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AUDITORS REPORT: CALENDAR YEAR 2017 HEALTH PLAN OF SAN MATEO RATE DEVELOPMENT TEMPLATE

MARCH 6, 2020

CONTENTS

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EXECUTIVE SUMMARY

Pursuant to federal requirements under Title 42 of the Code of Federal Regulations 438.602(e), the 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) [1]. DHCS contracted with Mercer Government Human Services Consulting (Mercer) to fulfill this requirement for the financial data submitted in the Medi-Cal Rate Development Template (RDT) for calendar year (CY) 2017 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 Bridge Year 2019-20 rating period (July 1, 2019 – December 31, 2020). The RDT tested was the final version, including any revisions stemming from resubmissions as a result of the RDT Q&A discussion guide process with the MCO.

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

- Schedule 1 Utilization and Cost Experience
- Schedule 1A – Global Subcontracted Health Plan Information
- Schedule 1C – Base Period Enrollment by Month
- Schedule 5 Large Claims Report
- Schedules 6a and 6b Financial Reports
- Schedule 7 Lag Payment Information

The data collected on Schedules 6a and 6b is reported on a modified accrual (incurred) basis for CY 2017 and does not follow Generally Accepted Accounting Principles with regards to retroactivity

[1] 42 CFR 438.602(e)

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 calendar year reported.

The procedures and results of the test work are enumerated in Table 1 of Section 2.

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PROCEDURES AND RESULTS

We have 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 CY 2017. HPSM's management is responsible for the content of the RDT and responded timely to all requests for information.

Table 1: Procedures

CATEGORY	DESCRIPTION	RESULTS
Utilization and Cost Experience	We compared summarized total net cost data from amounts reported in Schedule 1 to Direct Medi-Cal category of service (COS) totals from Schedule 6A and to total incurred claims by COS for Schedule 7 for consistency.	0% Variance.
Global Subcontracted Payments	We reviewed the contractual arrangement with HPSM's global subcontractor and tested the overall payments made to the global subcontractor by comparing results against amounts reported in Schedule 1A.	Variance: RDT overstated by 1.69%.
	We selected the three highest months of payment and five randomly selected additional months of payment to obtain membership rosters for each month selected. Twenty randomly selected members from each month were checked to ensure eligibility. The same members were compared against claims included in the fee-for-service (FFS) data provided by HPSM to see if claims were paid by both HPSM and the global subcontractor.	No FFS claims paid. All sampled members eligible
	We reviewed members included on the member roster to ensure there were no Coordinated Care Initiative members or payments provided in the step above.	None identified.
Member Months	We compared MCO reported member months from Schedule 1C to eligibility and enrollment information provided by the State. Our procedures are to request explanations for any member months with greater than 1% variance in total or greater than 2% variance by major category of aid.	Variance: RDT understated by 0.19% in total.

CATEGORY	DESCRIPTION	RESULTS
Capitation Revenue	We discussed how capitation was recorded. HPSM records capitation revenue on an accrual basis using eligibility from the 834 data multiplied by rates established on the most current rate sheet received from DHCS.	RDT understated by 0.15% for revenue based on estimated revenue calculation using the known capitation rates in place during 2017.
Interest and Investment Income	No interest and investment income was reported in the RDT. This was confirmed with HPSM. Mercer therefore utilized the same allocation methodology as HPSM used for other areas such as Administrative expenses to calculate the variance.	Variance: RDT understated by 100.00%.
Fee For Service Medical Expense	Using data files (paid claims files) provided by HPSM, we sampled and tested transactions for each major category of service (Inpatient, Outpatient, Physician, Pharmacy, Facility-Long Term Care (LTC), and All Others) and traced sample transactions through HPSM claims processing system, the payment remittance advice, and the bank statements.	No variance observed.
	We compared detailed lag tables for each major category of service (Inpatient, Outpatient, Physician, Pharmacy, Facility-LTC, and All Others) created from the data files provided by HPSM and compared the information reported in Schedule 7. We compared the paid claims amounts from Schedule 7, line 35 to total paid claims prior to the additional runout detail included in the data files, expecting no changes.	Variance: RDT understated in total by -0.49%.
	We compared total final incurred amounts including incurred but not reported estimates from Schedule 7 to total paid amounts from all months reported in the data files to verify the accuracy/reasonableness of Incurred But Not Reported (IBNR) for each category of service. 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 over/(understated): Inpatient 0.71%; Outpatient (0.33%); LTC 2.58%; Physician 0.43%; Pharmacy 0.15%; All Other 1.37%; In Total 0.60%.
	We reviewed a sample of claims from each category of service to verify control totals, verify eligibility, confirm the category of service grouping was correct, and confirm the year reported was correct.	Control totals: No variance noted. Eligibility: Verified for all members selected. COS Map: No variance noted. Service Year: No variance noted.

