Mercer

Government Human Services Consulting

State Fiscal Year 2021 Partnership HealthPlan of California Mainstream Rate Development Template

Auditor's Report

California Department of Health Care Services

February 27, 2024

Contents

Section 1

Executive Summary

Pursuant to federal requirements under Title 42 of the Code of Federal Regulations 438.602(e), the State of California Department of Health Care Services (DHCS) must periodically, but no less frequently than once every three years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each managed care organization (MCO). DHCS contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to fulfill this requirement for the financial data submitted in the Medi-Cal rate development template (RDT) for state fiscal year (SFY) 2021 by the Partnership HealthPlan of California (PHC). Mercer designed and DHCS approved procedures to test the accuracy, truthfulness, and completeness of self-reported financial data in the RDT.

The specific financial schedules selected for testing are used by Mercer as a critical part of the base data development process for capitation rate development related to the calendar year 2023 rating period. The RDT tested was the final version, including any revisions stemming from resubmissions as a result of the RDT Question and Answer discussion guide process with the MCO.

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

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

The data collected in the RDT is reported on a modified accrual (incurred) basis for SFY 2021 and does not follow generally accepted accounting principles with regards to retroactivity from prior year activity, including claim or capitation accruals, retroactive enrollment, or termination of enrollment of members from prior years. The data provided is designed to report only financial and enrollment activity incurred for the SFY reported.

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

Section 2

Procedures and Results

Mercer has performed the procedures enumerated in Table 1 below, which were designed by Mercer and were reviewed and agreed to by DHCS, solely to test the completeness, accuracy, and truthfulness of information reported in the Medi-Cal RDT from PHC for SFY 2021. PHC's management is responsible for the content of the RDT and has responded in a timely manner to all requests for information.

Table 1: Procedures

Fee-For-Service (FFS) Medical Expense	
Description of Procedures	**Results**
Mercer reviewed all paid claims data for each category of service (COS) to verify control totals, verify eligibility and enrollment in the Mainstream Medi-Cal program, confirm the COS grouping was correct, confirm the year reported was correct, and confirm enrollment with the MCO for date of service.	• Control Totals: No variance noted. • Eligibility: 0.11% of claim submissions with no matching eligibility totaling $3,406,786 or 0.13% of total medical expense and is included in the variance noted below. • COS Map: Review of each COS showed 78%–99% match. Discrepancies were reconciled and no further testing required. • Service Year: No variance noted. All dates of service fall within SFY 2021.
Mercer compared detailed lag tables for each major COS (Inpatient, Outpatient, Physician, Facility — LTC, and All Others) created from the paid claims data files provided by the MCO and compared the support to the information reported in Schedule 7. Mercer compared the paid claims amounts from Schedule 7, line 35 and the incurred but not reported (IBNR) amount from Schedule 7, line 40 to total paid claims data as provided by the MCO.	Variance: RDT FFS Expenses are over/(understated) as compared to the support provided: • Inpatient 0.49% • Outpatient 0.60% • LTC 2.72% • Physician 1.25% • All Other (5.35%) In Total 0.34% or $5,960,681, which is 0.22% of total medical expense.

	Per PHC, the variances above are primarily due to the following: • LTC and Physician: Majority of the variance is due to overstatement of IBNR estimates. • Other: Majority of the understatement is due to retroactive rate increases not known at the time of submission, marginally offset by an overstatement of IBNR. Based on the explanations provided by PHC, no additional test work deemed necessary.
Using data files (paid claims files) provided by the MCO, Mercer sampled and tested 60 transactions and traced them through the MCO's claims processing system, the payment remittance advice, and the bank statements.	No variance noted.

Global Subcontracted Payments	
Description of Procedures	**Results**
Mercer requested global capitation supporting detail. Mercer compared the support provided to the amounts reported in Schedule 1-A.	Variance: RDT Global Capitation Expense is understated by 0.72% or $1,427,377. This is 0.05% of medical expense. The total of the detail provided was more than the amounts reported in the RDT.
Mercer reviewed the contractual arrangement with the MCO's global subcontractor(s) and recalculated the total payment amounts using global roster information provided for all 12 months of SFY 2021 multiplied by the contracted rates.	Variance: Detailed support for global capitation expense is overstated by 0.12% or $245,764. This is 0.01% of medical expense. The recalculated amounts were less than the global capitation amount reported in the supporting detail provided.

