Mercer

Government Human Services Consulting

Calendar Year 2019 Aetna Coordinated Care Initiative Rate Development Template

Auditor's Report

California Department of Health Care Services

February 2, 2023

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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 Coordinated Care Initiative (CCI) rate development template (RDT) for calendar year (CY) 2019 by Aetna. 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 CY 2022 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 include, but were not limited to:

- Schedule 1.1–1.3 — Utilization and Cost Experience
- Schedule 1A — Global Subcontracted Health Plan Information
- Schedule 1B — Incentive Payments Arrangements
- Schedule 1.1U–1.3U — Utilization Management/Quality Assurance/Care Coordination (UM/QA/CC)
- Schedule 5 — Large Claims Report
- Schedules 6.1a-b and 6.2.3a-b — Financial Reports
- Schedule 7.1–7.3 — Lag Payment Information

The data collected in the RDT is reported on a modified accrual (incurred) basis for CY 2019 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 CY 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 CCI RDT from Aetna for the CY 2019. Aetna's management is responsible for the content of the RDT and responded timely to all requests for information.

Table 1: Procedures and Results

Category	Description	Non- CMC Results
Fee-for-Service (FFS) Medical Expense	Mercer obtained from Aetna, all adjudicated paid claims data for CY 2019 dates of service. Mercer reviewed all paid claims data for each category of service (COS) to verify control totals, verify eligibility, and enrollment in the CCI Medi-Cal program, confirm the COS grouping was correct, confirm the year reported was correct, and confirm enrollment with Aetna for date of service.	• Control Totals: No variance noted. • Eligibility: Verified for all members. • COS Map: No variance noted. • Service Year: No variance noted.
	Mercer compared detailed lag tables for each major COS (Inpatient, Outpatient, Physician, Pharmacy, Facility-Long-Term Care [LTC], and All Others) created from the paid claims data files provided by Aetna and compared the information reported in Schedule 7. Mercer compared the paid claims amounts from Schedule 7, line 35 and the Incurred but not reported (IBNR)	Variance: Overall total RDT FFS Expenses are over/(understated): • Inpatient (14.36%) • Outpatient 11.61% • LTC 7.43% • Physician 53.71% • Pharmacy (53.81%) • All Other 4.19% In Total 0.60% or $2,402

Category	Description	Non- CMC Results
	amount from Schedule 7 line 40 to total paid claims data as provided by Aetna. Mercer compared IBNR estimates from Schedule 7 to claims paid amounts during the months subsequent to the submission of the RDT to verify the accuracy/reasonableness of IBNR for each COS. Allowable absolute value variances were deemed to be not greater than 2% for inpatient claims and 1% for all other COS.	
	Using data files (paid claims files) provided by Aetna, Mercer sampled and tested 60 transactions for each major COS (Inpatient, Outpatient, Physician, Pharmacy, Facility-LTC, and All Others) and traced sample transactions through Aetna's claims processing system, the payment remittance advice, and the bank statements.	No variance noted.
Global Subcontracted Payments	Mercer requested overall global capitation supporting detail. Mercer compared the support provided to the amounts reported in Schedule 1A.	Not applicable. Aetna does not have global subcontract arrangements.
Sub-capitated Medical Expense	Mercer requested overall non-global sub-capitation supporting detail. Mercer compared the support provided to the amounts reported in Schedule 7.	Not applicable. Aetna does not have sub-capitated arrangements. However, Aetna erroneously reported $18,843 of sub-capitated expense on Schedule 7;

Category	Description	Non- CMC Results
		therefore, overstating overall medical expense by 4.50%
Utilization and Cost Experience	Mercer compared summarized total net cost data from amounts reported in Schedule 1 to Direct Medi-Cal COS totals from Schedule 6a and to total incurred claims by COS for Schedule 7 for consistency.	Schedule 1 understated by 98.87% or $37,506,737, when compared to Schedule 6a. However, Aetna does not separate their Mainstream and CCI population experience for Schedule 6a; therefore, the extreme variance to Schedule 1. There is no variance when Schedule 1 is compared to Schedule 7.
Provider Incentive Arrangements	Mercer requested a listing of all provider incentive payments; by provider, by month, and compared the amounts to Schedule 6a, lines 34–36.	Not applicable. Aetna does not have any provider incentive arrangements.
Reinsurance	Mercer reviewed the reinsurance contract and compared the amount on the RDT to the requested supporting schedule.	Not applicable. Aetna does not have a reinsurance contract in place for CCI.
Settlements	Mercer inquired of Aetna if they incurred any settlement amounts with providers related to CY 2019 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.	Aetna did not incur any settlements.
Third Party Liability (TPL)	Mercer reviewed TPL as a per member per month	The benchmark TPL PMPM and percentage

