

September 2006

Capitation Rate Development
Base Data Review and
Assessment
California Department of Health
Services

MERCER

Government Human Services Consulting

Contents

1. Executive Summary	1
▪ Introduction and Project Objectives.....	1
▪ Project Approach/Methodology	2
▪ Summary of Findings.....	3
2. Introduction.....	5
▪ Background.....	5
▪ Project Summary and Objectives.....	6
3. Methodology	8
▪ Obtain Base Data	8
▪ Steps to Test Encounter Data Viability.....	10
▪ Cognos PowerPlay	11
▪ Outlier Model.....	11
▪ Interpreting the Results of this Analysis.....	13
▪ Ad-Hoc Data	14
4. Findings.....	15
▪ Overall Data Quality	15
▪ Eligibility Data.....	15
▪ Claims and Encounter Data	15
▪ Inpatient Claims Data	16
▪ Pharmacy Claims Data.....	16
▪ O/P Claims Data	17
▪ Utilization Data.....	18
▪ Summarized Results by Managed Care Model and Individual Health Plans	24
▪ Unit Cost Data.....	27
▪ Applicability of Health Plan Financial Statements.....	27
5. Conclusions.....	29
▪ Findings and Recommendations	29



Executive Summary

Introduction and Project Objectives

In an effort to continue to improve the capitation rate development process, the California Department of Health Services (CDHS) engaged Mercer Government Human Services Consulting (Mercer) to perform a review and assessment of the various sources of base data available to the State. With the expansion of the Medi-Cal Managed Care programs over the years, there has been significant movement of beneficiaries on both a mandatory and voluntary basis, from FFS to managed care. One of the consequences of this is that for most Medi-Cal managed care populations, there is no longer sufficient or appropriate fee-for-service (FFS) data on which to base capitation rates. Therefore, other data sources must be utilized in the development of capitation rates. CDHS has been collecting service encounter data from their contracted health plans for many years. In addition, the Department of Managed Health Care (DMHC) requires the submission of quarterly and annual financial reporting from all Knox-Keene licensed health plans. Beyond historical FFS claims data, financial statement and encounter data are the most commonly relied upon data sources for Medicaid managed care programs nationally.

California utilizes a unique blend of managed care contract models to provide services to more than half of the State's Medi-Cal (Medicaid) eligible members. The three primary managed care contract models employed by CDHS include the County Organized Health System (COHS) model, the Two-Plan model, and the Geographic Managed Care (GMC) model. CDHS currently utilizes only the encounters collected from four of the five COHS, as well as their submitted financial statements, as the base data for capitation rate development for all three of their major managed care contract models. This represents approximately 8% of the Medi-Cal managed care enrollment.

For data to be truly useful it must be reasonably complete, accurate, and relevant (i.e., represent the population served). The Centers for Medicare and Medicaid Services (CMS) requires that capitation rates paid to at-risk managed care health plans be developed in an actuarially sound manner — Federal Register, Friday, June 14, 2002, 42 CFR

438.6(c)(1)(i). No state has 100% complete and accurate encounter data, but having reasonably complete encounter data and understanding data limitations is important in the rate development process.

The base data review and assessment (Review) is intended to enhance CDHS' understanding of the available data for use in Medi-Cal managed care capitation rate development. The Review is multi-faceted and covers several areas of focus, including Medi-Cal managed care encounter data, Medi-Cal FFS claims data, Medi-Cal health plan financial data, and ad-hoc reports from the Medi-Cal health plans. From this review CDHS hopes to identify which data sources are viable and appropriate for use in the capitation rate development process, and to develop a standardized methodology for selecting the best data for use in future rate development efforts.

This project did not focus on the determination of whether current or historical rates were actuarially sound; rather, the purpose was to determine whether encounter and financial data collected by the State is appropriate for use in future capitation rate development efforts, and if there are any other sources of data that can be used. In fact, the time period of the data reviewed for this analysis has not been used by CDHS in development of capitation rates for the Two-Plan, COHS, or GMC managed care plans. Mercer was also engaged by CDHS for a separate project that included the review of the capitation rate development process and current reimbursement structure utilized by CDHS. The results of that engagement are detailed in a separate report.

Project Approach/Methodology

The key steps in the approach to our reviews were as follows.

- Obtained a complete set of eligibility, encounter, and FFS data from Medstat, the State's data vendor, for dates of service from July 1, 2002, through December 31, 2004.
- Summarized the data by eligibility categories of aid (COAs), by major categories of service (COS), by county, by health plan (including a separate category for FFS). Data exclusions were also made to the FFS data to account for differences in covered COAs and COS in the managed care program. This was done to make the FFS data more comparable to the encounter data.
- Requested and reviewed limited ad-hoc utilization data from participating health plans.
- Calculated and compared the utilization statistics (as an indication of completeness of reporting) by COA groups and by COS among the health plans, by county, and against FFS and health plan ad-hoc reported statistics.
- Developed a model to systematically identify which data elements are in a reasonable range by eliminating outlier data points (i.e., unreasonably high or low).
- Reviewed financial statements filed with the DMHC to determine how directly applicable they are for use in capitation rate development.

Summary of Findings

With 22 separate contracted health plans providing Medi-Cal services for the time period under review in 22 counties, there are up to 44 separate data points per year to analyze for each view of data (i.e., by COA group, by COS). Since our data analysis time period spanned three separate fiscal years (two full year and one half-year periods), there are up to 132 data points for each subset of the data.

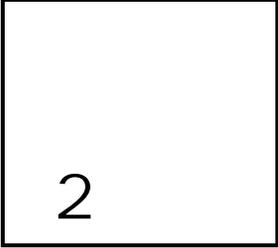
Based on our analysis, it appears that there are a sufficient number of viable data points for most major COA and COS groupings to substantially increase the amount and appropriateness of the base data set used for future capitation rate development. Some of the more notable findings/observations from the encounter data review and analysis include.

- Approximately 60% to 95% of the data points analyzed across all categories of service are considered viable for use in future capitation rate development. This represents a significant opportunity to improve the amount and applicability of data used in future capitation rate development efforts.
- The COS that appear to be more completely represented in encounter data than others include pharmacy, physician (primary care and specialists combined), and lab and radiology. Although encounter data for hospital inpatient and hospital outpatient/ER services is also largely viable.
- We found that viable encounter data exists for all three managed care contracting models.
- The health plans were able to report supportive ad-hoc data in a reasonable amount of time and in an appropriate format. CDHS may wish to utilize future ad-hoc reporting from the health plans to help fill in any particular data gaps identified.
- Some health plans have been more successful in fulfilling their encounter data reporting requirements than others. CDHS should work closely with their contracted health plans to continue to monitor and improve the completeness and overall encounter data quality.

