Mercer

Government Human Services Consulting

Calendar Year 2019 Aetna Mainstream Rate Development Template

Auditor's Report

California Department of Health Care Services

February 2, 2023

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 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 — Utilization and Cost Experience
- Schedule 1A — Global Subcontracted Health Plan Information
- Schedule 1C — Base Period Enrollment by Month
- Schedule 1U — 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 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 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

Category	Description	Results
Fee-for-Service (FFS) Medical Expense	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 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 IBNR amount from Schedule 7 line 40 to total paid claims data as provided by Aetna. Allowable absolute value	Variance: RDT Overall FFS Expenses are over/(understated): • Inpatient 4.42% • Outpatient 4.99% • LTC 43.88% • Physician 57.35% • Pharmacy 4.85% • All Other 33.17% In Total this is an overstatement of 11.16% or $4,963,511. This amount is 7.25% of total medical expense.

Category	Description	Results
	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 observed.
Global Subcontracted Payments	Mercer requested overall global capitation supporting detail. Mercer compared the support provided to the amounts reported in Schedule 1A.	N/A. Aetna has no global subcontract arrangements.
Sub-capitated Medical Expense	Mercer requested overall non-global subcapitation supporting detail. Mercer compared the support provided to the amounts reported in Schedule 7. The total of the detail provided was less than the amounts reported in the RDT.	Variance: RDT Sub-capitated Medical Expense is overstated by 23.90% or $3,922,728. This amount is 5.73% of total medical expense.
	Mercer reviewed a sample of the five highest provider payments, ten random payments, reviewed the related contractual arrangements, and recalculated the total payment amounts by sub-capitated provider	No variance noted.

Category	Description	Results
	using roster information provided by Aetna. The recalculated amounts were equal to the subcapitation amount reported in the supporting detail provided.	
	Mercer observed proof of payments via relevant bank statements, clearing house documentation or other online financial institution support for the sampled sub-capitated provider payments in the previous step. The proof of payment information was equal to the supporting detail provided for the sampled sub-capitated providers.	No variance noted.
	Mercer obtained roster information for the sampled provider payments and verified eligibility of members, confirmed enrollment with Aetna, and analyzed claims to verify none of the FFS claims paid should have been paid under the sub-capitated arrangement.	No variance noted.
	If applicable, Mercer reviewed full-dual category of aid (COA) subcontracted per member per month (PMPM) payment rates to determine if the amount(s) are at a reduced rate as compared to the non-full dual COAs.	All full-dual rates reasonably less than non-full dual rates.
	If any of the sub-capitated arrangements are a significant portion of	N/A. No single arrangement was a

Category	Description	Results
	Aetna's overall medical expense and/or major COS, Mercer obtained encounter data support and/or documentation supporting the reasonableness of the PMPM amounts included in the sub-capitated arrangement.	significant portion of overall medical expense.
	For sub-capitated arrangements 5% or more of total medical expense or major COS, 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.	Two of the sub-capitated arrangements reviewed met the 5% threshold, however neither contract contained administrative duties.
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 is understated 2.55% or $1,662,689, when compared to Schedule 6a. There is no variance when Schedule 1 is compared to Schedule 7.
Member Months	Mercer compared MCO-reported member months from Schedule 1C to eligibility and enrollment information provided by the State. Mercer's procedures are to request explanations for any member months with greater than 0.50%	Variance: RDT Total Member Months overstated by 0.55% in total. SPD and SPD/Dual member months overstated by 5.67% and 3.31%, respectively. Per Aetna, an issue was discovered with the dual

Category	Description	Results
	variance in total or greater than 1.0% variance by major COA.	status identification logic. The logic was updated in the 2020/2021 RDT to better identify dual members.
Provider Incentive Arrangements	Mercer requested a listing of all provider incentive arrangements, by provider, by month and compared the amounts to Schedule 6a, lines 34–36.	N/A. Aetna did not incur any provider incentive expenses.
Reinsurance	Mercer reviewed the reinsurance contract and compared the amount on the RDT to the requested supporting schedule.	No variance noted when comparing the premiums shown on the support to the reinsurance contract.
	Mercer recalculated reinsurance premiums, based on 2019 membership as of June 2020, to compare to reported amounts.	Variance: RDT was overstated by 2.28% or $3,836.
	Mercer recalculated recoveries for a sample of five members.	Aetna did not report reinsurance recoveries of $358,056, on Line 37, Reinsurance Net of Recovery. Rather, recoveries were reported on line 39, Third Party Liability Recoveries. No variance when recalculating recoveries.
	Mercer compared the amount of reinsurance recoveries as compared to the information in Schedule 5 for reasonableness.	Reported amounts in Schedule 5 are consistent with actual reinsurance recoveries.
Settlements	Mercer inquired of Aetna if they incurred any settlement amounts with providers related to	No settlements incurred.