CATEGORY	DESCRIPTION	RESULTS
Sub Capitated Medical Expense	We compared reported sub-capitation payments to amounts reported in Schedule 7.	Variance: RDT overstated by 1.13%
	We sampled membership from three subcontractors, verified eligibility of members and analyzed claims to verify none of the FFS claims paid should have been paid by the sub-capitated provider.	No variance noted.
	We reviewed subcontract agreements and recalculated payment amounts for reasonableness. We observed proof of payments for a sample of sub-capitated provider payments.	No unexplained variances noted.
Provider Incentive Arrangements.	We reviewed incentive arrangements and observed sample calculations for contractual compliance and reasonableness.	Variance: RDT overstated by 15.72%
Reinsurance	HPSM's reinsurance coverage is based on an annual pooled deductible for reinsurance reimbursement coverage. For 2017 the annual pooled deductible was not met, therefore, no additional reimbursement was received from the carrier	No variance noted.
	We recalculated reinsurance premiums to compare to reported amounts.	No variance noted.
	We recalculated recoveries for a sample of members.	N/A
Administrative Expenses	We benchmarked administrative expenses as a percentage of capitation across all COHS plans and compared to the amount reported in Schedule 6a, taking into consideration the membership size of the plan under review when reviewing the results. We compared detailed line items from the plan's trial balance mapped to line items in Schedule 6A for reasonableness. We reviewed allocation methodologies and recalculated for reasonableness.	The benchmark administrative percentage was 4.38% and HPSM reported 6.20%. Variance: RDT overstated by 0.23% compared to trial balance.

CATEGORY	DESCRIPTION	RESULTS
Utilization Management, Quality Assurance Care Coordination	We 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. We compared Utilization Management/Quality Assurance/Care Coordination (UM/QA/CC) costs as a percentage of revenue to benchmarks for reasonableness. Confirmed with HPSM management via interview that UM/QA/CC costs were not also included in general administrative expenses.	No variance noted.
Pharmacy	We confirmed and observed pharmacy benefit manager fees were recorded as administrative expenses and not included in pharmacy claims expenses in the RDT.	No variance noted.
Other Information	We reviewed the audited financial statements for the plan for the CY 2017 for a clean audit opinion or identification of significant deficiencies or material weaknesses.	No variance noted.
	We compared reported expenses, including IBNR and administrative expenses, to audited financial statements for consistency.	No material variances noted.
	We inquired how hospital-acquired conditions (HACs) were treated in the RDT and policies for payment.	HPSM does not generally reimburse for HACs. The DRG grouper utilizes a “Present on Admission” indicator offered on the UB-04 and requires this field to be populated when it may impact reimbursement. If the indicator reflects that the condition was not present on admission, the DRG rate will be updated accordingly. HPSM has also contracted with a vendor who audits inpatient submissions against the original medical record to confirm the claim was coded correctly.

CATEGORY	DESCRIPTION	RESULTS
		For per diem inpatient claims, HPSM's Health Services staff will dictate payable days. HPSM will not approve any days that would have otherwise not been necessary (including additional inpatient days resulting from hospital acquired conditions).

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SUMMARY OF FINDINGS

Based on the procedures performed, the total amount of gross medical expenditures in the RDT were overstated by $2,299,968 or 0.68% of total medical expenditures in the CY 2017 RDT.

Based on the procedures performed, the total amount of gross administrative expenditures in the RDT were overstated by $55,249, or 0.23% of total administrative expenditures in the CY 2017 RDT.

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

HPSM has reviewed this report and had no comments.

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