Our review of the DMHC required financial reports indicates they have limited value in Medi-Cal capitation rate development in their present form. That is because they may include expenditures for non-Medi-Cal populations and/or non-Medi-Cal covered services. This is a particularly significant issue for the commercial health plans that serve Medi-Cal members, but is true to some extent for almost every health plan. Many other states require Medicaid-specific financial reporting. Mercer recommends that CDHS require Medi-Cal specific financial reports be submitted by contracted health plans. This reporting requirement would eliminate non-Medi-Cal revenue and expense data from the reports. It is also important to obtain the data by major capitation risk group (similar to reporting by line of business) to make the information most useful in future capitation rate development.

We recommend CDHS utilize the health plan encounter data, with appropriate adjustments, in future capitation rate development efforts. Mercer also recommends that CDHS continue to evaluate the quality of their base data. Through on-going analysis,

implementation of corrective actions, and continual refinement of data reporting requirements and data selection methods, CDHS will develop and maintain the best possible information for use in capitation rate development and program oversight processes.

2

Introduction

Background

CDHS has entered into full-risk capitation arrangements with contracted health plans in order to arrange for the provision of covered Medi-Cal services for more than half of the Medi-Cal eligible members. There are three primary capitated contracting models covered under these full-risk arrangements. These include the Two-Plan Model, COHS model, and GMC model. These three managed care contracting models cover the vast majority of Medi-Cal members enrolled in health plans.

Under a capitated arrangement, the State pays a contractor a monthly fee, or capitation rate, for each Medi-Cal beneficiary enrolled in its plan. The contractor must then provide Medi-Cal covered medical services to the enrolled beneficiary as required by the contract. There are various methods of developing capitation rates, and the methodologies employed across the country are continually evolving. The goal is to develop actuarially sound capitation rates that account for the factors that directly affect projected health care costs, and costs of administration for the enrolled population. Some of the factors that would impact these expected costs are the members' age, gender, Medi-Cal eligibility aid code, geography, and eligibility status for Medicare.

With the expansion of the Medi-Cal Managed Care programs over the years, there has been significant movement of beneficiaries on both a mandatory and voluntary basis, from FFS to managed care. One of the consequences of this action is that for most Medi-Cal managed care populations, there is no longer sufficient or appropriate FFS data on which to base capitation rates. Therefore, other data sources must be utilized for the development of capitation rates. CDHS has been collecting service encounter data from their contracted health plans for many years. In addition, the DMHC requires the submission of quarterly and annual financial reports from all Knox-Keene licensed health plans. Beyond historical FFS claims data, financial statements and encounter data are the most commonly relied upon data sources for Medicaid rate development nationally.

Beginning with the 2003-04 rate period, and consistent with provisions set forth in the Balanced Budget Act (1997), in most programs CDHS moved from a FFS equivalent cost rate constrained by an upper payment limit, to experience based rates with a requirement to certify that rates are:

- developed following generally accepted actuarial principles and practices;
- appropriate for the populations to be covered and the services to be furnished under the contract; and
- developed using a methodology consistent with 42 Code of Federal Regulations, Section 438.6(c).

CDHS currently utilizes only the encounters collected from four of the five COHS, as well as their submitted financial statements, as the base data for capitation rate development for all three of their major managed care contract models. This means that encounter data from approximately 8% of the Medi-Cal managed care enrollment serves as the base data for the entire managed care program.

Project Summary and Objectives

Mercer was engaged by CDHS to conduct a review and assessment of the base data available for use in Medi-Cal managed care capitation rate development. CDHS understands that appropriate and reliable base data is a critical element of ensuring capitation rates are developed in an actuarially sound manner. Therefore, this was the first project assigned to Mercer under their actuarial contract with CDHS.

The base data review and assessment (Review) is intended to enhance CDHS' understanding of the available data for use in Medi-Cal managed care capitation rate development. The Review is multi-faceted and covers several areas of focus including Medi-Cal managed care encounter data, Medi-Cal FFS claims data, Medi-Cal health plan financial data, and ad-hoc utilization reports from the Medi-Cal health plans. From this review CDHS hopes to identify which data sources are viable and appropriate for use in the capitation rate development process, and to develop a standardized methodology for selecting the best data for use in future rate development. No state has 100% complete and accurate encounter data; but having reasonably complete encounter data and understanding the data limitations is important in the rate development process.

The Review did not focus on the determination of whether current or historical rates were actuarially sound; rather, the purpose was to determine whether encounter data collected by the State is appropriate for use in future capitation rate development efforts. In fact, the time period of the data reviewed for this analysis has not been used by CDHS in development of capitation rates for the Two-Plan, COHS, or GMC model plans. Mercer was engaged by CDHS to conduct a separate project that included the review of the capitation rate development process and current reimbursement structure utilized by CDHS. The results of that engagement are detailed in a separate report.

The results of the base data review are detailed in this report. It presents the method of information and data collection and analysis, an overview of the analysis results, conclusions as to the overall usefulness of the data collected by CDHS, as well as recommendations for continued improvement in data collection and refinement.

3

Methodology

In this section we first outline the high-level steps in our approach to provide an appropriate overview. Then, we present a more detailed discussion of the process used to obtain and analyze the data. The high-level steps involved in this project were as follows.

- Obtained a complete set of eligibility, encounter, and FFS data from Medstat, the State's data vendor, for dates of service from July 1, 2002, through December 31, 2004.
- Summarized the data by eligibility COA, by major COS, by county, and by health plan (including a separate category for FFS). Data exclusions were also made to the FFS data to account for differences in covered COAs and COS in the managed care program. This was done to make the FFS data more comparable to the encounter data.
- Requested and reviewed limited ad-hoc utilization data from participating health plans.
- Calculated and compared the utilization statistics (as an indication of completeness of reporting) by COA groups and by COS among the health plans, by county, and against FFS and health plan ad-hoc reported statistics.
- Developed a model to systematically identify which data elements are in a reasonable range by eliminating outlier data points (i.e., unreasonably high or low).
- Reviewed financial statements filed with the DMHC to determine how directly applicable they are for use in capitation rate development.

The following is a more detailed discussion of the major steps identified above.

Obtain Base Data

To review and assess the Medi-Cal encounter and FFS data, Mercer received data extracts from CDHS' data vendor, Thomson Medstat (Medstat). The data was received at a detailed level and covers dates of service from July 1, 2002, through December 31, 2004. Mercer requested and received all Medi-Cal encounter and FFS data files, as well as eligibility and enrollment files available for this time period. It should be noted that because of the size of the Medi-Cal eligible population, the volume of data received was

extremely large. Upon receipt of the data, Mercer used control totals provided by Medstat to confirm that all data provided was uploaded properly. We then ran a series of validation programs against the files to identify which data fields were populated and whether the various data fields contained valid values.

