, taking into consideration the membership size of the plan under review when reviewing the results.		
Mercer interviewed financial management to determine how health care quality improvement activities such as care coordination are isolated from general administrative expenses in the general ledger.	Confirmed with the MCO management that UM/QA/CC costs were not also included in general administrative expenses.	

Capitation Revenue		
Description of Procedures	**Results CMC**	**Results Non-CMC**
Mercer compared capitation amounts reported in Schedule 6a for calendar year 2020 plus January 2021–June 2021 (1H2021) 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: Using a straight average methodology, the variance for SFY 2021 is understated by $229,921 or 0.61%.	Variance: Using a straight average methodology, the variance for SFY 2021 is understated by $37,582,342 or 7.74%. Per CalOptima, the majority of this variance is due to the plan using a lower blended rate when estimating revenue payments.

Interest and Investment Income		
Description of Procedures	**Results CMC**	**Results Non-CMC**
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.	CalOptima did not report any interest or investment income in the RDT. Per CalOptima, interest and investment income was not allocated at the county level and therefore it was not disclosed in Schedule 6a. For reference, CalOptima's Audited Financial Statements reported $18.5 million as investment income for all lines of business.	

Other Information		
Description of Procedures	**Results CMC**	**Results Non-CMC**
Mercer reviewed the MCO's audited financial statements for SFY 2021 for a clean audit opinion or identification of significant deficiencies or material weaknesses.	Mercer confirmed a clean audit opinion.	
Mercer compared reported expenses, including IBNR and administrative expenses, to audited financial statements for consistency.	No material variances noted.	
Mercer requested information on the efforts to identify and recover provider overpayments and on how the recoveries are recorded in the RDT.	CalOptima provided the written policy for the identification and recovery of overpayments. Based on a review of that policy, CalOptima is appropriately excluding provider overpayments from the RDT medical expenses.	

Section 3: Summary of Findings CMC

Based on the procedures performed, the total amount of Capitation Revenue for the CMC SFY 2021 RDT was understated by $229,921 or 0.61%.

Based on the procedures performed, the total amount of gross medical expenditures in the CMC RDT were overstated by $1,768,621 or 0.38% of total medical expenditures in the SFY 2021 RDT. CalOptima should prepare to properly record a portion of their provider sub-capitation expense as administrative expense in future RDT reporting, thus reducing medical expense.

Based on the procedures performed, administrative expenditures in the CMC SFY 2021 RDT had no variance.

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

CalOptima reviewed and accepted this report.

Section 4: Summary of Findings Non-CMC

Based on the procedures performed, the total amount of Capitation Revenue for the Non-CMC SFY 2021 RDT was understated by $37,582,342 or 7.74%. CalOptima should ensure accurate reporting of capitation revenue in future RDT reporting.

Based on the procedures performed, the total amount of gross medical expenditures in the Non-CMC RDT were overstated by $72,000 or 0.01% of total medical expenditures in the SFY 2021 RDT. CalOptima should prepare to properly record a portion of their provider sub-capitation expense as administrative expense in future RDT reporting, thus reducing medical expense.

Based on the procedures performed, administrative expenditures in the Non-CMC SFY 2021 RDT were overstated by $213,798 or 1.61%.

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

CalOptima reviewed and accepted this report.

Appendix A: Administrative Duties in CMC Subcontracted Arrangements

Administrative Task	Monarch	Prospect
Quality Management	X	X
Quality Measure Tracking		
Member Grievance		
Encounter Submission		
Claims Adjudication and Payment		
Member Services		
Provider Services		
Case Management		
Claims Processing	X	X
Utilization Management	X	X
Provider Relations and Education		
Provider Contracting		
Credentialing and Re-Credentialing	X	X

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