Mercer selected the three highest months of payment by globally subcontracted health plan/provider and five randomly selected additional months of payment. Mercer observed proof of payments via relevant bank statements, clearing house documentation, or other online financial institution support for the sampled global capitated payments.	Variance: No variance noted. The proof of payment information supported the detail provided for the sampled global capitation payments.
Mercer obtained roster information for the globally subcontracted provider and verified eligibility of members, confirmed enrollment with the MCO, and analyzed claims to verify none of the FFS Claims paid should have been paid under the global arrangement.	Eligibility was verified for 99.96% of the members on the provided rosters. The amount of global capitation paid for the ineligible members was $104,005 and is included in the variance noted above. FFS claims totaling $7,376,659 were paid for members that were part of the global contract. This represents 0.27% of total medical expense and is reasonable based on the few services that are carved out of the global arrangement.
Mercer compared the global per member per month (PMPM) payment rates to relevant PMPM experience for non-global members for reasonableness.	Mercer found the average global PMPM to be reasonable as compared to the cost experience of the non-global membership, given the fact that the members assigned to Kaiser are generally healthier than PHC's direct member population. Per the contract with PHC, Kaiser does not accept risk for members with higher acuity and those with certain conditions.
If applicable, Mercer reviewed Full Dual member global contracted PMPMs to determine whether the amount(s) are at a reduced rate as compared to the non-Full Dual category of aid (COA) groups.	Confirmed reduced rates as compared to the non-Full Dual COA groups.
Mercer reviewed the sampled global capitated contracts to determine	Per review of the global contract, all administrative functions in Appendix A

delegated administrative duties. Using this information, Mercer then reviewed the amount of administrative dollars reported in the RDT as compared to the delegated administrative functions.	were delegated to the global subcontractor. PHC identified 5.33% of the global capitation expense as administrative in the Schedule 1-A Data tab in the RDT, however this was not removed from medical expense. This amount is considered within an acceptable range for industry standards.
Mercer reviewed members included on the member roster to ensure there were no Coordinated Care Initiative members or payments provided in the steps above.	None identified.

Sub-Capitated Medical Expense	
Description of Procedures	**Results**
Mercer requested non-global sub-capitation supporting detail. Mercer compared the support provided to the amounts reported in Schedule 7.	Variance: RDT Sub-capitated Medical Expense is understated by 0.01% or $25,017. The total of the detail provided was more than the amounts reported in the RDT.
Mercer reviewed a sample of the five highest provider payments and 10 random payments, reviewed the related contractual arrangements, and recalculated the total payment amounts by sub-capitated provider using roster information provided by the MCO.	Variance: Detailed support for sub-capitation expense is understated by 0.55% or $126,674, or 0.04% of total sub-capitation expense. The recalculated amounts were more than the sub-capitation amount reported in the supporting detail provided.
Mercer observed proof of payments via relevant bank statements, clearinghouse documentation, or other online financial institution support for the sampled sub-capitated provider payments in the previous step. The proof of payment information validated	No variance noted.

the supporting detail provided for the sampled sub-capitated providers.	
Mercer obtained roster information for the sampled provider payments and verified eligibility of members and confirmed enrollment with MCO.	Eligibility was verified for 99.90% of rostered members in the sample. The amount of non-global sub-capitation paid for the ineligible members is $30,849 and is included in the variance noted above.
If applicable, Mercer reviewed Full Dual COA subcontracted PMPM payment rates to determine whether the amount(s) are at a reduced rate as compared to the non-Full Dual COAs.	Confirmed reduced rates as compared to the non-Full Dual COA groups.
For sub-capitated arrangements 5% or more of total medical expense, Mercer reviewed the sampled sub-capitated contracts to determine delegated administrative duties. Using this information, Mercer then reviewed the amount of administrative dollars reported in the RDT as compared to the delegated administrative functions.	PHC did not have any sub-capitated arrangements that exceeded the 5% or more of total medical expense threshold.

Utilization and Cost Experience	
Description of Procedures	**Results**
Mercer compared summarized total net cost data from amounts reported in Schedule 1 to total incurred claims by COS for Schedule 7 for consistency.	Schedule 1 is overstated by less than 0.01% or $74,461, when compared to Schedule 7. This variance is less than 0.01% of total medical expense.