Due to the extreme volume of data, it was necessary to summarize it into a higher level of detail so that it could be more readily accessed and analyzed. The summaries included grouping all encounter and FFS claims data by:

- time periods based on date of service — fiscal quarter and year;
- eligibility COA grouping (we utilized the same COA groupings that form the basis for Medi-Cal's capitation rate groups), including Medicare eligibility status —
 - Family,
 - Aged with Medicare,
 - Aged without Medicare,
 - Disabled with Medicare,
 - Disabled without Medicare,
 - Adult,
 - Breast and Cervical Cancer (BCCPT),
 - AIDS with Medicare,
 - AIDS without Medicare,
 - OBRA,
 - Long Term Care (LTC) with Medicare, and
 - LTC without Medicare;
- age groups (<1 year, 1–13, 14–44, 45–64, and 65 years and older);
- gender;
- whether the COA is a voluntary or mandatory population for Medi-Cal managed care, by model;
- enrolled health plan (including FFS);
- enrolled county of eligibility;
- COS —
 - Inpatient Hospital (I/P),
 - I/P Mental Health,
 - Outpatient (O/P) Hospital,
 - Emergency Room (ER) (hospital),
 - O/P Facility (non-hospital),
 - Primary Care Physician (PCP),
 - Specialty Physician,
 - Other Physician,
 - Non-physician Professional,
 - Pharmacy,
 - Lab/Radiology,
 - Durable Medical Equipment (DME)
 - FQHC, and
 - LTC Facility (e.g., nursing home or intermediate care facility);

- various measures such as —
 - member months,
 - visits/days,
 - admissions,
 - units of service,
 - billed charges, and
 - net paid amount.

Mercer worked closely with CDHS staff to identify the best approach to accurately classify the raw data into these various classifications. Although the data was in a summarized form, it remained at a detailed enough level to appropriately analyze. The size of the summarized data set was still very large. Therefore, Mercer developed and utilized a Cognos PowerPlay Cube (California Base Data Cognos Cube) to enable quick separation/grouping of the data for ease of analysis.

Mercer also made an ad-hoc request for select utilization and member month data from the Medi-Cal contracted health plans. The information was used to make comparisons to the encounter and FFS data received from Medstat. Details regarding this ad-hoc request are included later in this section of the report.

In addition, Mercer pulled DMHC filed financial reports for the Medi-Cal contracted health plans from the DMHC website. DMHC reporting instructions were also obtained for review.

Steps to Test Encounter Data Viability

Utilizing the validated and summarized data described above, the following comparisons were made at a COA group level for state fiscal year (SFY) 02/03, 03/04, and the first half of SFY 04/05 encounter and FFS data.

- 1) Compare I/P hospital days (i.e., utilization) reported through encounters by health plan, by county, to:
 - a) other Medi-Cal health plan encounter data (i.e., comparison among plans, within contract model) to identify averages and high and low outliers;
 - b) I/P days incurred in FFS counties for overall reasonableness;
 - c) I/P days reported in response to the ad-hoc request of health plans as a test of reasonableness; and
 - d) DMHC filed financial reports for consistency.
- 2) The approach outlined above was duplicated for several COS, including ER visits, O/P hospital visits, other O/P facility visits, pharmacy scripts, PCP and specialty physician visits, LTC facility days, and lab and radiology services. These COS, along with I/P days, account for the vast majority of medical costs for the Medi-Cal eligible members.

Cognos PowerPlay

As mentioned previously, Mercer utilized Cognos PowerPlay as one of the tools for the review and summarization of the Medi-Cal encounter and FFS data. Cognos PowerPlay is an on-line analytical processing software that allows users to analyze and summarize large volumes of data quickly by several different measures and varying levels of detail. All demographic and statistical variables needed to properly analyze the dataset were included in the construction of the California Base Data Cognos Cube.

Outlier Model

Mercer first utilized Cognos to sort the encounter and FFS claims data into the appropriate level of detail. Then the results were imported into an Excel model that was developed to identify outlier data (i.e., unreasonably low or high data points). The following sections outline the outlier model.

Data Dimensions

Utilization and cost data for the various COA groups were imported into this model by SFY, Medi-Cal health plan (including FFS), and COS.

The Family COA group data was further subdivided by age group (< 1, 1–13, 14–44, 45–64, and 65+) and gender (male, female, and both). Age roll-ups of 45+ and All Ages are also built into the model.

The Aged & Disabled COA group data is further subdivided by Medicare status [dual eligible (for Medi-Cal and Medicare) or non-dual eligible (i.e., only Medi-Cal eligible)], for a total of four demographic groupings in the Aged & Disabled data. Note that the definition of “dual eligible” for all physician-related services (categories of service) was defined as Medi-Cal eligible members also eligible for Medicare Part A & B or Part B only, while for all other services we define dual eligible as Medi-Cal members also eligible for Medicare Part A & B or Part A only.

The data was divided into the following COS: I/P, Pharmacy, PCP, Specialty Physician, Non-physician Professional, O/P Hospital, O/P Facility, ER, Laboratory/Radiology, and DME. Subtotal service roll-ups of All Physician (PCP + Specialty Physician), O/P (O/P Hospital + O/P Facility), and O/P + ER (O/P Hospital + O/P Facility + ER) were also built into the model.

Measures

The first measure on which the data is analyzed is annualized utilization per 1,000 members (Util/1000). This is a measure of the number of units used by 1,000 members enrolled for an entire year and is computed as $(\text{Units}) / (\text{Member Months}) * 12,000$. In the case of the SFY05 data, the half year of data was annualized. Mercer utilized different “units” depending on the COS. For example, the unit utilized for I/P Hospital is a day. So, the measure used is actually days/1,000 members annually. For O/P hospital and ER as

well as Physician Services we used “visits” as the unit measure where we grouped all such services into a single visit per day. For Pharmacy we utilized “scripts” as the unit measure and for Lab and Radiology we utilized procedures. These various definitions of units allowed us to most appropriately capture utilization in a relevant manner for measurement across the categories of service.

The data was also analyzed on the Unit Cost measure. In the process of developing the California Base Data Cognos Cube, a mechanism to identify only those claims/encounters with a non-zero Paid Amount was created. Then, by filtering on only those claims/encounters with a non-zero Paid Amount, a “Units with Paid Amount” field was created and used in the denominator of the Unit Cost computation, to obtain a more correct measure of the Unit Cost.

Auto Elimination Mechanism

After the data from the California Base Data Cognos Cube was summarized, it was reviewed for reasonableness. This review revealed that some of the 132 data points in each Demographic/Service grouping were clearly erroneous or not reasonable [e.g., Health Net/Los Angeles showed less than 100 I/P Hospital days per 1,000 in the Family 14–44 F (14–44 year old female) group for all three years, which is unreasonably low].

