Mercer

Government Human Services Consulting

State Fiscal Year 2021 Health Plan of San Mateo Mainstream Rate Development Template

Auditor's Report

California Department of Health Care Services

January 8, 2024

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 state fiscal year (SFY) 2021 by the Health Plan of San Mateo (HPSM). 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 included, but were not limited to:

- Schedule 1 — Utilization and Cost Experience
- Schedule 1-A — Global Subcontracted Health Plan Information
- Schedule 1-C — Base Period Enrollment by Month
- Schedule 1-U — UM/QA/CC
- Schedule 5 — Large Claims Report
- 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 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 Table 1 of Section 2.

Section 2

Procedures and Results

Mercer has performed the procedures enumerated in Table 1 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 HPSM for SFY 2021. HPSM's management is responsible for the content of the RDT and has responded in a timely manner to all requests for information.

Table 1: 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: 0.01% of claim submissions with no matching eligibility totaling $4,410 or 0.00% of total medical expense and is included in the variance noted below. • COS Map: Review of each COS showed 82%–100% match. Discrepancies were reconciled and no further testing required. • Service Year: No variance noted. All dates of service fall within SFY 2021.
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 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) amount from Schedule 7, line 40 to total paid claims data as provided by the MCO. Allowable absolute value variances were deemed to be equal to or less	Variance: RDT FFS Expenses are over/(understated) as compared to the support provided: • Inpatient 3.27% • Outpatient (1.30%) • LTC 1.59% • Physician (0.97)% • All Other 0.94% In Total 1.15% or $3,150,632, which is 0.74% of total medical expense. Per HPSM, the variances above are primarily due to the following:

than 2% for inpatient claims and 1% for all other categories of service.	• Difference in classification logic used by HPSM which categorizes Federally Qualified Health Center expense as Physician versus DHCS logic which categorizes as Outpatient. • Retroactive claims adjustments due to payment rate changes not known at the time of RDT submission. • Over/under estimate of IBNR. Based on the reconciliation provided by HPSM, no additional test work deemed necessary. HPSM is reviewing the logic provided by DHCS to ensure alignment for future 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 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.	Variance: RDT Global Capitation Expense is overstated by 0.11% or $33,518. The total of the detail provided was less than the amounts reported in the RDT.
Mercer reviewed the contractual arrangement with the MCO's global subcontractor(s) and recalculated the total payment amounts using global roster information provided for all 12 months of SFY 2021 multiplied by the contracted rates.	Variance: Detailed support for global capitation expense is overstated by 0.35% or $104,935. The recalculated amounts were less than the global capitation amount reported in the supporting detail provided.

Mercer selected the three highest months of payment by globally subcontracted health plan/provider and five randomly selected additional months of payment. Mercer observed proof of payments via relevant bank statements, clearing house documentation, or other online financial institution support for the sampled global capitated payments.	Variance: Detailed support for global capitation expense is understated by 0.40% or $75,263. The proof of payment information was higher than the supporting detail provided for the sampled global capitation payments.
Mercer obtained roster information for the globally subcontracted provider and verified eligibility of members, confirmed enrollment with the MCO, and analyzed claims to verify none of the FFS Claims paid should have been paid under the global arrangement.	Eligibility was verified for 99.92% of the members on the provided rosters. The amount of global capitation paid for the ineligible members was $14,954 and is included in the variance noted above. FFS claims totaling $1,020,375 were paid for members that were part of the global contract. This represents 0.24% of total medical expense and is reasonable based on the services carved out of the global arrangement.
Mercer compared the global per member per month (PMPM) payment rates to relevant PMPM experience for non-global members for reasonableness.	Mercer found the average global PMPM to be reasonable as compared to the cost experience of the non-global membership.
If applicable, Mercer reviewed Full Dual member global contracted PMPMs to determine whether the amount(s) are at a reduced rate as compared to the non-Full Dual category of aid (COA) groups.	Confirmed reduced rates as compared to the non-Full Dual COA groups.
Mercer reviewed the sampled global 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.	Per review of the global contract, all administrative functions in Appendix A were delegated to the global subcontractor. HPSM segregated 9.29% of the global capitation expense as administrative expense in the RDT. This amount is considered within an

	acceptable range for industry standards.
Mercer reviewed members included on the member roster to ensure there were no Coordinated Care Initiative members or payments provided in the steps above.	None identified.