Member Months	
Description of Procedures	**Results**
Mercer compared MCO-reported member months from Schedule 1-C to eligibility and enrollment information provided by the State. Mercer's procedures are to request explanations for any member months with greater	Variance: RDT Member Months are overstated by 0.04% in total.

than 0.5% variance in total or greater than 1.0% variance by major COA.	

Provider Incentive Arrangements	
Description of Procedures	**Results**
Mercer requested a listing of all provider incentive arrangements, by provider and by month, and compared the amounts to Schedule 1.	No variance noted.
From the listing of provider incentive payments, Mercer sampled the highest two payment amounts and one random payment. Mercer observed proof of payments for the sampled provider incentive payments.	No variance noted. The proof of payment information validated the supporting detail provided for the sampled provider incentive payments.
Mercer reviewed the listing of provider incentive payments for any payments to related parties. If the review of the provider incentive payment listing showed payments to related parties, and the sample selection in the previous step did not include related party arrangements, Mercer selected the two highest related party provider incentive payments. Mercer observed proof of payments for the sampled related party provider incentive payments.	PHC had no related parties as defined by the Financial Accounting Standard Board. However, PHC had 81% of board members who held executive positions at hospitals or provider organizations that provided services to PHC's Medi-Cal members. Per external auditor reports, these were not deemed related party transactions as provider specific contract terms are not presented to the Board for decision nor does the Board sign provider contracts. Therefore, no further testing deemed necessary.
If related party provider incentive payments were noted, Mercer reviewed the incentive terms to determine whether the terms align with similar arrangements for non-related parties.	Not applicable.

Reinsurance	
Description of Procedures	**Results**
Mercer reviewed the reinsurance contract and compared the amount on the RDT to the requested supporting schedule.	PHC did not have any reinsurance contracts during SFY 2021.

Settlements	
Description of Procedures	**Results**
Mercer inquired of the MCO if they incurred any settlement amounts with providers related to SFY 2021 dates of service. If settlements exist, Mercer noted whether the amounts are actual, or estimates based on the status of the settlements and where the amount(s) are reported in the RDT.	No settlements were paid for SFY 2021.

Third-Party Liability (TPL)	
Description of Procedures	**Results**
Mercer reviewed information submitted by the MCO as to how TPL is identified and reported. Per DHCS All Plan Letter (APL) 21-007, the MCO is not required to collect TPL, however, they are required to report to DHCS service and utilization information for covered services related to TPL.	Per review of the support provided and confirmation with DHCS, PHC is submitting TPL information as required by APL 21-007. No further testing necessary.

Administrative Expenses	
Description of Procedures	**Results**
Mercer benchmarked administrative expenses as a percentage of net revenue across all County Organized Health System (COHS) plans and compared to the amount reported in Schedule 6a, taking into consideration	The benchmark administrative percentage was 4.71% of Net Revenue and PHC reported 4.03%. PHC is one of the largest COHS model plans, therefore this difference is considered reasonable.

the membership size of the plan when reviewing the results.	
Mercer compared detailed line items from the MCO's trial balance mapped to line items in Schedule 6a and Schedule 6b for reasonableness. Mercer reviewed allocation methodologies and recalculated for reasonableness.	The RDT Administrative Expense is understated by 0.61% or $661,975, or 0.02% of Net Revenue. The allocation methodology was deemed reasonable.

Taxes	
Description of Procedures	**Results**
Mercer reviewed to ensure proper reporting of federal, State, and local taxes on line 59 of Schedule 6a. If no taxes were reported on Schedule 6a, Mercer confirmed the organization is not subject to taxes.	PHC is exempt from income taxes; therefore, no taxes reported on the RDT.

Related Party Transactions	
Description of Procedures	**Results**
Mercer obtained related party agreements for medical services and reviewed to determine whether the terms are at fair market value. Mercer compared the terms (e.g., PMPM or other payment rate amounts) to other similar non-related party terms for reasonableness.	As noted earlier, PHC had no related parties as defined by the Financial Accounting Standard Board. However, PHC had 81% of board members who held executive positions at hospitals or provider organizations that provided services to PHC's Medi-Cal members. Per external auditor reports, these were not deemed related party transactions as provider specific contract terms are not presented to the Board for decision nor does the Board sign provider contracts. Therefore, no further testing deemed necessary.
If related party contracts are a material portion of the related medical COS, Mercer also reviewed any allocation methodologies for reasonableness.	Not applicable.

