Mercer

Government Human Services Consulting

Calendar Year 2019 LA Care Coordinated Care Initiative Rate Development Template

Auditor's Report

California Department of Health Care Services

September 26, 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 LA Care (LA Care). 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 1C — Base Period Enrollment by Month
- Schedule 1.1U–1.3U — 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 LA Care for the CY 2019. LA Care's management is responsible for the content of the RDT and responded timely to all requests for information.

Table 1: Procedures

Category	Description	Results Cal MediConnect (CMC)	Results Non-CMC
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 Coordinated Care Initiative (CCI) Medi-Cal program, confirm the COS grouping was correct, confirm the year reported was correct, and confirm enrollment with LA Care for date of service.	• Control totals: No variance noted. • Eligibility: Verified for all claims. • COS Map: 96% match for Non-Pharmacy claims and 95% for Pharmacy claims. • Service Year: All dates fall within CY 2019 COS Matching test for pharmacy confirmed 95% of audit FFS data submitted. LA Care reported pharmacy experience reported in the RDT is based on what was paid to their pharmacy benefit manager. The remaining 5% of the data submission totaled $1,826,033, 2.54% of Pharmacy expense, or 0.14% of total medical expense, was excluded from testing below.	
	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 LA Care and compared	Variance: RDT FFS Expenses are overstated: • Inpatient 3.46% • Outpatient 8.47% • LTC 2.50% • Physician 1.92% • Pharmacy 0.22% • All Other 1.69% In Total overstated by 2.30% or	Variance: RDT FFS Expenses are over/(understated): • Inpatient (18.26%) • Outpatient 0.77% • LTC 2.10% • Physician 1.36% • Pharmacy 13.25 • All Other 3.67% In Total overstated by 1.91% or

Category	Description	Results Cal MediConnect (CMC)	Results Non-CMC
	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 LA Care. Allowable absolute value variances were deemed to be not greater than 2% for inpatient claims and 1% for all other COS.	$3,591,189, or 1.48% of Total Medical Expense.	$13,055,819, which is 1.22% of Total Medical Expense. Inpatient IBNR, as a total dollar amount, was significantly understated, while offset by an overstatement of IBNR for LTC and All Other medical expense. Pharmacy was overstated by $1,395,369 or 1.13% of total medical expense due to the pharmacy experience reported in the RDT being based on what was paid to their pharmacy benefit manager, noted above.
	Using data files (paid claims files) provided by LA Care, Mercer sampled and tested 67 transactions across each major COS (Inpatient, Outpatient, Physician, Pharmacy, Facility-LTC, and All Others) and traced sample transactions through LA Care's claims processing system, the payment remittance advice,	No variance noted.	

Category	Description	Results Cal MediConnect (CMC)	Results Non-CMC
	and the bank statements.		
Global Subcontracted Payments	Mercer requested overall global sub-capitation supporting detail. Mercer compared the support provided to the amounts reported in Schedule 1A. The total of the detail provided was less than the amounts reported in the RDT.	Not applicable.	Variance: RDT Global Capitation Expense is overstated by 1.60% or $6,061,343, which is 0.50% of Total Medical Expense.
	Mercer reviewed the contractual arrangement with LA Care's global subcontractor(s) and recalculated the total payment amount using global roster information provided for all 12 months of 2019 multiplied by the rates established on the most current rate sheet received from DHCS, adjusted for the global subcontracted arrangement.	Not applicable.	No variance noted.
	Mercer selected the three highest months of payment to globally subcontracted health plan/providers and five randomly selected additional months of payment.	Not applicable.	Variance: Proof of payment for the sampled global payments was overstated by 2.28% or $3,439,694, or 0.32% of Total Medical Expense.

Category	Description	Results Cal MediConnect (CMC)	Results Non-CMC
	Mercer observed proof of payments via relevant bank statements, clearing house documentation or other online financial institution support for the sampled global capitated payments. The proof of payment information was less than the supporting detail provided for the sampled global capitated providers.		This variance is included in the overall global capitation expense variance noted above. Payments tested covered both Mainstream and CCI populations and contained payment retroactive activity known at the time of payment.
	Mercer obtained roster information for the globally subcontracted provider and verified eligibility of members, confirmed enrollment with LA Care, and analyzed claims to verify none of the FFS claims paid should have been paid under the global arrangement.	Not applicable.	Enrollment was confirmed for 99.57% of the members on the provided rosters. Capitation for the ineligible members totaling $697,475 or 0.07% of Total Medical Expense was removed from the global sub-capitation supporting detail mentioned above. FFS claims totaling $299,024 or 0.04% of Total FFS claims were paid for members that were part of the global contracts. This is 0.03% of Total Medical Expense.

