Mercer

Government Human Services Consulting

State Fiscal Year 2021 Contra Costa Health Plan Mainstream Rate Development Template

Auditor's Report

California Department of Health Care Services

May 23, 2024

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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 Contra Costa Health Plan (CCHP). 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 CCHP for SFY 2021. CCHP'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 $1,229,876 or 0.00% of total medical expense and is included in the variance noted below. • COS Map: Review of each COS showed 83%–100% match. Majority of the lower match rate was in Physician and Outpatient COS. • Service Year: No variance noted.
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 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 not greater than 2% for inpatient claims and 1% for all other categories of service.	Variance: RDT FFS Expenses are over/(understated): • Inpatient 0.10% • Outpatient 2.15% • LTC 23.77% • Physician 0.15% • All Other 2.83% In Total 1.27% or $5,968,529. The majority of the larger variances above are due to the overstatement of IBNR.

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 understated by 0.15% or $164,690. This amount is 0.02% of total medical expense.
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 rates established in the contract with the subcontractor.	Variance: Detailed support for global capitation expense is understated by 0.48% or $460,189. The recalculated amounts were more 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, clearinghouse documentation, or other online financial institution support for the sampled global capitated payments.	Variance: Detailed support for global capitation expense overstated by 0.27% or $179,739. This amount is 0.03% of total medical expense. The proof of payment information was less than the supporting detail provided for the sampled global capitated providers.
Mercer obtained roster information for the globally subcontracted providers 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 99.10% of members. The amount of global capitation paid for the ineligible members is $99,801 and is included in the variance noted above.

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. CCHP segregated 0.53% of the global capitation expense in the Schedule 1-A Data tab in the RDT. This amount is considered low when compared to 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 overall non-global sub-capitation supporting detail. Mercer compared the support provided to the amounts reported in Schedule 7.	Not applicable. Per CCHP no sub-capitated arrangements, however $4,409,160 is shown as sub-capitated payments were reported on Schedule 7. Per CCHP, this amount is an estimated amount based on historical experience and reconciled and paid annually for outpatient surgeries. No additional sub-capitation testing deemed necessary.

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.	No variance noted.
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 0.13% 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, lines 34–36.	Variance: RDT Provider Incentive Expense is overstated by 100.00% or $749,674. The full amount reported represents case management fees and should have been reported on the UM/QA/CC line item. This amount represents 0.11% 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.	Not applicable. No sample test work performed as the full amount reported as provider incentives is actually case management fees as noted above.
Mercer reviewed the listing of provider incentive payments for any payments to related parties. If the review of the	Not applicable. No related parties per CCHP.

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.	
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.	Not applicable. No related parties per CCHP.

Reinsurance	
Description of Procedures	**Results**
Mercer requested reinsurance supporting detail. Mercer compared the support provided to the amount reported in the RDT.	CCHP does not have reinsurance but leverages the support of the County funds as needed. No further test work deemed necessary.

Settlements	
Description of Procedures	**Results**
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 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 incurred per CCHP.

Third-Party Liability (TPL)	
Description of Procedures	**Results**
Mercer reviewed information submitted by the MCO as how TPL is identified	Per review of the support provided and confirmation with DHCS, CCHP is

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.	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 Two-Plan/GMC plans and compared to the amount reported in the RDT, taking into consideration the membership size of the plan when reviewing the results.	The administrative percentage reported by CCHP was within an acceptable range as compared to industry standards.
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.	The RDT Administrative Expense is understated by 13.22%, or $3,342,806, or 0.52% of Net Revenue. The primary driver of the variance is compensation expense as well as an incorrect amount reported for interest paid on late claims. No allocations per CCHP.

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.	CCHP 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	Not applicable. Per CCHP, no related party relationships.

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.	

UM/QA/CC	
Description of Procedures	**Results**
Mercer benchmarked UM/QA/CC expenses as a percentage of total medical expense across all Two-Plan/GMC 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 1.70% and CCHP reported 2.68%. This variance is within an acceptable range.
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.	Variance: Schedule 1-U is overstated by 15.05% or $2,616,914, which is 0.39% of total medical expense. If the $749,674 of case management fees that was erroneously reported as Provider Incentives is included, the variance is an overstatement of 18.56%, or $3,366,588, which is 0.50% of total medical expense. Per CCHP, the support provided was incorrect. The support excluded some accounts and the reported amount is correct. A revised support schedule was not provided.
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 the 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 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 0.63%, or $6,375,945. Per discussion with CCHP, 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.	There is no interest allocation. Each line of business receives interest payments which are calculated by the Contra Costa County Auditor-Controller which is primarily based on the Medi-Cal line of business average daily cash balance. No further test work deemed necessary.

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.	No variance noted.
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	CCHP provided the written policy for the identification and recovery of overpayments. Based on a review of

overpayments and on how the recoveries are recorded in the RDT.	that policy, CCHP is appropriately excluding 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 $6,375,945, or 0.63%.

Based on the procedures performed, the total amount of gross medical expenditures in the RDT was overstated by $9,170,419 or 1.35%, of total medical expenditures in the SFY 2021 RDT.

Based on the procedures performed, administrative expenditures in the SFY 2021 RDT were understated by $3,342,807, or 13.32%. This represents 0.49% of Total Revenue. The majority of the variance relates to incorrect reporting of interest paid on late claims. CCHP should enact procedures to ensure accurate reporting for future RDTs.

As noted in the Global Subcontracted Payments section, Kaiser, the global contractor, provides several administrative services. CCHP should prepare to properly record a portion of their global capitation expense as administrative in future RDT reporting, thus reducing medical expense.

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

CCHP reviewed and accepted this report.

Appendix A

Administrative Duties in Subcontracted Arrangements

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

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