As such, the first step in this analysis was to automatically eliminate data points that were clearly outside of a reasonable range. The starting point for developing a baseline for reasonableness is the FFS average, since that data is assumed to be substantially complete. Then, based on the FFS data points, high and low “Auto-Elimination” tolerances were set for each Demographic/Service grouping. Values exceeding the upper threshold = (high tolerance) * (FFS Average) or falling below the lower threshold = (low tolerance) * (FFS Average) are eliminated immediately. Such data points are displayed with a strikethrough in the data analysis sheets.

Mercer used professional judgment to develop the factors used for high and low tolerances for auto-elimination of the data. For instance, for I/P services under a managed care program, it is expected and well documented that utilization would be less than under a FFS program. At the same time, there are limits to how much I/P utilization can be reduced from FFS. So, for I/P we used a threshold of 50% of the FFS utilization and 150% of the FFS utilization for our low and high auto-elimination thresholds. On the other hand, for physician services, particularly primary care, it is expected and appropriate that utilization under a managed care model would be higher than a FFS model. Therefore, we used 90% of the FFS utilization as the lower threshold and 350% of the FFS utilization as the upper threshold.

Also, it is important to note that, in an effort not to inadvertently bias our calculation of Raw Averages, values eliminated based on this criterion are *not* included in any of the “Raw” Straight/Weighted Averages displayed on the analysis sheets.

Outlier Analysis Mechanism

Once we pulled the raw data and eliminated clearly unreasonable data points, the next step was to identify and remove outliers within the remaining data. The purpose of performing an outlier analysis was to systematically identify which data points are outside reasonably expected results. In this way, some judgment can be made as to how much and which data points are viable for use in future capitation rate development efforts.

Because each managed care model has some uniqueness to its program design, plan data was grouped together according to the county and model it represented, in order to facilitate a fair comparison among plans. After this was done, outliers were determined based on the raw weighted or straight average and the standard deviation of each managed care model group, along with the pre-selected outlier tolerance for a given demographic group. Please note that either a *weighted* or *unweighted* standard deviation can be utilized based on the user's preference. Outliers were then identified and an outlier adjusted weighted or straight average can be calculated on the remaining data points.

There are several considerations that go into selecting an appropriate outlier tolerance. The two most important factors are the size (measured in member months) of the demographic grouping and the size (measured in units or dollars) of the service under consideration. In general, the larger the group or service, the more tightly clustered we would expect to see Util/1000 and Unit Cost among plans, which would suggest a low tolerance should be selected, and vice versa. As a frame of reference, a tolerance of 1.00 standard deviations would generally be considered very strict, while a tolerance exceeding 2.00 would be very broad. In light of this observation, outlier tolerances should remain *relatively consistent* by demographic group across services, with small variations being possible due to differences in service size, or other relevant information that may affect the credibility (either positively or negatively) of the Demographic/Service group being considered.

Interpreting the Results of this Analysis

The primary and most obvious way to utilize this analysis is for determining how much of the current data can be useful in rate setting. Included in this analysis is a Summary of Viable Data Points, which tabulates the number of data points remaining after the auto-elimination and outlier analysis have taken place for each plan. Clearly, incorporating the most appropriate data points into the Base Data of a rate setting exercise is desirable on many fronts. This analysis can be used as a tool in determining which plans or groups of plans have sufficiently credible data to use in the rate setting process.

An immediate corollary to the primary use of this analysis is a way to provide insight into which plans have particularly good or particularly bad data reporting. This would be especially useful in determining which plans the State may want to specifically target in an effort to further increase the volume of usable encounter data for future rate setting.

Ad-Hoc Data

As mentioned previously, the Review also included a request and review of ad-hoc utilization data from the contracted Medi-Cal health plans. Mercer requested utilization data for selected aid code groups and COS for a two-year period (covering SFY03 and SFY04). Health plans contracted in more than one county were also asked to report each county separately.

A template in MS Excel was provided to each of the Medi-Cal contracted health plans for this request. In addition, Mercer was available for discussions with health plans that wanted clarification regarding the request. Mercer subsequently provided more detailed uniform instructions to all of the health plans to ensure a reasonable level of consistency.

The purpose of this ad-hoc request was to obtain recent extracts of data directly from the health plans, to use as a reasonableness check against the Medi-Cal encounter data extract received from Medstat. Mercer received the ad-hoc utilization data from 14 Medi-Cal health plans. The following is the list of plans that responded: Alameda Alliance for Health, Blue Cross of California, CalOPTIMA, Central Coast Alliance, Community Health Group, Health Plan of San Joaquin, Health Plan of San Mateo, Inland Empire Health Plan, Kern Family Health Care, Partnership Health Plan, San Francisco Health Plan, Santa Barbara Regional Health Authority, Santa Clara Family Health Plan, and WHA Community Health Plan.

The ad-hoc data was summarized by SFY, county, aid code group, and COS, and compared to the summarized Medi-Cal encounter data received from Medstat. Results and discussion regarding this comparison can be found in the next section of this report.

4

Findings

Overall Data Quality

As mentioned previously, Mercer received encounter, claims, and eligibility data extracts from Medstat. The data was received at an individual claims detail level and covers dates of service from July 1, 2002, through December 31, 2004. Upon receipt of the data, Mercer used a carefully developed SAS program to clean and validate all files before any analysis was performed.

Eligibility Data

Mercer performed a review and validation of the eligibility data received from Medstat. Some of the items reviewed within the eligibility data included overall control totals received from Medstat, record counts, counts of unique member IDs, enrollment date ranges, birth dates, plan ID, and calculation of member months. Mercer performed a comparison of the member months from the eligibility files to the member months within the Medical Director's Report released by CDHS. The member months tied out very closely with the Medical Director's Report.

Claims and Encounter Data

The following is a discussion of the validation results for the key file types of claims and encounter data received from Medstat. It is important to note here that Medstat used an approach to defining claim type by grouping all claims associated with a particular episode of care into a single claim type. For example, all claims associated with an episode that involved an I/P stay could be contained in the I/P file type, including physician and pharmacy claims. This methodology has an impact on the type of unit reported for each record. To correct this discrepancy, Mercer applied its own claim type definition to each record in a manner that is much more likely to be consistent with the State's approach, making the units associated with each record much more reliable. Specifically, Mercer assigned a claim type to each record such that services with like

units were grouped in each claim type category. The validation findings that follow are organized by the claim file type as defined by Medstat.

Inpatient Claims Data

Overall the validation of the inpatient file yielded reasonable results. Perhaps the most significant finding was the issue mentioned above regarding claim type assignment. Other high-level validations showed reasonable results, including record counts, net paid amounts, and service and admit date ranges. Diagnosis code information was consistent in the primary diagnosis field (DX1); however, approximately 30% of the records were missing a secondary diagnosis. Approximately 50% of the records were missing a procedure or surgical procedure code, and 48% are missing a revenue (UB92) code.

