Mercer

Government Human Services Consulting

State Fiscal Year 2021 Health Plan of San Mateo Coordinated Care Initiative Rate Development Template

Auditor's Report

California Department of Health Care Services

May 24, 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 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 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 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 the SFY 2021. HPSM's management is responsible for the content of the RDT and responded timely to all requests for information.

Table 1: 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 91.40%–99.99% match rate. • Service Year: No variance. All dates fall within SFY 2021.	
Mercer compared detailed lag tables for each major COS (Inpatient, Outpatient, Physician, 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.	Variance: RDT FFS Expenses are over/(understated): • Inpatient 0.50% • Outpatient (1.13%) • LTC 0.94% • Physician 1.08% • All Other (0.91%) In Total 0.31% or $579,583, or 0.23% of total medical expense. Per HPSM, the variances above are	Variance: RDT FFS Expenses are over/(understated): • Inpatient (2.22%) • Outpatient 1.79% • LTC 0.75% • Physician 3.40% • All Other 0.83% In Total 0.79% or $568,663, or 0.77% of total medical expense. Per HPSM, the variances above are

	primarily due to the following: • Difference in classification logic used by HPSM which categorizes Federally Qualified Health Center expense. • 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.	primarily due to the following: • Difference in classification logic used by HPSM which categorizes Federally Qualified Health Center expense. • 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 observed.	

Global Subcontracted 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.	Not applicable.	No variance noted. The total of the detail provided was equal to the amounts reported in the RDT.
Mercer reviewed the contractual arrangement with the MCO's global subcontractor(s) and recalculated the total payment amount using global roster information provided for all 12 months of SFY 2021 multiplied by the contracted rates.	Not applicable.	No variance noted. The recalculated amounts are equal to 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.	Not applicable.	No variance noted. The proof of payment information is equal to the supporting detail provided for the sampled global capitated providers.
Mercer compared the global per member per months (PMPMs) payment rates to relevant PMPM experience for non-global members for reasonableness.	Not applicable.	Mercer found the average global PMPM to be significantly lower than the cost experience of the non-global membership. This is due to the fact that LTC, IHSS, MSSP,

		and CBAS are excluded from the global contract.
If applicable, Mercer reviewed Full-Dual member global contracted PMPMs to determine if the amount(s) are at a reduced rate as compared to the non-Full Dual category of aid (COA) groups.	Not applicable.	Not applicable. HPSM pays Kaiser one blended rate across all 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.	Not applicable.	Per review of the global contract, all administrative functions in Appendix A were delegated to the global subcontractor. HPSM did not allocate any global capitation to administrative expense in the RDT. Therefore, this is likely an understatement of administrative expenses and an equal overstatement of medical expenses. However, this amount would be immaterial due to total global medical expense being less than $14,000.

Sub-Capitated Medical Expense		
Description of Procedures	**Results CMC**	**Results Non-CMC**
Mercer requested overall non-global sub-capitation supporting detail.	No variance noted.	No variance noted.

Mercer compared the support provided to the amounts reported in Schedule 7.	The total of the detail provided is equal to the amounts reported in the RDT.	The total of the detail provided is equal to the amounts reported in the RDT.
Mercer reviewed a sample 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.	Variance: Detailed support for sub-capitated amounts is understated by 1.21% or $70,569. The recalculated amounts were more than the sub-capitation amount reported in the supporting detail provided.	No variance noted.
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.	No variance noted. The proof of payment information was equal to the supporting detail provided for the sampled sub-capitated providers.	No variance noted. The proof of payment information was equal to the supporting detail provided for the sampled sub-capitated providers.
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 99.69% of rostered members in the sample. The amount of non-global sub-capitation paid for the ineligible members is $17,797 and is included in	Not applicable due to subcontractor being paid a flat monthly rate. Mercer confirmed and agreed with HPSM's method of allocation.

	the variance noted above.	
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.	Not applicable for either subcontractor. One contractor was paid a blended rate for all members which is appropriate based on review of the services covered under the contract. The other subcontractor was paid a flat monthly rate and expenses were allocated based on encounters.	Not applicable due to subcontractor was paid a flat monthly rate and expenses were allocated based on encounters.
For sub-capitated arrangements 5% or more of total medical expense or 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.	HPSM did not have any sub-capitated arrangements that exceeded 5% or more of the total medical expense threshold.	HPSM did not have any sub-capitated arrangements that exceeded 5% or more of the total medical expense threshold.

