Mercer

Government Human Services Consulting

Delaware Medicaid Managed Care Financial Reporting Templates (FRTs) Review Summary Report — Calendar Year 2021

Diamond State Health Plan (DSHP) and Diamond State Health Plan Plus (DSHP Plus)

State of Delaware

October 31, 2023

Contents

Section 1

Executive Summary

In response to federal requirements under Title 42 CFR 438.602 (e), Mercer Government Human Services Consulting (Mercer GHSC or Mercer) has performed relevant procedures for the State of Delaware (State). According to the requirements, the State 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), prepaid inpatient health plans (PIHP), or prepaid ambulatory health plans (PAHP). The regulation does not require this audit to be in accordance with Generally Accepted Accounting Principles (GAAP), therefore the procedures described in this report may or may not be in accordance with a GAAP audit.

Procedures are demonstrated for the Diamond State Health Plan (DSHP) and DSHP Plus programs (hereunto referred to as “DSHP”), at the consolidated MCO level, not at the individual contract/county/region level. In addition, only the direct MCO financial submissions were subject to the procedures.

The specific financial data submitted by the DSHP MCOs that were subject to review is the calendar year (CY) 2021 DSHP Financial Reporting Templates (FRTs). These specific financial data were selected because they are used by the State’s actuary, Mercer, as a critical part of the base data development for capitation rates. These FRTs are the final versions, including any revisions stemming from resubmissions as a result of the FRT quarterly and annual question and answer (Q&A) process with the MCOs (FRT observations).

The following summary is the result of relevant procedures as described in the CY 2021 Financial Reporting Template Review Procedures.

Section 2

Summary of Procedures and Results

Medicaid Member Eligibility Reporting

Mercer compared the member months from the FRT Schedule D, Line 1 with the State-provided, Delaware Medicaid Enterprise System (DMES) actual member month data files. This comparison tests for parity between the financial reported member months and DMES reported member months.

Table 1 **FRT Reported Member Months to DMES Enrollment Relativity by Capitation Rate Cell**

MCO	TANF/MCHIP Newborns	TANF Children	TANF Adults	MAGI Adult	SSI Child
All MCO	0.9931	0.9970	0.9911	0.9852	0.9971

MCO	SSI Adult	CHIP/MCHIP	NF/HCBS Dual	NF/HCBS Non-Dual	Community Well
All MCO	0.9923	0.9938	0.9972	1.0092	0.9857

MCO	All Rate Cell
All MCO	0.9918

Mercer's Actuarial Rate-Setting team is aware of the reporting variances between Schedule D, Line 1 and the DMES eligibility. These expected differences are driven by how MCOs are reporting eligibility compared to the basis Mercer uses for calculating member months for use in rate-setting. These differences are accounted for during the rate-setting process. No further action is needed to correct the differences by the MCOs.

Medical Claims Payment Reporting

Mercer compared claims payment reporting from FRT incurred but not reported (IBNR) Schedules H through N payment lag tables with DMES system paid encounter data using data cutoff dates aligned to the FRT paid data cutoff. This comparison tests for parity between financial reported paid dollars and DMES system reported paid dollars.

Table 2 FRT Reported Paid Dollars to DMES System Paid Dollars Relativity by FRT Reported Eligibility Category

MCO	Non-LTSS	LTSS	All Categories
All MCO	1.0206	1.0123	1.0185

The numbers above represent the FRT paid dollars divided by the DMES paid dollars. The Mercer Actuarial Rate-Setting team is aware of the differences in reported paid amounts between reported financial information and State provided encounter payment details. Mercer accounts for these differences by using these data sources in tandem, where DMES paid amounts form the basis for the capitation rate, which is then reviewed and validated based on observed runout patterns identified in the FRT submitted data. No action is needed from the MCOs to correct the differences between DMES encounter submitted and FRT reported values.

Medical Claims Accrual, Global/Sub-Capitation, and Settlements Reporting

Mercer compared FRT IBNR Schedules H through N, Line 46 Total Incurred Claims as reported via the CY 2021 Annual FRT submission with the CY 2021 Line 46 Total Incurred Claims from the CY 2022 Annual FRT submission. This comparison tests the MCO reported total incurred dollars for the CY 2021 service year, against the same service year reported within the next year's annual submission. Effectively, CY 2021 service months are reviewed at 120 days post-service period, and 485 days post-service period (120 days + 365 days).

Table 3 CY 2021 FRT Medical Services Total Incurred Costs: CY 2021 Q4 FRT/CY 2022 Q4 FRT

FRT Service Category	All MCOs
Inpatient Hospital	107.0%
Other Institutional	99.5%
Home/Community	98.9%
Outpatient Facility	101.9%
Physician/Professional	104.6%
Outpatient Pharmacy	101.1%
Other Medical	99.4%
SUM	**102.5%**

Table 3 represents CY 2021 total incurred services reported 120 days post-period divided by CY 2021 total incurred services reported 485 days post-period. This should be interpreted based on the following narrative for Inpatient Hospital:

Total Incurred Inpatient Hospital was overstated by 7.0%. This overstatement was a result of the total reported incurred services being revised downward from one annual report to the next.