Some of the results of the validation were skewed by the method used by Medstat to classify claim type. For example, admit date (ADMITDT) information was missing on almost half the records in the I/P file; however, if the data is limited to the I/P claim type (i.e., CLMTYPE = 2), then admit date information is missing on only 0.2% of the records.

Net paid amounts within the 95% confidence interval range were at reasonable levels and consistent across State fiscal years. In addition, all of the ICD-9 and UB92 diagnosis and revenue codes provided were valid. Approximately 5% of the procedure codes provided were invalid from a national perspective, and appear to be local codes.

Mercer also checked the referential integrity between the I/P claims data and the eligibility data, which appeared to be adequate. The following is an overall summary by fiscal year.

Fiscal Year	# of Unique Members in Claims	# of Unique Members in Eligibility	% Referential Integrity	Total # of Dollars in Claims	Total # of Dollars that tie to Someone in Eligibility	% Referential Integrity based on Dollars
FY03	518,118	512,910	98.99%	\$4,513,282,529	\$4,443,919,446	98.46%
FY04	539,823	535,398	99.18%	\$4,951,644,651	\$4,889,262,659	98.74%
FY05*	288,752	286,305	99.15%	\$2,508,491,800	\$2,471,711,703	98.53%

* FY05 only contained six months of data.

Pharmacy Claims Data

Mercer performed a validation of the pharmacy claims file type as well. Record counts and net paid amounts for the pharmacy claims files tied out to the control totals provided by Medstat. In addition, the 95% confidence interval ranges for the net paid amounts were at reasonable levels. Approximately 5% of the NDCs are missing in the pharmacy claims. This would impact any type of analysis that utilizes NDC codes. However, 100% of the NDC codes that were provided were valid.

Mercer also evaluated the number of claims (scripts) by PHP for Quarter 3 of FY04. The following is an overall summary:

	Rx Number of Claims (Scripts)	% of Total Number of Claims
MCO	7,839,436	33.05%
FFS	15,878,691	66.95%
Total	23,718,127	100.00%

The Medi-Cal MCOs account for 33% of the total utilization based on number of claims (scripts).

The overall referential integrity between the pharmacy claims data and the eligibility data appears to be adequate. The following is an overall summary by fiscal year.

Fiscal Year	# of Unique Members in Claims	# of Unique Members in Eligibility	% Referential Integrity	Total # of Dollars in Claims	Total # of Dollars that tie to Someone in Eligibility	% Referential Integrity based on Dollars
FY03	4,353,543	4,347,108	99.85%	\$4,035,376,080.11	\$4,033,994,785.07	99.97%
FY04	4,639,402	4,634,227	99.89%	\$4,610,306,153.87	\$4,609,754,740.61	99.99%
FY05*	3,372,434	3,368,873	99.89%	\$2,450,907,714.81	\$2,450,502,185.05	99.98%

* FY05 only contained six months of data.

O/P Claims Data

Similar to the pharmacy claims files, the record counts and net paid amounts in the O/P claims data tied out to control totals provided by Medstat. Approximately 24% of the records are missing a primary diagnosis (DX1), and approximately 4% of the records are missing a procedure or surgical procedure code. This would impact any type of analysis or categorization of claims by diagnosis or procedure code. Over 99% of the ICD-9 (Dx1 and Dx2) provided are valid. However, only 64% of the procedure codes (PROCI) are valid from a national perspective. Most of the invalid procedure codes (approximately 80%) appear to be due to X and Z codes (i.e., local codes). This will impact any analysis that would categorize claims based on standard CPT codes. Also, the 95% confidence interval ranges for the net paid amounts are within a reasonable range.

The overall referential integrity between the O/P claims data and the eligibility data appears to be adequate. The following is an overall summary by fiscal year.

Fiscal Year	# of Unique Members in Claims	# of Unique Members in Eligibility	% Referential Integrity	Total # of Dollars in Claims	Total # of Dollars that tie to Someone in Eligibility	% Referential Integrity based on Dollars
FY03	5,587,737	5,568,586	99.66%	\$12,538,208,540	\$12,520,650,207	99.86%
FY04	6,079,296	6,059,125	99.67%	\$13,414,107,604	\$13,398,030,658	99.88%
FY05*	4,769,643	4,755,133	99.70%	\$6,753,549,197	\$6,743,074,616	99.84%

* FY05 only contained six months of data.

Utilization Data

This section includes selected exhibits with results of the outlier analysis on utilization to illustrate the overall findings of the base data review. Keep in mind that a “viable” or “credible” data judgment does not necessarily mean the data reported is incorrect; rather, it is outside the norm or average expected value and, therefore, would most likely be excluded from capitation rate development as base data. In addition, the judgment that a data point is viable does not necessarily mean that is 100% complete. Occurrences of data points that are not viable or credible can be due to substantially incomplete data (i.e., underreporting) or to higher than expected extremes in utilization patterns (high or low).

The data included in our analysis covered 22 separate contracted health plans providing Medi-Cal services in 22 counties. That translates to up to 44 separate data points per year to analyze for each view of data (i.e., by COA group, by COS). Since our data analysis time period spanned 3 separate fiscal years (2 full year and one half-year periods), there are up to 132 data points for each subset of the data. CDHS is currently utilizing data from 4 COHS plans in 7 counties, or 7 of the 44 data points (15.9%) as the base data for capitation rate development. These plans represent just 8% of the Medi-Cal managed care membership.

I/P Hospital

The results from the outlier analysis on utilization for I/P hospital encounters for selected aid code groups are shown below:

	Family All Ages M&F			Aged Duals & Non-Duals			Disabled Duals & Non-Duals		
	Viable Data Points	Total Data Points	Percentage	Viable Data Points	Total Data Points	Percentage	Viable Data Points	Total Data Points	Percentage
No. of Removed COHS Data Points	5	24	20.8%	8	24	33.3%	8	24	33.3%
No. of Included COHS Data Points	19	24	79.2%	16	24	66.7%	16	24	66.7%
No. of Removed 2 Plan Data Points	12	69	17.4%	22	62	35.5%	19	68	27.9%
No. of Included 2 Plan Data Points	57	69	82.6%	40	62	64.5%	49	68	72.1%
No. of Removed GMC Data Points	9	33	27.3%	10	30	33.3%	12	32	37.5%
No. of Included GMC Data Points	24	33	72.7%	20	30	66.7%	20	32	62.5%
Total No. of Removed Data Points	26	126	20.6%	40	116	34.5%	39	124	31.5%
Total No. of Included Data Points	100	126	79.4%	76	116	65.5%	85	124	68.5%

As shown in the table above, the utilization component of the I/P hospital encounter data for all managed care models was reasonably credible, as 65% to 79% of the data points in each of the aid code groups were judged to be viable according to the analysis. The family aid code group had the highest percent of viable data points across the managed care contracting models. This may be due to the voluntary enrollment of aged and disabled aid categories in the Two-Plan and GMC counties. Voluntary enrollment tends to lead to more varied utilization results across health plans. Therefore, identifying data as “viable” can be more challenging in these cases. Generally speaking, these aid categories tend to have more fluctuation in utilization. However, with more than 60% of these data points being considered viable, it is encouraging and represents a substantial increase in credible base data that can be utilized in the future by CDHS in rate development efforts.