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.	No variance noted.	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 understated by 0.21% in total.	Variance: RDT Member Months overstated by 0.15% 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 1.79% or $53,608, which is 0.02% of total medical expense. RDT was overstated because estimates used were higher than actual payments.	
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	Not applicable. There were no provider incentive payments made to related parties.	

related party provider incentive payments.	
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.

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.	Variance: RDT was overstated by 10.60% or $3,069, which 0.00% of total medical expense.	Not applicable.
Mercer recalculated reinsurance premiums, based on SFY 2021 membership as of February 2023, to compare to reported amounts.	Variance: RDT was understated by 0.27% or $343. The recalculated amount is included in the overall variance reported in the prior line item.	Not applicable.
Mercer recalculated recoveries for a sample of four members.	No variance noted.	Not applicable.
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.	Not applicable.

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.	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, HPSM is submitting TPL information as required by APL 21-007. No further testing necessary.	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 CMC**	**Results Non-CMC**
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 benchmark administrative percentage is 6.36% and HPSM reported 6.53%.	The benchmark administrative percentage is 3.58% and HPSM reported 1.51%.

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.	Variance: RDT reported Administrative Expense is overstated by 1.18%, or $209,306. The variance is primarily due to allocation methodology between CMC and Non-CMC.	Variance: RDT reported Administrative Expense is understated by 7.54%, or $84,149. The variance is primarily due to allocation methodology between CMC and Non-CMC.

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.	HPSM 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 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,	HPSM's related party transactions are not a material portion of the related COS expense.	

Mercer also reviewed any allocation methodologies for reasonableness.	
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 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 amount reported on Schedule 1-U, taking into consideration the membership size of the plan under review when reviewing the results.	The benchmark UM/QA/CC percentage is 4.27% and HPSM reported 3.99%. This difference is considered reasonable.	The benchmark UM/QA/CC percentage is 1.87% and HPSM reported 1.10%. This difference is considered reasonable.
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	Variance: Using a straight average methodology, the	No variance noted.

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 for SFY 2021 is understated at $679,441 or 0.93%. Per discussion with HPSM, the majority of this variance is due to timing of payments versus timing of the RDT submission.	

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.	No variance noted.	

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.	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. HPSM 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 CMC

Based on the procedures performed, the total amount of Capitation Revenue for the CMC SFY 2021 RDT was understated by $679,441 or 0.93%.

Based on the procedures performed, the total amount of gross medical expenditures in the CMC RDT were overstated by $644,064 or 0.18% of total medical expenditures in the SFY 2021 RDT. In addition, the plan should prepare for properly recording a portion of their provider sub-capitation expense as administrative, thus reducing their medical expense.

Based on the procedures performed, administrative expenditures in the CMC SFY 2021 RDT were overstated by $209,306 or 0.78%.

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

HPSM reviewed and accepted this report.

Section 4

Summary of Findings Non-CMC

Based on the procedures performed, there was no variance in the total amount of Capitation Revenue reported for the Non-CMC SFY 2021 RDT.

Based on the procedures performed, the total amount of gross medical expenditures in the Non-CMC RDT were overstated by $560,859 or 0.50% of total medical expenditures in the SFY 2021 RDT. In addition, the plan should prepare for properly recording a portion of their global and provider sub-capitation expense as administrative, thus reducing their medical expense.

Based on the procedures performed, administrative expenditures in the Non-CMC SFY 2021 RDT were understated by $84,149 or 3.95%.

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 comment:

The finding indicates that HPSM did not allocate any global capitation to administrative expense in the RDT. On the RDT, instead of reporting the administration component of the global capitation separately, DHCS/Mercer instructed the Plans to report the total global capitation and Assumed Admin/UG Load % in Global Capitation Payments on Schedule 1-As. It's the Health Plan's understanding that Mercer will allocate a portion of the total global capitation to the administrative expenses during the rate setting process.

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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