Category	Description	Non- CMC Results
	(PMPM) and as a percentage of medical expense on Schedule 6a line 39 as compared to benchmark information across those plans reporting a value for TPL.	were $0.241 and 1.97%, respectively. Aetna reported $0.00 PMPM and 0.00% for the TPL PMPM and percentage of medical expense, respectively. Aetna should ensure any TPL is captured appropriately on the RDT.
Administrative Expenses	Mercer benchmarked administrative expenses as a percentage of net revenue across all Two-Plan/GMC plans and compared to the amount reported in Schedule 6a, taking into consideration the membership size of the plan under review when reviewing the results.	The benchmark administrative percentage was 4.17% for non-Cal MediConnect (non-CMC) CCI health plans and Aetna reported 22.21%. Contrary to RDT instructions, Aetna does not separate the Mainstream and CCI populations for Schedule 6a reporting, therefore the large variance from the benchmark.
	Mercer compared detailed line items from the plan's trial balance mapped to line items in Schedule 6a and Schedule 6b for reasonableness. Mercer reviewed allocation methodologies and recalculated for reasonableness.	Variance: RDT understated 3.25%, or $269,890, as compared to the audit support. As noted, Aetna does not segregate Mainstream and CCI for Schedule 6a. However, the amount reported for administrative costs does not agree to the amount reported in the Mainstream RDT (which also does not segregate Mainstream and CCI). The variance reported here is strictly the difference between the amount reported on Schedule 6a and the audit support provided, knowing that neither amount

Category	Description	Non- CMC Results
		represents CCI-only administrative costs.
Taxes	Mercer reviewed to ensure proper reporting of federal, state, and local taxes on line 59 of Schedule 6a. If no taxes reported on Schedule 6a, we confirmed the organization is not subject to taxes.	No taxes reported on Schedule 6a. Taxes are reported on the Aetna audited financial statements however. Therefore, an allocation of taxes should have been made and reported on Schedule 6a.
Related Party Transactions	Mercer obtained related party agreements for medical services and reviewed to determine if 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.	Not applicable. No related party agreements in place for CCI for medical services.
	When applicable, Mercer obtained related party corporate allocation methodologies for administrative services. Where significant, Mercer recalculated the amounts for reasonableness.	Aetna has an administrative services agreement with Aetna Medicaid Administrators, LLC (AMA) for administrative services. Per the contract, Aetna pays AMA 15% of the premium revenue. This amount is more than triple the benchmark administrative percentage for all Two-Plan/GMCs of 4.17%. In addition, another 7% is reported on top of the related party agreement of 15%. Although Aetna is the smallest of the Two-Plan/GMCs, therefore a smaller base over which

Category	Description	Non- CMC Results
		to spread all administrative costs, 15%-22% is higher than would be expected.
UM/QA/CC	Mercer benchmarked UM/QA/CC expenses as a percentage of total medical expense across all Two-Plan/GMC plans and compared to the amount reported on Schedule 6a, taking into consideration the membership size of the plan under review when reviewing the results.	The benchmark UM/QA/CC percentage was 2.05% and Aetna reported 0.00% on Schedule 6a. However, Aetna reported $10,871 of UM/QA/CC on Schedule 1-U. This amount is 2.59% of total non-CMC medical expense. Per Aetna, Schedule 1-U is correct and Schedule 6a is understated by this amount.
	Mercer compared detailed line items from the plan mapped to line items in Schedule 1-U for reasonableness. Mercer reviewed allocation methodologies and recalculated for reasonableness.	No variance.
	Mercer interviewed financial management to determine how health care quality improvement activities such as care coordination are isolated from general administrative expenses in the general ledger. Confirmed with Aetna management via interview that UM/QA/CC costs were not also included in general administrative expenses.	Aetna reported $0 of UM/QA/CC expenses on Schedule 6a, however Schedule 1-U reported $10,871. Per discussion with Aetna, Schedule 1-U is correct. These costs are appropriately not also reported in general administrative expenses.

