Mercer

Government Human Services Consulting

Delaware Medicaid Managed Care Financial Reporting Templates (FRTs) Review Procedures — 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) is performing review 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 will be performed 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 will be subject to the review steps.

The specific financial data submitted by the DSHP MCOs that will be 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 for capitation rate development. These FRTs will be the final versions, including any revisions stemming from resubmissions as a result of the FRT quarterly and annual Q&A process with the MCOs (FRT observations).

The key schedules to be used from the MCO-reported FRTs include, but are not limited to:

1. Schedule A — Quarterly Balance Sheet
2. Schedule B — Quarterly Income Statement
3. Schedule C — Footnotes
4. Schedule D — Total Profitability by Rate Cell
5. Schedule F — Risk Mitigation Revenue
6. Schedules H through N — Service Based Payment Lag
7. Schedule O — Sub-Capitated Categorical
8. Schedule P — Federally Qualified Health Center (FQHC) Payments
9. Schedule AA — Non State Plan Expenditure
10. Schedule BB — Maternity Report
11. Schedules CC — Long-Term Services and Supports (LTSS) Profitability Detail

Section 2

Procedures

Procedures contained herein are established as minimum requirements. Findings from the procedures will be reported to the State. Discrepancies will be included in the findings. Where significant differences exist, follow-up questions will be prepared for the MCO. In addition, if a significant error rate is noted, additional testing may be performed if necessary to extrapolate. Additional ad hoc procedures may be added and performed as agreed to by the Division of Medicaid and Medical Assistance (DMMA) and Mercer.

As all MCOs were subject to review of their CY 2021 FRTs, the plan from here forward is to review each MCO on a recurring basis. Mercer and DMMA will work together to implement the review.

The specific procedures to be performed are as follows:

Medicaid Member Eligibility Reporting — Schedules B/D

1. Mercer will collect enrollment data via State-provided actual member month data files received for the applicable CY. The enrollment data for the year under review will be received through a date subsequent to the end of the enrollment year to allow sufficient capture of retroactive eligibility, and to align closely with the timing of the MCO FRT submissions.
    A. This information is extracted from the DMMA data systems and reviewed by Mercer quarterly. Extracted data includes eligibility span data files and capitation payment data files.
2. Mercer begins by arraying the collected information for validation via the following metrics (Mercer may review additional fields depending on findings):
    A. Month/year of eligibility
    B. Delaware Medicaid Enterprise System (DMES) aid category
    C. Quarter of extracted data (to compare data points across extracted data sets; this supports identification of data anomalies resulting from historical or current DMES system changes)
    D. MCO capitation rate cell
    E. Payer classification:
        i. MCO or fee-for-service
    F. Dual status
    G. Capitation payment month
    H. Maternity kick payment record

3. At the rate cell, MCO, and eligibility month level Mercer will compare the MCO FRT Schedule B and Schedule D reported member months against the data prepared from steps 1 through 2.
4. Mercer generates charts and data visualization measures to aid in the demonstration of eligibility trends, helping to identify anomalies, and potential recommendations for data reporting improvements across the managed care data life cycle.
5. Mercer shares significant findings on recommended next steps for addressing data quality with DMMA. Mercer and DMMA maintains quarterly, standardized FRT observations (in the form of questions to MCOs), which allow for direct MCO input on FRT reporting.

Medical Claims Payment Reporting — Schedules H through N

1. Mercer will collect MCO final adjudicated encounter data for the applicable CY. The data is extracted from the State-provided DMES system quarterly. The encounter data for the year of service under review will be received through a cut-off date following the final date of service for the CY under review, with sufficient claims payment runout detail to align with the MCO FRT reporting timeline.
    A. i.e., If the MCO FRT reported paid claims through quarter one with a paid cutoff date of April 1, Mercer would utilize an extracted DMES encounter database with cutoff in April to minimize differences in cutoff dates, thereby ensuring the comparison between DMES system and MCO FRT reporting are on a consistent paid cutoff basis.
2. Mercer begins by arraying the collected information for validation via the following metrics (as with eligibility data review, Mercer may review additional fields depending on findings):
    A. Month/year of service date
    B. Rate cell name
    C. Quarter of extracted data (to compare data points across extracted data sets; this supports identification of data anomalies resulting from historical or current DMES system changes)
    D. Eligibility MCO name
    E. DMES category of service
    F. Accepted/denied claim status
    G. Maternity status flag (Mercer derived)
    H. Claim type indicator (derived from primary claim types, UB-92, HCFA-1500/ CMS-1500, NCPDP, with additional DMES claim components hierarchy applied)
    I. Final adjudicated paid amount

J. Incurred but not reported (IBNR) Schedule H through O category of service (Mercer derived)

3. At the rate cell, MCO, service month, extracted data version, category of service, accepted/denied status, and maternity status level the encounter data is compared to the MCO FRT reported Schedule H through N payment lag schedules. Variations in aggregate reported amounts across all schedules, as well as variations at the individual schedule level are reviewed.

4. Mercer generates charts and data visualization measures to aid in the demonstration of claim payment trends across the measured variables. Details developed in item #3 above are referred to support and explain findings from elements Mercer identifies for further review.