Category	Description	Results Cal MediConnect (CMC)	Results Non-CMC
	Mercer compared the global per member per month (PMPM) payment rates to relevant PMPM experience for non-global members for reasonableness.	Not applicable.	The weighted average global expense PMPM of $375.89 is less than the weighted average non-global medical expense PMPM of $481.96. LA Care's global members contain only 6.64% of the high-cost categories of aid (COAs) (e.g., Institutional/ Community-Based Adult Services/Multipurpose Senior Support Program), while the Direct membership maintained the rest. Therefore, the overall global PMPM is significantly less than the Direct PMPM and appears to be reasonable.
	If applicable, Mercer reviewed Full-Dual member global contracted PMPMs to determine if the amount(s) are at a reduced rate as compared to the non-Full Dual COA groups.	Not applicable.	LA Care pays each global subcontractor a negotiated blended capitation rate for all COAs. Therefore, the Full-Dual PMPM's are the same as the non-Full Dual PMPM's by COA. The blended rate was sufficiently less than the Full-Dual PMPM received from DHCS, suggesting a

Category	Description	Results Cal MediConnect (CMC)	Results Non-CMC
			reasonable reimbursement rate.
	Mercer reviewed the sampled global 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.	Not applicable.	Per review of the global contract, LA Care's global subcontractors provide several administrative services on behalf of LA Care's globally sub-capitated members. See Appendix A for details. LA Care did not segregate a portion of the global capitation expense as administrative expense; therefore, overstating medical expense and understating administrative expense.
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 2.59% or $3,123,125, or 1.29% of Total Medical Expense. CMC subcapitation expense was reported in the RDT with estimated quality withhold payments. Audit support is based off final reconciliation of	Variance: RDT Sub-capitated Medical Expense is overstated by 0.04% or $407, or 0.00% of Total Medical Expense.

Category	Description	Results Cal MediConnect (CMC)	Results Non-CMC
		quality withhold payments.	
	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 using roster information provided by LA Care.	Variance: Detailed support for sub-capitated amounts is understated by 2.14% or $17,594, or 0.01% Total Medical Expense. The recalculated amounts were less than the subcapitation amount reported in the supporting detail provided.	Variance: Detailed support for sub-capitated amounts is overstated by 0.02% or $57. The recalculated amounts were more than 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.	Variance: Detailed support for subcapitation sampled is overstated by 4.23% or $43,076, or 0.02% Total Medical Expense. The proof of payment information was less than the supporting detail provided for the sampled sub-capitated providers.	Variance: Detailed support for the sampled subcapitation sampled is understated by 0.06% or $200. The proof of payment information was more than the supporting detail provided for the sampled sub-capitated providers.
	Mercer obtained roster information for the sampled provider payments and verified eligibility of members, confirmed enrollment with LA	Eligibility was confirmed for 95.74% of members. Capitation for the ineligible members totaling $30,033 or	Eligibility was confirmed for 99.95% of members. Capitation for the ineligible members totaling $123 or

Category	Description	Results Cal MediConnect (CMC)	Results Non-CMC
	Care, and analyzed claims to verify none of the FFS claims paid should have been paid under the sub-capitated arrangement.	0.01% of Total Medical Expense was removed from the non-global sub-capitation supporting detail mentioned above. Mercer analyzed FFS claims and confirmed claims paid were appropriately paid under the sub-capitated arrangement.	0.00% of Total Medical Expense was removed from the non-global sub-capitation supporting detail mentioned above. Mercer analyzed FFS claims and confirmed claims paid were appropriately paid under the sub-capitated arrangement.
	If applicable, Mercer reviewed Full-Dual COA subcontracted PMPM payment rates to determine if the amount(s) are at a reduced rate as compared to the non-Full Dual COAs.	Confirmed.	Confirmed.
	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	Optum Health Plan of California and Regal Medical Group met the threshold criteria. The contract with Regal Medical Group partially delegated some administrative services, See Appendix A for Details. LA Care did not segregate a portion of the	No arrangements were more than 5% of total medical expense.

