

State Fiscal Year 2021 Inland Empire Health Plan Mainstream Rate Development Template

Auditor's Report

California Department of Health Care Services

July 22, 2024

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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 rate development template (RDT) for state fiscal year (SFY) 2021 by Inland Empire Health Plan (IEHP). 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 the Table(s) of Section 2.

Section 2: Procedures and Results

Mercer has performed the procedures enumerated in the Table(s) 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 IEHP for SFY 2021. IEHP's management is responsible for the content of the RDT and has responded in a timely manner to all requests for information.

Table(s): 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.	<ul style="list-style-type: none"> Control totals: No variance noted. Eligibility: 0.07% of claim submissions with no matching eligibility totaling \$1,565,827 or 0.04% of total medical expense and is included in the variance noted below. COS Map: Review of all COS showed 97%–98% for all COS except for the Other COS at 87%. Per IEHP, COS grouping logic used for the RDT submission was based on internal reporting purposes rather than the RDT rate setting logic which caused the low match rate in the Other COS. IEHP will adjust their COS grouping logic for future RDT submissions. Service Year: 183 claims were outside the service dates totaling \$161,362 or 0.00% of total medical expense. This amount has been excluded from the testing.
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 this support to the information reported in	<p>Variance: RDT FFS Expenses are over/(understated) as compared to the support provided:</p> <ul style="list-style-type: none"> Inpatient (0.29%) LTC 0.79% Outpatient 0.11%

Fee-For-Service (FFS) Medical Expense	
Description of Procedures	Results
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.	<ul style="list-style-type: none"> Physician 0.99% All Other (0.42%) <p>In total, 0.06% or \$1,268,683, which is 0.03% of total medical expense.</p>
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.	<p>Variance: RDT Global Capitation expense is overstated by 0.63%, or \$2,188,466, which is 0.05% of total medical expense.</p> <p>The total of the detail provided was less than the amounts reported in the RDT.</p>
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 rates established in the contract with the subcontractor.	Variance: Detailed support for global capitation overstated by 0.72% or \$2,468,909. The recalculated roster amounts were less than the global capitation amounts 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.	No variance notes.

Global Subcontracted Payments	
Description of Procedures	Results
Mercer obtained roster information for the globally subcontracted providers and verified eligibility of members, confirmed enrollment with IEHP, and analyzed claims to verify none of the FFS Claims paid should have been paid under the global arrangement.	Eligibility was verified for 99.94% of members. The amount of global capitation paid for the ineligible members is \$239,927 and is included in the roster recalculation variance noted above.
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.
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.	Mercer confirmed reduced rates as compared to the non-Full Dual COA groups.
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.	Per review of the global contract, all administrative functions in Appendix A were delegated to the global subcontractor. IEHP segregated 6.70%, or \$23,205,254, of the global capitation expense in the Schedule 1-A Data tab in the RDT. The administrative component was not removed from medical expense. Therefore, this is an understatement of administrative expenses and an equal overstatement of medical expenses.
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 Expenses	
Description of Procedures	Results
Mercer requested overall non-global sub-capitation supporting detail. Mercer compared the support provided to the amounts reported in Schedule 7.	<p>Variance: RDT Sub-capitated Medical Expense is understated by 0.13%, or \$597,472.</p> <p>The total of the detail provided was greater than the amounts reported in the RDT.</p>
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.	<p>Variance: Detailed support for sub-capitated amounts in the sample test work is overstated by 0.13%, or \$43,458. The recalculated roster amounts were less than the sub-capitation amount reported in the supporting detail provided.</p>
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.	<p>No variance noted.</p> <p>The proof of payment information validated the supporting detail provided for the sampled sub-capitated providers.</p>
Mercer obtained roster information for the sampled provider payments and verified eligibility of members, confirmed enrollment with the MCO and validated the amounts paid by member.	<p>Eligibility was verified for 99.90% of members. The amount of non-global sub-capitation paid for the ineligible members is \$13,585 and is included in the roster recalculation procedures noted above.</p>
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.	<p>Not applicable as the non-global sub-capitated arrangements do not apply to dual status members.</p>
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	<p>IEHP did not have any sub-capitated arrangements that exceeded the 5% or more of total medical expense threshold.</p>

Sub-Capitated Medical Expenses	
Description of Procedures	Results
information, Mercer then reviewed the amount of administrative dollars reported in the RDT as compared to the delegated administrative functions.	