5. Mercer makes recommendations to DMMA, which may or may not include communication to the MCOs, during each quarterly review as needed to ensure the data is sufficient for rate setting. This is implemented through quarterly and annual, standardized FRT observations (in the form of questions to MCOs), which allows for direct MCO input on FRT reporting concerns.

Medical Claims Accrual, Global/Sub-Capitation, and Settlements Reporting — Schedules B/D and H through O

On a quarterly and annual basis Mercer performs an analysis of the MCO's FRT reported Schedule H through N service based payment lag information, subtotal lines 39 through 46, which encompass the following FRT metrics related to medical claim activities on an LTSS service and non-LTSS service basis:

A. Line 39, Global/Subcapitation Payments

B. Line 40, Schedule M only, MCO Pharmacy Rebates

C. Line 41, Settlements

D. Line 43, Estimated incurred but not paid (IBNP), less any explicit margin for adverse deviation

E. Line 44, Explicit margin for adverse deviation

Mercer also compares aggregated Schedule H through N level line 46, Total Incurred Claims reporting to the reported medical expenses identified within the Schedules B and D.

Mercer uses data established in steps 1 and 2 of the "Medical Claims Payment Reporting — Schedules H through N" section of the procedures in conjunction with current and historically submitted MCO FRT schedule H through N payment lag tables to review and test for reasonability of the MCO's established pattern of unpaid claim liability accruals. During review, Mercer takes into account the FRT reported data elements established above in this section regarding Schedules B, D, H through N, and O.

Mercer will also utilize the MCO FRT reported Schedule O, Sub-Capitated Categorical data presented in the report at the sub-capitated provider name and category of service level. Various metrics requested from the MCO on this report include:

A. Related/affiliated party status

B. DMES encounter submitted indicator

C. Rate cell name

DMMA and Mercer consider it a priority in rate setting activities to ensure that DMES system reported encounter data is aligned and reviewed appropriately to MCO FRT reported data. In regards to sub-capitated provider arrangements, Mercer and DMMA have established as part of quarterly and annual FRT observations (in the form of questions to MCOs) a collection of questions designed to ensure sub-capitated provider arrangements are correctly handled in rate-setting. Such questions include, but are not limited to:

A. Request for additional information at Schedule O reported provider level.

B. Request for claim identification methodology within DMES as applicable.

C. Request for confirmation of MCO FRT reported Schedule O service category alignment to Schedule B and D and Schedule H through N service category alignment.

D. Request for confirmation that reported sub-capitation paid dollars reported in medical lines are not administrative (non-medical) in nature, and an itemization of medical and administrative portions if so.

Special Contract Arrangement Reporting — Schedule F

DMMA contracts with their MCO subcontractors and in doing so may create special risk mitigation arrangements. Such arrangements may affect the reporting of MCO risk in the MCO FRT submissions. Schedule F, Risk Mitigation Revenue is established to itemize this reporting, which is summarized in Schedules B/D line 5.

Mercer has established the following procedures to review these reported amounts for reasonability.

1. Mercer identifies contracted risk mitigation arrangements with DMMA, and includes explicit line items within the FRT template files for the MCOs to fill out by individual arrangement.

2. Mercer and DMMA throughout the course of an MCO contract year generate approved, calculated risk mitigation arrangement settlement files.

3. Mercer uses finalized settlement files containing revenue payment or recoupment obligations between DMMA and the MCOs to compare to the reported positive or negative revenue line reporting within the Schedule B/D line 5 and Schedule F reported amounts.

4. Mercer and DMMA utilize the standardized quarterly and annual MCO FRT observations (in the form of questions to the MCOs) for clarification and validation of reported values.

Administrative Expense Reporting — Schedules B/D, B.1, and MLR

The MCO FRT submissions include an itemized schedule B.1, Health Care Quality Improvement (HCQI), & Admin which provides a breakout of Schedule B/D reported lines 69 and 75. Mercer uses the following procedures for reviewing and validating MCO reported administrative and HCQI expenses.

1. Mercer reviews the MCO FRT submitted Schedules B/D and B.1 for reported administrative and HCQI expense detail.
2. Quarterly reported patterns of administrative and HCQI expenses are reviewed, and MCOs are directed to use Schedule C, Footnotes or the Schedule T, Supplemental Working Area to describe any Schedule B.1 line 23 “other administrative costs”. Mercer reviews the Schedule C and T details to further review such costs when provided by the MCO.
3. Mercer reviews MCO calculated, 42 CFR § 438.8 CMS standard medical loss ratio (MLR) percentages and their underlying required calculation methodology submissions to establish metrics on MCO use of capitation revenue in regards to medical versus administrative spending.
4. Mercer and DMMA utilize the standardized quarterly and annual MCO FRT observations (in the form of questions to the MCOs) procedure, as well as the observations procedure in the CMS MLR review period when significant findings are identified for the MCO to react to or provide more detail on.

Other Procedures

1. Obtain audited financial statements and related management letter for CY 2021. Review for any concerns that may lead to a need for additional procedures.
2. Review Schedule T, Supplemental Working Area for additional MCO notes provided outside of the official FRT instructions guide and FRT template guidance.

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