Category	Description	Results
	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.	
	If settlement amounts are material, Mercer requested supporting documentation and performed the following procedures:	N/A. No settlements incurred.
Third Party Liability (TPL)	Mercer reviewed TPL as a 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.	The benchmark TPL PMPM and percentage were $0.22 and 0.04%, respectively. Aetna reported $1.79 PMPM and 0.54% for the TPL PMPM and percentage of medical expense, respectively. The entire TPL amount, however, is reinsurance recoveries and should have been reported on Line 37. Therefore, Aetna's reported TPL amount is not accurate and overstated 100%.
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 6.07% and Aetna reported 20.14%. Based on test work findings, adjustments were made to remove previously included UM/QA/CC and to add calculated PBM fees erroneously reported in the pharmacy spend line of Schedule 6a. Aetna's resulting adjusted administrative percentage

Category	Description	Results
		is 18.55%. Of the total adjusted administrative expense, Compensation accounts for 42.66% and Affiliate Administrative Services accounts for 39.85%. Even without the Affiliate Administrative Services expense, Aetna's administrative expense percentage would still be 85.57% higher than the benchmark at 11.26%. See also Related Party Transactions section below for additional information. It should also be noted that Aetna is the smallest of the Two-Plan/GMC plans thus smaller enrollment over which to spread their administrative costs.
	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 is overstated by 7.89% or $1,058,513. Majority of the variance is due to Aetna double-counting UM/QA/CC expense in both administrative and UM/QA/CC expense.
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.	Confirmed taxes are reported appropriately.
Related Party Transactions	Mercer obtained related party agreements for medical services and	Aetna is owned by CVS Health Corporation. A subsidiary, CVS Caremark,

Category	Description	Results
	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.	is the pharmacy benefit manager (PBM) for Aetna. Per CVS Caremark, they "…*did not bill for a per claim administration fee as typically seen in transparent contracts. The contract between Aetna and CVS Caremark in 2019 was a locked pricing arrangement. In that arrangement, the PBM will be responsible for any amounts owed to Participating Pharmacies that exceed the payment it receives from Aetna for Claims that are subject to Lock-In Pricing and will retain any amount that it receives from Aetna that is more than the amount it is obligated to pay the Participating Pharmacies. The difference (spread) is what we consider our fee for PBM services."* The resulting amount was $1.2 million. This amount is approximately 17% of the pharmacy spend reported on Schedule 6a. See the pharmacy section below for test work and resulting adjustment.
	If related party contracts are a material portion of the related medical COS, Mercer also reviewed any allocation methodologies for reasonableness.	The PBM fee/spread amount mentioned directly above is higher than considered reasonable industry standard. See pharmacy section below for adjustment.

Category	Description	Results
	Mercer reviews that all services included in the related party agreements are allowable for Medicaid rate setting.	PBM services are allowable for Medicaid rate setting. However, spread pricing is not. See pharmacy section for adjustment.
	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 virtually all necessary administrative services. Per the contract, Aetna pays AMA 15% of the premium revenue. This amount is more than double the benchmark administrative percentage for all other Two-Plan GMCs of 6.04%. Although Aetna is the smallest of the Two-Plan/GMCs, thus a smaller base over which to spread all administrative costs, 15% 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 1.57% and Aetna reported 3.61%. Aetna attributes the disparity to the small membership of the plan and that the plan is a start up in CY2019, therefore a smaller base for which to spread contractually required costs across. As mentioned above, given Aetna is a very small plan, it is expected their percentage would be

Category	Description	Results
		higher than the benchmark.
	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.	Variance: Schedule 1-U is understated by 0.37%, or $10,871.
	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 that UM/QA/CC costs of $1,233,058 were double counted as UM/QA/CC and as administrative expense, therefore overstating administrative expense. See relevant section above.
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.	PBM fees were included in the RDT on the pharmacy spend line of Schedule 6b. Aetna requested and received the PBM fee amount from CVS. See related party section above for details on the arrangement. The resulting PBM amount included spread pricing, which is not an allowable expense for capitation rate setting. CVS was not able to provide the PBM fees separate from the spread. Mercer used an industry standard of 3% of pharmacy spend to arrive at an allowable amount of PBM fee of approximately

Category	Description	Results
		$175k. This amount should have been reported as an administrative cost. The full amount of PBM/spread included in the RDT was approximately $1.2 million. Therefore, the remainder of $1.02 million causes an overstatement of total medical expense and is included as a variance for this report.
	Mercer benchmarked pharmacy rebate expenses on a PMPM basis across all Two-Plan/GMC plans and compared to the amount reported on Schedule 7.	The benchmark PMPM for pharmacy rebates is ($0.95) and Aetna reported $0.00. Aetna failed to report $398,283 of pharmacy rebates, therefore overstating the pharmacy expense line item in the RDT. The rebate amount equates to ($1.99) PMPM.
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: Overall RDT revenue is overstated by 21.07% or $13,942,322. Aetna does not segregate Mainstream and CCI reporting for Schedule 6a, however CCI revenue is only approximately $490k of this variance. Per Aetna, Rate range and Prop 56 were inadvertently excluded from the RDT reporting. In addition, HQAF pass through was reported as a positive amount rather than negative. In addition, Aetna does not segregate Mainstream and CCI for Schedule 6a reporting,

Category	Description	Results
		therefore CCI revenue is also erroneously included.
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 overstated by 10.02% or $42,304.
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, Aetna's reported amounts were

Category	Description	Results
		reasonable as compared to the audited financial statements after adjusting for known reporting errors such as double counting or excluding expenses.
	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 $10,545,896 or 15.40% of total medical expenditures in the CY 2019 RDT. This amount includes over-reporting of medical expenses in Schedule 6a due to the lack of segregation of Mainstream and CCI expenses.

Based on the procedures performed, administrative expenditures in the CY 2019 RDT were overstated by $1,058,513 or 7.89%.

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. Expenses are not reported on multiple line items within the RDT.
5. Pharmacy spread pricing is excluded from the RDT.

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

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