Category	Description	Non- CMC Results
Pharmacy	Mercer confirmed and observed pharmacy benefit manager (PBM) fees were recorded as administrative expenses and not included in pharmacy claims expenses in the RDT.	Aetna did not report any PBM fees for the CCI RDT. Schedule 6a reported $0.00 for total pharmacy spend and Schedule 1 and 7 reported only $4,675 in pharmacy spend. Therefore, PBM expense, if any, would be immaterial. No additional testing performed.
	Mercer benchmarked pharmacy rebate expenses on a PMPM basis across all Two-Plan/GMC plans and compared to the amount reported on Schedule 7.	Aetna did not report any pharmacy rebates for the CCI RDT. Between Schedules 1, 6a and 7, only $0 or $4,675 in pharmacy expense was reported. Rebates would be immaterial therefore no additional testing performed.
Capitation Revenue	Mercer compared capitation amounts reported in Schedule 6a with the CAPMAN file received from DHCS. The CAPMAN file contains all amounts paid to the Health Plan by DHCS.	Variance: RDT is overstated 98.58% or $34,012,678. Aetna does not segregate Mainstream and CCI for Schedule 6a, therefore the large variance. The amount reported on Schedule 6a, however, does not total the Mainstream and CCI revenue.
Interest and Investment Income	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.	Variance: RDT is understated by 57.86% or $142,214 as compared to the audited financial statements. As Aetna does not exclude Mainstream from Schedule 6a reporting, this variance is across both Mainstream and CCI reporting.

Category	Description	Non- CMC Results
Other Information	Mercer reviewed the audited financial statements for the plan for the CY 2019 for a clean audit opinion or identification of significant deficiencies or material weaknesses.	Per Aetna, no internal control letter issued by their independent auditor's due to no material weaknesses noted. However, per review of the CY2020 internal control letter: *For the year ended December 31, 2020, management did not have adequate controls in place to monitor that the intercompany expense allocations have been appropriately calculated and accounted for in the financial statements. This control deficiency led to the material misstatement and restatement of the 2020 financial statements.*
	Mercer compared reported expenses, including IBNR and administrative expenses, to audited financial statements for consistency.	Aetna does not segregate Mainstream and CCI for Schedule 6a reporting purposes nor for Schedule 6b (Administrative Costs) purposes. Piecing together Medical and Administrative costs from other schedules and combining Mainstream and CCI amounts, Aetna's reported amounts were reasonable as compared to the audited financial statements.
	Mercer inquired how hospital-acquired conditions (HACs) were treated in the RDT and policies for payment.	Aetna follows established policies and procedures to review for services provided for certain conditions for HACs and ultimate denial of payment.

Section 3

Summary of Findings

Based on the procedures performed, the total amount of gross medical expenditures in the RDT were overstated by $37,538,854 or 98.95% of total medical expenditures in the CY 2019 RDT. This amount represents the overstatement as compared to Schedule 6a. When comparing Schedules 1 and 7 reported information to supporting documentation, Schedules 1 and 7 are overstated less than $3,000, or 0.60%.

Based on the procedures performed, administrative expenditures in the CY 2019 RDT were understated by $269,890, or 3.25% when compared to supporting documentation. However, overall administrative percentage is higher than expected (22.21%) as compared to benchmarks and other relevant sized plans.

Based on the defined variance threshold, the results of the audit for both medical and administrative expenses are determined to be material. Aetna should institute procedures to ensure the following:

1. Appropriate segregation of Mainstream and CCI revenue and expenses for all RDT required reporting.
2. Allocations should be used in areas such as administrative expenses where Aetna's general ledger does not segregate by program.
3. Expenses are reported on the appropriate line items of the RDT.
4. TPL was reported as zero. Efforts should be made to ensure Medicaid is the payor of last resort and any TPL is reported appropriately.

Aetna reviewed this report and had no comments refuting any results in this report.

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