Category	Description	Results Cal MediConnect (CMC)	Results Non-CMC
	dollars reported in the RDT as compared to the delegated administrative functions.	capitation expense as administrative expense; therefore, overstating medical expense and understating administrative expense. The contract with Health Plan of California did not identify any delegated activities.	
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.	There is no variance when Schedule 1 is compared to Schedule 6a. Schedule 1 is understated by $1,812 or 0.00% as compared to Schedule 7. This amount represents 0.00% of Total Medical expense.	There is no variance when Schedule 1 is compared to Schedule 6a or to Schedule 7.
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.	Variance: RDT Provider Incentive Expense is overstated by 19.82% or $1,868,966, or 0.77% of Total Medical Expense. This variance is due to reasonably accrued incentives reported in the RDT not earned by the time of payment.	No variance noted.

Category	Description	Results Cal MediConnect (CMC)	Results Non-CMC
	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.	No variance noted.
	Mercer reviewed the listing of provider incentive payments for any payments to related parties, including Board of Directors members. 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.	On Schedule 6.1a incentives were paid to two organizations that also had seats on LA Care's Board of Directors. Proof of payment: No variance noted.	On Schedule 6.2.3a no related party provider incentive payments identified.
	If related party provider incentive payments were noted, Mercer	Mercer confirmed incentive terms align with similar	Not applicable.

Category	Description	Results Cal MediConnect (CMC)	Results Non-CMC
	reviewed the incentive terms to determine if the terms align with similar arrangements for non-related parties.	arrangements for non-related parties.	
Reinsurance	Mercer reviewed the reinsurance contract and compared the amount on the RDT to the requested supporting schedule.	Mercer confirmed there was no reinsurance coverage during CY 2019.	
Settlements	Mercer inquired of LA Care 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.	Settlements are reported on Schedule 7 and are based on actual amounts. LA Care reported $(36,897,161), or (15.23%) of Total Medical Expense, in settlements resulting from reconciling overpayments for the period. Of the reported Settlements, ($37,319,034) are Part D Low Income Cost Sharing and Reinsurance recoveries from Centers for Medicare & Medicaid Services. While it would be expected on Schedule 7 that pharmacy claims be reported net of	Settlements are reported on Schedule 7 and are based on actual amounts, representing 0.03% of Total Medical Expense.

Category	Description	Results Cal MediConnect (CMC)	Results Non-CMC
		rebates, reporting cost sharing and reinsurance recoveries as settlements is not preferred, the reported total appropriately ties to Schedule 1.1 and therefore is adequate for rate setting purposes; no variance.	
	If settlement amounts are material, Mercer requested supporting documentation and performed the additional procedures.	Excluding the explainable amount mentioned above, settlements are not material.	Settlements are not material.
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 $0.10 and 0.01%, respectively. LA Care reported ($1.01) PMPM and (0.08%). The benchmark for TPL for CMC includes reporting of recoveries net of claims rather than net of TPL expense; therefore, CMC TPL benchmark is positive. Therefore, based on LA Care's method of reporting, resulting reported	The benchmark TPL PMPM and percentage were ($0.24) and (0.05%), respectively. LA Care reported ($0.48) PMPM and (0.11%). These differences are within a reasonable amount.

Category	Description	Results Cal MediConnect (CMC)	Results Non-CMC
		TPL amounts are considered reasonable.	
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 4.60% of Net Revenue and LA Care reported 0.78%. A significant portion of the total CMC admin expense was allocated to the CMC Medicare side. While 86% of revenue is derived from Medicare the administrative expense percentage is significantly lower than the benchmark.	The benchmark administrative percentage was 4.17% of Net Revenue and LA Care reported 4.19%.
	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 administrative expense is understated by $160,311, or 8.01%. The understatement is due to claims interest expense underreported for the population due to a correction in reconciling the allocation between Medicare and Medi-Cal lines of business.	No variance noted.

Category	Description	Results Cal MediConnect (CMC)	Results Non-CMC
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.	LA Care is exempt from federal and State income taxes.	LA Care is exempt from federal and State income taxes.
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.	LA Care reported no related parties. However, there were five entities that had representatives who served as part of LA Care's Board of Directors. Across the CCI RDT submission, these entities accounted for $13,297,302 or 1.01% of total Medical Expense. Not material.	
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	The benchmark UM/QA/CC percentage was 3.14% and LA Care reported 1.26%.	The benchmark UM/QA/CC percentage was 2.15% and LA Care reported 0.64%. In total, the UM/QA/CC expenses reported across CMC and Non-CMC appear to be at a reasonable level.