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 from Schedule 7.	Schedule 1 is understated by 0.00%, or \$97,686, when compared to Schedule 7. This variance is 0.00% of total medical expense.

Member Months	
Description of Procedures	Results
Mercer compared the 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 than 0.5% variance in total or greater than 1.0% variance by major COA.	Variance: RDT Member Months are understated by 0.15% in total.

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.	Variance: RDT Provider Incentive Expense is overstated by 9.38%, or \$9,781,331. This amount represents 0.23% of total medical expense. The overstatement is a result of the actual incentive amount differing from what was estimated at the time of the RDT submission.
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	No variance noted. The proof of payment information validated the supporting detail provided for the sampled provider incentive payments.

Provider Incentive Arrangements	
Description of Procedures	Results
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.	Mercer confirmed there are no related parties or provider incentive payments to related parties.

Reinsurance	
Description of Procedures	Results
Mercer requested reinsurance supporting detail. Mercer compared the support provided to the amount reported in the RDT.	Not applicable. IEHP does not have any reinsurance arrangements.

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

Third-Party Liability (TPL)	
Description of Procedures	Results
Mercer reviewed information submitted by the MCO as 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, IEHP 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 Two-Plan/GMC plans and compared to the amount reported in the RDT, taking into consideration the membership size of the plan when reviewing the results.	The administrative percentage reported by IEHP was within an acceptable range as compared to industry standards. IEHP is one of the largest Medi-Cal health plans.
Mercer compared detailed line items from the plan's trial balance for reasonableness when mapped to line items in Schedule 6a and/or Schedule 6b. If applicable, Mercer reviewed allocation methodologies and recalculated for reasonableness.	No variance noted.

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, we confirmed the organization is not subject to taxes.	IEHP is exempt from income taxes; therefore, no taxes were 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.	No related parties noted.

UM/QA/CC	
Description of Procedures	Results
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 1-U, taking into consideration the membership size of the plan when reviewing the results.	The UM/QA/CC percentage reported by IEHP was within an acceptable range as compared to industry standards.
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 overstated by 0.01%, \$12,044, or 0.00% of total medical expense.
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. Mercer confirmed with MCO that UM/QA/CC costs were not also included in general administrative expenses.	Confirmed.

Capitation Revenue	
Description of Procedures	Results
Mercer compared capitation amounts reported in Schedule 6a for calendar year 2020 plus January–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: Using a straight average methodology, the variance for SFY 2021 is estimated at \$6,516,139, or 0.15%.

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.	Variance: RDT is overstated by 9.85%, or \$278,385. The reported interest and investment income is based on an allocation methodology. The variance is 0.01% of total Net Revenue, therefore, no additional testing deemed necessary.

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.	IEHP received a clean audit report.
Mercer compared reported expenses, including IBNR and administrative expenses, to audited financial statements for consistency.	No material variances noted.
Mercer requested information on the efforts to identify and recover provider overpayments and on how the recoveries are recorded in the RDT.	IEHP provided information for the identification and recovery of overpayments. Based on a review of that information, IEHP is appropriately excluding provider overpayments from 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 overstated by \$6,516,139 or 0.15%.

Based on the procedures performed, the total amount of gross medical expenditures in the RDT was overstated by \$12,655,366, or 0.30%, of total medical expenditures in the SFY 2021 RDT.

Based on the procedures performed, there was no variance noted for administrative expenditures in the SFY 2021 RDT. However, the plan should prepare to properly record a portion of their global and provider sub-capitation expense as administrative in future RDT reporting, 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.

IEHP reviewed this report and had the following comments:

For future RDT reporting, if Managed Care Plans (MCP) are required to report a portion of our global and provider sub-capitation expense as administrative expense, then we will need clear guidance/methodology from DHCS/Mercer on how to identify, calculate, and/or determine the administrative expense portion of the capitation expense.

Appendix A: Administrative Duties in Subcontracted Arrangements

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



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