Sub-Capitated Medical Expense	
Description of Procedures	**Results**
Mercer requested 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 0.50% or $83,154. The total of the detail provided was more than the amounts reported in the RDT.
Mercer reviewed a sample of the five highest provider payments and 10 random payments, reviewed the related contractual arrangements, and recalculated the total payment amounts by sub-capitated provider using roster information provided by the MCO.	Variance: Detailed support for sub-capitation expense overstated by 1.97% or $57,598, or 0.35% of total sub-capitation expense. This variance is due to payments made for ineligible members. 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. The proof of payment information validated the supporting detail provided for the sampled sub-capitated providers.	No variance noted.
Mercer obtained roster information for the sampled provider payments and	Eligibility was verified for 99.71% of rostered members in the sample. The

verified eligibility of members and confirmed enrollment with MCO.	amount of non-global sub-capitation paid for the ineligible members is $57,598 and accounts for the variance noted above.
If applicable, Mercer reviewed Full-Dual COA subcontracted PMPM payment rates to determine whether the amount(s) are at a reduced rate as compared to the non-Full Dual COAs.	Not applicable as the non-global sub-capitated arrangements do not apply to dual status members.
For sub-capitated arrangements 5% or more of total medical expense, 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.	HPSM did not have any sub-capitated arrangements that exceeded the 5% or more of total medical expense threshold. It is noted that per HPSM, the sub-capitated contracts with primary care providers and specialists do not include administrative services in SFY 2021.

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 for Schedule 7 for consistency.	Schedule 1 is understated by 0.74% or $2,152,867, when compared to Schedule 7. This variance is 0.50% of total medical expense.

Member Months	
Description of Procedures	**Results**
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 are overstated by 0.15% 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 1.	Variance: RDT Provider Incentive Expense is overstated by 4.25% or $388,129. The overstatement was due to differences between budgeted and actual expenses and represents 0.09% of total medical expense.
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.
Mercer reviewed the listing of provider incentive payments for any payments to related parties. If the 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.	No variance noted. The proof of payment information validated the supporting detail provided for the sampled related party provider incentive payments.
If related party provider incentive payments were noted, Mercer reviewed the incentive terms to determine whether the terms align with similar arrangements for non-related parties.	The related party incentive terms aligned with similar arrangements for non-related parties.

Reinsurance	
Description of Procedures	**Results**
Mercer reviewed the reinsurance contract and compared the amount on	Variance: Reported reinsurance is overstated by 6.71% or $56,518. This

the RDT to the requested supporting schedule.	amount is 0.01% of total medical expense.
Mercer recalculated reinsurance premiums, based on SFY 2021 membership as of February 2023, to compare to reported amounts.	Variance: RDT was overstated by 1.92% or $28,291. The recalculated amount is included in the overall variance reported in the prior line item.
Mercer recalculated recoveries for a sample of five members.	No variance noted.
Mercer compared the amount of reinsurance recoveries as compared to the information in Schedule 5 for reasonableness.	Reported amounts in Schedule 5 are consistent with reinsurance recoveries reported based on review of the reinsurance threshold.

Settlements	
Description of Procedures	**Results**
Mercer inquired of the MCO if they incurred any settlement amounts with providers related to SFY 2021 dates of service. If settlements exist, 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**
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, HPSM is submitting TPL information as required by APL 21-007. No further testing necessary.