The Mercer Actuarial Rate-Setting team takes the differences between 120 days reporting of total incurred services and subsequent quarterly and annual reporting (between 150 and 485 days post-service period) into account when developing rates. Mercer performed quarterly question and answer activities with the MCOs where necessary to further understand changing incurred amounts. MCOs reported variances in the Schedule T Supplemental Working Area. No action is needed from the MCOs to address the differences in reported total incurred amounts between reporting versions.

Special Contract Arrangement Reporting

Mercer compared FRT Risk Mitigation Schedule F, High Cost Outpatient Drug Risk Sharing and Global Risk Corridor lines with State approved MCO submitted risk mitigation settlement files for the two respective arrangements. The High Cost Outpatient Drug Risk Sharing arrangement is a contracted mechanism designed to address outpatient drugs with significant claim cost and utilization volatility that may not necessarily be captured through the capitation rate development, and which can also be volatile in utilization and cost between MCOs. The arrangement results in net payable/receivable settlements on a recurring basis as claims data comes available. The Global Risk Corridor arrangement is another contracted risk mitigation mechanism designed to adjust MCO revenues based on MCO reported medical loss ratio (MLR) percentages that deviate from the MLR percentage thresholds inherent in the contracted capitation rate development. The arrangement results in net payable/receivable settlements on a recurring basis as claims data comes available. This comparison tests MCO reported risk mitigation settlements with expected arrangement amounts as determined by final settlement calculations.

Table 4 CY 2021 Special Arrangements: Risk Mitigation Mechanism Accrual to Actual Relativity

Risk Mitigation Accrual to Actual Relativity	All MCO
High Cost Outpatient Drug Risk Sharing	0.65
Global Risk Corridor	1.66
SUM	**1.31**

Table 4 represents the CY 2021 annual reported MCO FRT accrued risk mitigation arrangement receivable/payable divided by the official settlement calculation receivable/payable. The Mercer Actuarial Rate-Setting team is aware of the many variables that contribute to differences between MCO expectations for risk mitigation arrangement results, and the actual results which are provided to them by the State. The following is a list of variables that contribute to these reported differences between both arrangements.

- MCO risk mitigation reporting timelines
- MCO annual/quarterly reporting timelines
- State timeline to notify MCOs of final settlement amounts
- State timeline to process settlements through payment system
- Differences in transaction methodology for **receivable to MCO** versus **payables to State**
- Delays in processing due to MCO submission data errors
- State reviews resulting in exceptions or exclusions of reported drug detail (High Cost Outpatient Drug Risk Sharing)
- Changes in MCO expectations of expected annual MLR (Global Risk Corridor)

The risk mitigation arrangements contracted between the State and its MCOs are unpredictable by nature. The High Cost Outpatient Drug Risk Sharing arrangement receivable/payable may be estimated by the MCO before calculations are finalized by the State based on actual claims utilization. The timeline for validation of reported claims utilization and finalization of the settlement can result in the MCO financial reporting period closing before final settlement amounts are known. The nature of the Global Risk Corridor arrangement is such that the delay in calculation of final settlement compared to MCO accrual of expected settlement amount will always result in the MCO Annual FRT reported amount being accrued before any official settlement is calculated. MCO reported Global Risk Corridor amounts in any given Annual FRT may include a mixture of current year settlement accruals, and adjustments to prior year accruals. Risk mitigation results do not impact future actuarial rate-setting activities. No action is needed from the MCOs to address the differences between accrued and actual settlement amounts.

Administrative Expense Reporting

Mercer reviews MCO administrative/non-medical expenses via the required 42 CFR § 438.8 MLR annual reports as part of its overall administrative expense review process. The MLR annual reports are based on MCO financial reported information, adjusted for the effects of the Global Risk Corridor.

Table 5 CY 2021 MLR Reporting

MCO	CHIP	All Other Medicaid
All MCO	82.3%	91.7%

Table 5 represents the reported incurred claims and activities that improve health care quality divided by reported premium revenue less applicable federal, State, and local taxes and licensing and regulatory fees. This review element demonstrates the portion of the MCO's capitation revenues being spent on administrative expenses as (100% - [Reported MLR %] = [Admin as % of Capitation Revenue]). The Mercer Actuarial Rate-Setting team is aware of these amounts, which represent underlying financial data from the Annual FRT submissions used in rate development. The administrative component which results in 17.7% for the Children's Health Insurance Program (CHIP) population does not require correction

by the MCOs. The All Other Medicaid population administrative component which is 8.3% does not require correction by the MCOs.

Section 3

Summary of Findings

Based on the review procedures performed, the total amount of CY 2021 reported eligibility member months within the Annual FRTs is 0.82% lower than DMES.

The total amount of CY 2021 reported paid dollars within the Annual FRTs is 1.85% higher than the encounter data as reported to DMES. The total amount of incurred services for the CY 2021 service period was revised downward by 2.5% in FRT reporting available subsequent to the original annual reporting used for the CY 2024 capitation rate development.

Based on the review procedures performed, the total amount of reported risk mitigation arrangement receivable/payable accruals was 30.9% higher than actual settlement amounts finalized by the State.

Based on the review procedures performed for administrative expenses, the MCO reported 42 CFR § 438.8 Centers for Medicare & Medicaid Services (CMS) standard MLR ratios did not require correction.

Based on the differences reported between sources in this review, Mercer and the State do not believe the variances to be material, and do not warrant corrective action.

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