Mercer reviews that all services included in the related party agreements are allowable for Medicaid rate setting.	Not applicable.
When applicable, Mercer obtained related party corporate allocation methodologies for administrative services. Where significant, Mercer recalculated the amounts for reasonableness.	Per PHC, there were no allocated administrative services provided.

UM/QA/CC	
Description of Procedures	**Results**
Mercer benchmarked UM/QA/CC expenses as a percentage of total medical expense across all COHS plans and compared to the amount reported on Schedule 1-U, taking into consideration the membership size of the plan when reviewing the results.	The benchmark UM/QA/CC percentage was 1.69% and PHC reported 1.57%. This difference is considered reasonable.
Mercer interviewed financial management to determine how healthcare quality improvement activities such as care coordination are isolated from general administrative expenses in the general ledger.	Confirmed with the MCO management that UM/QA/CC costs were not also included in general administrative expenses.

Capitation Revenue	
Description of Procedures	**Results**
Mercer compared capitation amounts reported in Schedule 6a for calendar year 2020 plus January 2021–June 2021 (1H2021) with the Capitation Management System (CAPMAN) file received from DHCS for the same period. The CAPMAN file contains all amounts paid to the health plan by DHCS.	Variance: RDT is understated by 2.42% or $100,205,274. Using a straight average methodology, the variance for SFY 2021 is estimated at $66,803,516 and remains 2.42%. Per discussion with DHCS, much of this variance is due to timing of payments versus timing of RDT submission.

Interest and Investment Income	
Description of Procedures	**Results**
Mercer requested interest and investment income for the MCO entity as a whole and information regarding how the income provided in Schedule 6a was allocated to the Medi-Cal line of business.	No variance noted.

Other Information	
Description of Procedures	**Results**
Mercer reviewed the plan's audited financial statements for SFY 2021 for a clean audit opinion or identification of significant deficiencies or material weaknesses.	Mercer confirmed a clean audit opinion.
Mercer compared reported expenses, including IBNR and administrative expenses, to audited financial statements for consistency.	No material variances noted in total.
Mercer requested information on the efforts to identify and recover provider overpayments and on how the recoveries are recorded in the RDT.	PHC provided the policy for the identification and recovery of overpayments. Based on a review of that policy, PHC is appropriately excluding provider overpayments in the RDT medical expenses.

Section 3

Summary of Findings

Based on the procedures performed, the total amount of capitation revenue for the SFY 2021 RDT was understated by $66,803,516, or 2.42%. Per discussion with DHCS, much of this variance is due to timing of payments versus timing of RDT submission.

Based on the procedures performed, the total amount of gross medical expenditures in the RDT were overstated by $4,521,267 or 0.11% of total medical expenditures in the SFY 2021 RDT.

Based on the procedures performed, administrative expenditures in the SFY 2021 RDT were understated by $661,975 or 0.40%. However, the plan should be properly recording a portion of their global and provider sub-capitation expense as administrative, thus reducing their medical expense.

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

PHC reviewed this report and had the following comments:

We would like to thank DHCS and the Mercer team for their work on the RDT audit. While the summary of findings has been determined to be immaterial, regarding the reporting of administrative expenditures in the SFY 2021 RDT, we disagree with this finding. Specifically, the RDT instructions for this reporting period did not clearly outline the requirements in which we were audited against. We reported the global subcontractor administrative percentage, consistent with the RDT instructions.

Partnership HealthPlan of California is appreciative of the thorough review and partnership on the SFY 2021 audit.

Appendix A

Administrative Duties in Subcontracted Arrangements

Administrative Task	Kaiser (Global)
Quality Management	X
Quality Measure Tracking	X
Utilization Management	X
Case Management	X
Member Services	X
Member Grievance	X
Claims Processing	X
Claims Adjudication and Payment	X
Encounter Submission	X
Provider Services	X
Provider Contracting	X
Provider Relations and Education	X
Credentialing and Recredentialing	X

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