Administrative Expenses	
Description of Procedures	**Results**
Mercer benchmarked administrative expenses as a percentage of net revenue across all County Organized Health System (COHS) plans and compared to the amount reported in Schedule 6a, taking into consideration the membership size of the plan when reviewing the results.	The benchmark administrative percentage was 4.71% of Net Revenue and HPSM reported 6.51%, primarily driven by Compensation Expense. HPSM is one of the smaller COHS plans by membership. Therefore, the higher administrative percentage is considered reasonable.
Mercer compared detailed line items from the MCO's trial balance mapped to line items in Schedule 6a and Schedule 6b for reasonableness. Mercer reviewed allocation methodologies and recalculated for reasonableness.	The RDT Administrative Expense is overstated by 0.52%, or $143,142, or 0.04% of Net Revenue. The allocation methodology was deemed reasonable.
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.	HPSM is exempt from income taxes; therefore, no taxes 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.	HPSM had no related parties as defined by the Financial Accounting Standard Board. However, San Mateo Health Commission, the governing body of HPSM, had two members who held executive positions at hospitals or provider organizations that provided services to HPSM's Medi-Cal members.

	HPSM's related party 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.	HPSM's related party transactions accounted for less than 5% of the related COS expense.
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.
When applicable, Mercer obtained related party corporate allocation methodologies for administrative services. Where significant, Mercer recalculated the amounts for reasonableness.	Per HPSM, there were no administrative services provided by related parties.

UM/QA/CC	
Description of Procedures	**Results**
Mercer benchmarked UM/QA/CC expenses as a percentage of total medical expense across all COHS plans and compared to the amount reported on Schedule 1-U, taking into consideration the membership size of the plan when reviewing the results.	The benchmark UM/QA/CC percentage was 1.69% and HPSM reported 2.63%. This difference is primarily driven by HPSM's Whole Child Model aid code as the plan provides extensive case management and care coordination for that population.
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**
Mercer compared capitation amounts reported in Schedule 6a for calendar year 2020 plus January–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: RDT is understated by 1.68% or $10,568,620. Using a straight average methodology, the variance for SFY 2021 is estimated at $7,045,746 and remains 1.68%. Per discussion with HPSM, the majority of this variance is due to timing of payments versus timing of RDT submission.
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.	No variance noted.
Other Information	
Description of Procedures	**Results**
Mercer reviewed the plan's audited financial statements for SFY 2021 for a clean audit opinion or identification of significant deficiencies or material weaknesses.	HPSM received 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.	HPSM provided the written policy for the identification and recovery of overpayments.

	HPSM monitors claims payments closely through both contracted third-party vendors and internally. The vendors monitor high-cost inpatient diagnostic related group paid claims to ensure billed charges are accurate and coordination of benefits is occurring to ensure Medi-Cal is payer of last resort. HSM has a dedicated team of auditors that audit claims for payment processing accuracy. Areas of concern are reviewed via routine internally developed reporting and oversight. Overpayments caused by retroactive changes are logged as projects and tracked to completion. HPSM is appropriately excluding any provider overpayments from the RDT medical expenses.

Section 3

Summary of Findings

Based on the procedures performed, the total amount of capitation revenue for the SFY 2021 RDT was understated by $7,045,746, or 1.68%.

Based on the procedures performed, the total amount of gross medical expenditures in the RDT were overstated by $1,392,776 or 0.33% of total medical expenditures in the SFY 2021 RDT.

Based on the procedures performed, administrative expenditures in the SFY 2021 RDT were overstated by $143,142 or 0.52%.

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

HPSM reviewed this report and had the following comments:

HPSM agreed with the findings except for the FFS Medical Expense findings. Support was provided to document additional members as eligible, and the report was adjusted accordingly.

Appendix A

Administrative Duties in Subcontracted Arrangements

Administrative Task	Kaiser (Global)
Quality Management	X
Quality Measure Tracking	X
Utilization Management	X
Case Management	X
Member Services	X
Member Grievance	X
Claims Processing	X
Claims Adjudication and Payment	X
Encounter Submission	X
Provider Services	X
Provider Contracting	X
Provider Relations and Education	X
Credentialing and Recredentialing	X

Mercer Health & Benefits LLC
2325 East Camelback Road, Suite 600
Phoenix, AZ 85016
www.mercer-government.mercer.com