The encounter utilization data was also compared to the ad-hoc data received from the health plans (specifically for 2004). That comparison showed that in all cases, the outlier adjusted average I/P encounter utilization statistics fell within the low and high range of ad-hoc reported data. This lends additional credibility to the judgment of encounter data viability.

O/P Hospital & ER

The results from the outlier analysis on utilization for O/P hospital and ER encounters for selected aid code groups are shown below:

	Family All Ages M&F			Aged Duals & Non-Duals			Disabled Duals & Non-Duals		
	Viable Data Points	Total Data Points	Percentage	Viable Data Points	Total Data Points	Percentage	Viable Data Points	Total Data Points	Percentage
No. of Removed COHS Data Points	5	24	20.8%	4	24	16.7%	5	24	20.8%
No. of Included COHS Data Points	19	24	79.2%	20	24	83.3%	19	24	79.2%
No. of Removed 2 Plan Data Points	20	69	29.0%	29	69	42.0%	18	69	26.1%
No. of Included 2 Plan Data Points	49	69	71.0%	40	69	58.0%	51	69	73.9%
No. of Removed GMC Data Points	16	35	45.7%	17	32	53.1%	18	35	51.4%
No. of Included GMC Data Points	19	35	54.3%	15	32	46.9%	17	35	48.6%
Total No. of Removed Data Points	41	128	32.0%	50	125	40.0%	41	128	32.0%
Total No. of Included Data Points	87	128	68.0%	75	125	60.0%	87	128	68.0%

As shown in the table above, the utilization component of the O/P hospital and ER encounter data for all health plans was at a slightly lower level of credibility than the inpatient data discussed previously, as 60% to 68% of the data points in each of the aid code groups were judged to be viable according to the analysis. These percentages were brought down primarily due to the impact of the GMC model health plans, with approximately 50% of their data points being judged as viable. Overall though, there appears to be adequate encounter data for hospital O/P and ER utilization to significantly improve the base data used in future rate development efforts.

Again, this encounter utilization data was compared to the ad-hoc data received from the health plans (specifically for 2004). That comparison showed that in all cases the outlier adjusted average ER encounter utilization statistics fell within the low and high range of ad-hoc reported data.

Physician

The results from the outlier analysis on utilization for physician (primary care and specialty) encounters for selected aid code groups are shown below:

	Family All Ages M&F			Aged Duals & Non-Duals			Disabled Duals & Non-Duals		
	Viable Data Points	Total Data Points	Percentage	Viable Data Points	Total Data Points	Percentage	Viable Data Points	Total Data Points	Percentage
No. of Removed COHS Data Points	6	24	25.0%	2	24	8.3%	1	24	4.2%
No. of Included COHS Data Points	18	24	75.0%	22	24	91.7%	23	24	95.8%
No. of Removed 2 Plan Data Points	16	69	23.2%	11	69	15.9%	14	69	20.3%
No. of Included 2 Plan Data Points	53	69	76.8%	58	69	84.1%	55	69	79.7%
No. of Removed GMC Data Points	5	35	14.3%	5	35	14.3%	4	35	11.4%
No. of Included GMC Data Points	30	35	85.7%	30	35	85.7%	31	35	88.6%
Total No. of Removed Data Points	27	128	21.1%	18	128	14.1%	19	128	14.8%
Total No. of Included Data Points	101	128	78.9%	110	128	85.9%	109	128	85.2%

The utilization component of the physician encounter data for all health plans was very credible, as 79% to 85% of the data points in each of the aid code groups were judged to be viable according to the analysis. In addition, the results were fairly consistent across the three aid code groups presented in the table above. This high level of credibility is commendable, as higher levels of underreporting due to the existence of sub-capitation arrangements with physicians are common across states. This level of credibility is a significant improvement from the 8% of the managed care data used currently.

This encounter utilization data was compared to the ad-hoc data received from the health plans (specifically for 2004). That comparison showed that in all cases, the outlier adjusted average physician encounter utilization statistics fell within the low and high range of ad-hoc reported data.

Pharmacy

The results from the outlier analysis for pharmacy encounters for selected aid code groups are shown below:

	Family All Ages M&F			Aged Duals & Non-Duals			Disabled Duals & Non-Duals		
	Viable Data Points	Total Data Points	Percentage	Viable Data Points	Total Data Points	Percentage	Viable Data Points	Total Data Points	Percentage
No. of Removed COHS Data Points	2	24	8.3%	0	24	0.0%	2	24	8.3%
No. of Included COHS Data Points	22	24	91.7%	24	24	100.0%	22	24	91.7%
No. of Removed 2 Plan Data Points	15	69	21.7%	9	68	13.2%	5	68	7.4%
No. of Included 2 Plan Data Points	54	69	78.3%	59	68	86.8%	63	68	92.6%
No. of Removed GMC Data Points	4	35	11.4%	2	35	5.7%	0	35	0.0%
No. of Included GMC Data Points	31	35	88.6%	33	35	94.3%	35	35	100.0%
Total No. of Removed Data Points	21	128	16.4%	11	127	8.7%	7	127	5.5%
Total No. of Included Data Points	107	128	83.6%	116	127	91.3%	120	127	94.5%

As expected, the pharmacy encounter data has the highest level of credibility, with 83% to 94% of the data points being judged as viable across aid code groups and managed care models in total. The pharmacy encounter data is expected to be at a high level of completion due to the nature of pharmacy claims processing. Pharmacies use a point of service type of claims system, where the submissions are made electronically at the time a medication is dispensed. Therefore, the primarily electronic nature of pharmacy claims contribute to ease of complete and timely reporting.

This encounter utilization data was compared to the ad-hoc data received from the health plans (specifically for 2004). That comparison showed that in all cases, the outlier adjusted average pharmacy encounter utilization statistics fell within the low and high range of ad-hoc reported data.