Category	Description	Results Cal MediConnect (CMC)	Results Non-CMC
	reviewing the results.		
	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 noted.	No variance noted.
	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.	Mercer confirmed with LA Care management via interview that UM/QA/CC costs were not also included in general administrative expenses.	Mercer confirmed with LA Care management via interview that UM/QA/CC costs were not also included in general administrative expenses.
Pharmacy	Mercer confirmed and observed pharmacy benefits manager fees were recorded as administrative expenses and not included in pharmacy claims expenses in the RDT.	Confirmed.	Confirmed.
	Mercer benchmarked pharmacy rebate expenses on a PMPM basis across	The benchmarked pharmacy rebate PMPM is ($43.70) and LA Care reported ($52.31).	The benchmarked pharmacy rebate PMPM is ($0.11) and LA Care reported ($0.03).

Category	Description	Results Cal MediConnect (CMC)	Results Non-CMC
	all Two-Plan/GMC plans and compared to the amount reported on Schedule 7.	This difference is within a reasonable range.	This difference is within a reasonable range.
Capitation Revenue	Mercer compared capitation revenue 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 by 2.10% or $742,679.	Variance: RDT is understated by (0.01%) or ($76,676).
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 $70,401 or 21.53%, or 0.03% of Net Revenue.	Variance: RDT is overstated by $1,149,959 or 12.15%, or 0.10% of Net Revenue.
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.	LA Care received a clean audit opinion for CY 2019 and there were no unremediated material internal control weaknesses identified in the audit opinion.	
	Mercer compared reported expenses, including IBNR and	No material variances noted.	

Category	Description	Results Cal MediConnect (CMC)	Results Non-CMC
	administrative expenses, to audited financial statements for consistency.		
	Mercer inquired how hospital-acquired conditions (HACs) were treated in the RDT and policies for payment.	LA Care uses claims software that will not include diagnoses in the APR-DRG calculation if the "present on admission" flag is not "yes". Additionally, claims audit staff will review claims with diagnosis codes that are hospital acquired conditions where the POA flag is either "no" or missing. Therefore, no costs for HACs are included in the RDT expense reporting.	

Section 3

Summary of Findings CMC

Based on the procedures performed, the total amount of gross medical expenditures in the RDT were overstated by $8,581,469 or 3.55% of total medical expenditures in the CY 2019 RDT. The majority of the variance is a result of overestimates made for Subcapitation Quality Withhold payments and Provider Incentives, appropriately based off of previous years' experience. Actual results were less than RDT reported amounts, therefore does not warrant corrective action.

Based on the procedures performed, administrative expenditures in the CY 2019 RDT were understated by $160,311 or 8.01%, or 0.06% of Net Revenue.

Based on the defined variance threshold, the results of the audit are determined to be material, however the overstatement is due to estimates made using prior experience and do not warrant corrective action. It is recommended that LA Care consider actual outcomes of previous performance in future reporting.

LA Care reviewed this report and had no comments.

Section 4

Summary of Findings Non-CMC

Based on the procedures performed, the total amount of gross medical expenditures in the RDT were overstated by $19,117,569 or 1.78% of total medical expenditures in the CY 2019 RDT.

Based on the procedures performed, administrative expenditures in the CY 2019 RDT showed no variance. However, the plan should be properly recording a portion of their global subcapitation expense as administrative, 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.

LA Care reviewed this report and had the following comments:

At the time of completing the CY 19 RDT, we applied the four-part clinical risk-bearing entity ("CRBE") test to global subcontractors and as a result considered the total payments made to the global subcontractors to be health care expenses. We received legal guidance on the application of this test to the global subcontractors for MLR reporting and were told it was appropriate to assume the total expense was medical per memo from our legal counsel.

We were also aware that Mercer made adjustments to our global subcontractor rates to remove perceived administrative expenses, regardless of what was reported in the RDT. As such, our opinion that the entire global sub-capitation should be considered medical expense did not affect our revenue rates. Even if we were to say that some of the expense should be considered admin, we would have no way to accurately estimate the admin percentage. The RDT instructions do not require that obtain reporting from our global subcontractors as to their actual admin costs. Additionally, DHCS has been routinely collecting RDT information from our global subcontractors so they would have better information than we would on the global subcontractors' admin expenses.

Appendix A

Administrative Duties in Sub-capitated Arrangements

Administrative Task	Anthem Blue Cross	Blue Shield of California	Kaiser Foundation HP	Regal Medical Group
Quality Management and Improvement	X*[1]	X*	X*	
Population Health Management	X	X	X	
Network Management	X	X	X	
Utilization Management	X*	X*	X*	X
Credentialing and Re-credentialing	X	X	X	X
Member Connections	X	X	X	X
Members' Rights and Responsibilities	X*	X*	X*	

[1] In all categories LA Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, Federal, State and regulatory guidelines and accreditation standards.

In categories marked with an X*, LA Care retains additional responsibilities beyond those mentioned above.

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