Lab and Radiology

The results from the outlier analysis for lab and radiology encounters for selected aid code groups are shown below:

	Family All Ages M&F			Aged Duals & Non-Duals			Disabled Duals & Non-Duals		
	Viable Data Points	Total Data Points	Percentage	Viable Data Points	Total Data Points	Percentage	Viable Data Points	Total Data Points	Percentage
No. of Removed COHS Data Points	5	24	20.8%	3	24	12.5%	5	24	20.8%
No. of Included COHS Data Points	19	24	79.2%	21	24	87.5%	19	24	79.2%
No. of Removed 2 Plan Data Points	11	69	15.9%	12	68	17.6%	9	69	13.0%
No. of Included 2 Plan Data Points	58	69	84.1%	56	68	82.4%	60	69	87.0%
No. of Removed GMC Data Points	9	35	25.7%	6	35	17.1%	6	35	17.1%
No. of Included GMC Data Points	26	35	74.3%	29	35	82.9%	29	35	82.9%
Total No. of Removed Data Points	25	128	19.5%	21	127	16.5%	20	128	15.6%
Total No. of Included Data Points	103	128	80.5%	106	127	83.5%	108	128	84.4%

The lab and radiology encounter data also showed reasonable credibility with 80% to 84% of the data points being judged as viable according to the analysis. The encounter data utilization was also compared to the ad-hoc utilization provided by the health plans. That comparison showed a noticeable disconnect as the ad-hoc utilization was roughly double the encounter utilization. This may be a definitional issue of how “procedures” were defined by Mercer versus how the health plans defined them. Additional analysis will have to be done to better understand this difference.

Summarized Results by Managed Care Model and Individual Health Plans

This section includes summarized credibility results from the outlier analysis by managed care model for the family aid code group.

COHS Health Plans

The tables below show the percentage of viable data points by COHS health plans and COA for the following categories of service: I/P hospital, O/P hospital and ER, physician, pharmacy, and Lab and Radiology for the utilization component.

Utilization

		Family	Aged	Disabled	Total
County Organized Health System	<u>Central Coast Alliance for Health</u>				
	Central Coast Alliance for Health/Monterey	73.3%	100.0%	93.3%	88.9%
	Central Coast Alliance for Health/Santa Cruz	100.0%	93.3%	100.0%	97.8%
	<i>Total Central Coast Alliance</i>	86.7%	96.7%	96.7%	93.3%
	<u>Partnership Health Plan</u>				
	Partnership Health Plan of CA/Yolo	80.0%	86.7%	73.3%	80.0%
	Partnership Health Plan of CA/Napa	66.7%	66.7%	73.3%	68.9%
	Partnership Health Plan of CA/Solano	100.0%	100.0%	93.3%	97.8%
	<i>Total Partnership Health Plan</i>	82.2%	84.4%	80.0%	82.2%
	<u>Other County Organized Health System</u>				
	CalOPTIMA/Orange	93.3%	100.0%	100.0%	97.8%
	Health Plan of San Mateo	53.3%	60.0%	53.3%	55.6%
	Santa Barbara Health Initiative (SBHI)	83.3%	77.8%	72.2%	77.8%
	<i>Total County Organized Health System</i>	81.6%	84.4%	80.9%	82.3%

Several of the COHS health plans have consistently viable data (utilization component) over the 3 periods reviewed in the outlier analysis. In addition, most of the COHS health plans have consistently viable utilization data across the categories of service. For the time period of data analyzed, it appears that the COHS data is the most complete/viable, although it is only by a slim margin.

Two-Plan Health Plans

The table below shows the percentage of viable data points by Two-Plan health plans and COA for the following categories of service: I/P hospital, O/P hospital and ER, physician, pharmacy, and Lab and Radiology for the utilization component.

Utilization

		Family	Aged	Disabled	Total
Two Plan	<u>Blue Cross</u>				
	Blue Cross/Alameda	100.0%	80.0%	93.3%	91.1%
	Blue Cross/Contra Costa	100.0%	80.0%	93.3%	91.1%
	Blue Cross/Fresno	66.7%	86.7%	93.3%	82.2%
	Blue Cross/Kern	40.0%	80.0%	70.0%	63.3%
	Blue Cross/San Joaquin	93.3%	93.3%	93.3%	93.3%
	Blue Cross/Santa Clara	86.7%	93.3%	93.3%	91.1%
	Blue Cross/San Francisco	100.0%	66.7%	93.3%	86.7%
	Blue Cross/Stanislaus (SCLI)	93.3%	73.3%	53.3%	73.3%
	Blue Cross/Tulare	80.0%	93.3%	86.7%	86.7%
	<i>Total Blue Cross</i>	<i>86.2%</i>	<i>83.1%</i>	<i>86.2%</i>	<i>85.1%</i>
	<u>Health Net</u>				
	Health Net/Fresno	93.3%	50.0%	86.7%	78.6%
	Health Net/Kern County	60.0%	60.0%	80.0%	66.7%
	Health Net/LA	40.0%	60.0%	40.0%	46.7%
	Health Net/Tulare	93.3%	36.4%	80.0%	73.2%
	<i>Total Health Net</i>	<i>74.0%</i>	<i>51.2%</i>	<i>70.0%</i>	<i>65.7%</i>
	<u>Inland Empire Health</u>				
	Inland Empire Health Plan/Riverside	80.0%	93.3%	93.3%	88.9%
	Inland Empire Health Plan/San Bernardino	93.3%	80.0%	93.3%	88.9%
	<i>Total Inland Empire Health</i>	<i>86.7%</i>	<i>86.7%</i>	<i>93.3%</i>	<i>88.9%</i>
	<u>Molina Medical</u>				
	Molina Medical/Riverside	80.0%	73.3%	86.7%	80.0%
	Molina Medical Centers/San Bernadino	86.7%	66.7%	73.3%	75.6%
	<i>Total Molina Medical Centers</i>	<i>83.3%</i>	<i>70.0%</i>	<i>80.0%</i>	<i>77.8%</i>
	<u>Other Two Plan</u>				
	Alameda Alliance for Health	66.7%	53.3%	73.3%	64.4%
	Contra Costa Health Plan	93.3%	73.3%	86.7%	84.4%
	Health Plan of San Joaquin	60.0%	71.4%	78.6%	69.8%
	Kern Health Systems	100.0%	80.0%	100.0%	93.3%
	LA CARE	60.0%	73.3%	66.7%	66.7%
	San Francisco Health Plan	20.0%	78.6%	57.1%	51.2%
Santa Clara Family Health	80.2%	68.9%	81.3%	77.0%	
<i>Total Two Plan</i>	<i>79.1%</i>	<i>73.7%</i>	<i>81.4%</i>	<i>78.1%</i>	

Similar to the utilization component of the COHS and GMC health plans, the Two-Plan health plans are very consistent in terms of utilization data across categories of service. There are several Two-Plan health plans that had very high levels of consistency in their data as shown in the table above.

GMC Health Plans

The table below shows the percentage of viable data points by GMC health plan and COA for the following categories of service: I/P hospital, O/P hospital and ER, physician, pharmacy, and Lab and Radiology for the utilization component.

Utilization

		Family	Aged	Disabled	Total
Geographic Managed Care	<u>Blue Cross</u>				
	Blue Cross/Sacramento	100.0%	86.7%	100.0%	95.6%
	Blue Cross/San Diego	73.3%	80.0%	100.0%	84.4%
	Total Blue Cross	86.7%	83.3%	100.0%	90.0%
	<u>Health Net</u>				
	Health Net/Sacramento	46.7%	60.0%	40.0%	48.9%
	Health Net/San Diego	60.0%	60.0%	73.3%	64.4%
	Total Health Net	53.3%	60.0%	56.7%	56.7%
	<u>Kaiser Foundation</u>				
	Kaiser Foundation/Sacramento	80.0%	80.0%	93.3%	84.4%
	Kaiser Foundation/San Diego	80.0%	73.3%	73.3%	75.6%
	Total Kaiser Foundation	80.0%	76.7%	83.3%	80.0%
	<u>Other Geographic Managed Care</u>				
	Community Health Group/San Diego	93.3%	80.0%	80.0%	84.4%
	Molina Medical Centers/Sacramento	66.7%	66.7%	66.7%	66.7%
	Sharp Health Plan/San Diego	73.3%	100.0%	80.0%	83.3%
	Universal Care/San Diego	85.7%	76.9%	85.7%	82.9%
University of California/San Diego	80.0%	70.0%	60.0%	70.0%	
Western Health Advantage/Sacramento	69.2%	75.0%	63.2%	69.0%	
Total Geographic Managed Care	72.6%	73.9%	70.7%	72.4%	

The GMC health plans show good consistency across categories of service in terms of the utilization component of the encounter data. Several health plans had high levels of consistency across years and categories of service.

Unit Cost Data

As part of our analysis on encounters, Mercer reviewed the Unit Cost data fields. The results were surprisingly favorable with approximately 92% of all health plan encounters containing non-zero amounts in the “Net Pay” field, and 99% containing non-zero amounts in the “Billed Charges” field. This data can be very useful in future capitation rate development efforts. Typically, rates would be developed using some combination of information related to average unit cost. The unit cost (i.e., net paid amount) from health plan encounters can be compared to average FFS unit costs and to Medi-Cal specific financial report information [usually done on a per-member-per-month (PMPM) basis]. The combination of these sources of data, along with some application of judgment regarding program goals, can yield the necessary information to appropriately price unit costs for capitation rate development.

Applicability of Health Plan Financial Statements

As mentioned previously, DMHC requires the submission of quarterly and annual financial reporting from all Knox-Keene licensed health plans. CDHS has used certain health plan submitted financial statements as a source of base data in the development of capitation rates. Mercer reviewed submitted financial statements for Medi-Cal managed care plans, as well as the submission instructions from DMHC. The following relevant points summarize the key findings of our review.

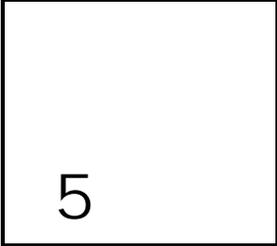
DMHC required financial statement format calls for revenues and expenses to be reported in total for all lines of business. That means Medi-Cal contracted health plans that also have contracts to serve the Healthy Families (Title XXI) members, Medicare members (through Medicare Advantage), and/or provide coverage to commercial/private members, report their revenues and expenses for all of these lines of business in a consolidated manner. Therefore, there is no way to identify the relevant revenues and expenses that specifically relate to the Medi-Cal line of business. The majority of the Medi-Cal members are served by health plans whose membership base is less than 90% Medi-Cal members, thereby making even the bottom line (i.e., net income or loss) questionably applicable for consideration in program oversight and capitation rate development.

There are 7 Medi-Cal health plans whose membership is made up of more than 90% Medi-Cal members. However, 2 of these health plans make wide use of global sub-capitation arrangements. That means they contract with, and pass through, some portion of the Medi-Cal premium to another Knox-Keene licensed health plan to provide coverage to their enrolled Medi-Cal members. In those cases, the financial reporting does not appropriately capture expenditures by category of service, as is most helpful for base data to be used in capitation rate development.

To be truly useful for Medi-Cal managed care program oversight and capitation rate development, financial reporting should:

- be Medi-Cal specific;
- be split by major capitation risk groups;

- include detailed instructions regarding revenue and expenditure classifications (to promote consistency in reporting among health plans); and
- be carefully reviewed and scrutinized upon each submission, with an eye toward continual correction and refinement.

5

Conclusions

The base data review and assessment provided Mercer with a better understanding of the key issues impacting reported Medi-Cal encounter, FFS, and financial data. The review also served to provide information on alternative sources of base data for use in future Medi-Cal capitation rate development efforts. Further, the review facilitated understanding of reporting issues with contracted health plans, and provided information to mitigate data variations in capitation rate development efforts.

Findings and Recommendations

Mercer found the overall data quality across health plans and categories of service to be encouraging, with some room for improvement. By editing encounters to ensure key data fields are populated with valid values, the overall usefulness of the data can be improved for purposes of Medi-Cal capitation rate setting, as well as for program oversight activities. We also recommend monitoring encounter volume by health plan against established benchmarks by category of service. This will provide a more timely indication of encounter reporting deficiencies. It takes a commitment of staff and resources to ensure a program's overall data quality remains acceptable and/or is improving.

Review of the utilization component of the encounter data revealed that, overall, the encounter data for all managed care models would be appropriate for use in capitation rate development. Though the data wouldn't be suitable without certain adjustments, much more is available, and at an acceptable level for use as base data for capitation rate development than has been utilized in the past. Currently, the base data for Medi-Cal capitation rate development consists of a partial database of the COHS health plan data. Based on findings from this base data review, there is much more data currently available that would be appropriate for use for future rate development purposes. Mercer recommends a review of the findings of this base data review as it relates to enhancing the current rate development process, to include the use of a more expansive data set, as well as use of the encounter data for the calculation or estimate of adjustments used in the rate development process.

As mentioned previously, Mercer also requested ad-hoc utilization data from the current Medi-Cal health plans. The majority of the health plans were responsive to the request. Upon receipt of the data from the health plans, it was summarized and compared to the encounter data received from Medstat. The comparison yielded results that support our conclusion that the encounter data currently available is reasonably complete and viable for use in future rate development projects.

The DMHC financial reporting instructions were not developed with the needs of CDHS/Medi-Cal in mind. That reporting is appropriate and adequate for DMHC to oversee the financial viability of Knox-Keene licensed health plans. However, the level of detail required is entirely insufficient for use in Medi-Cal capitation rate development and other oversight activities. Therefore, Mercer recommends that CDHS implement Medi-Cal specific financial reporting requirements for their contracted health plans. Mercer and CDHS have discussed this with the contracted health plans on two separate occasions to ensure we understand any concerns they may have regarding the future reporting requirements.

MERCER

Government Human Services Consulting

Mercer Government Human Services
Consulting
3131 E. Camelback Road, Suite 300
Phoenix, AZ 85016-4536
602 522 6500