Mercer

Government Human Services Consulting

State Fiscal Year 2021 Kern Health Systems Mainstream Rate Development Template

Auditor's Report

California Department of Health Care Services

February 22, 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 Kern Health Systems (KHS). 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 KHS for SFY 2021. KHS'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: 0.10% of claim submissions with no matching eligibility totaling $890,582 or 0.11% of total medical expense and is included in the variance noted below. • COS Map: Review of all COS showed 96%–99% match for all COS. • 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 this 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 3.87% • Outpatient 1.40% • LTC (0.82%) • Physician 0.79% • All Other (1.44%) In Total 1.74%, or $10,330,681, which is 1.32% of total medical expense. The larger variances above are due primarily to over/under estimating of IBNR.

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 overstated by 0.23%, or $59,726. The total of the detail provided was less 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 rates established in the contract with the subcontractor.	Variance: Detailed support for global capitation expense is overstated by 1.11%, or $291,361. The recalculated 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.	Variance: Detailed support for global capitation expense is overstated by 3.32%, or $579,098. The proof of payment information was less than the supporting detail provided for the sampled global capitated providers. The majority of the variance is due to subsequent capitation rate changes paid to KHS by DHCS, which alters the payment rates paid to the global contractor. The rate changes were not known to KHS at the time of RDT submission. No further test work deemed necessary.
Mercer obtained roster information for the globally subcontracted providers	Eligibility was verified for 99.86% of members. The amount of global

and verified eligibility of members, confirmed enrollment with MCO, and analyzed claims to verify none of the FFS Claims paid should have been paid under the global arrangement.	capitation paid for the ineligible members is $29,839 and is included in the roster recalculation procedures 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.	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.	Mercer reviewed the global capitated contract with Kaiser to determine the level of administrative functions included. See Appendix A for details. KHS identified 8.45% of the global capitation expense as administrative in the Schedule 1-A Data tab in the RDT. This amount is considered within an acceptable range for industry standards. The administrative component was not removed from medical expense.
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 overall non-global sub-capitation supporting detail. Mercer	No variance noted. The supporting detail provided included $4,551,980 of manual payments for readiness and

compared the support provided to the amounts reported in Schedule 7.	alternate payment methodology amounts due to COVID-19. These amounts were paid to Kern Medical Center. This amount represents 27% of the total sub-capitation reported, and 35% of total sub-capitation excluding the COVID-19 payments.
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-capitated amounts in the sample test work is overstated by 2.79%, or $127,449. The recalculated amounts were less 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.	No variance was noted in the review of the detailed support for the sampled sub-capitated providers. The proof of payment information verified 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 the MCO and validated the amounts paid by member.	Eligibility was verified for 99.96% of members. The amount of non-global sub-capitation paid for the ineligible members is $4,052 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.	The sub-capitation agreements do not delineate between Full Dual and non-Full Dual COA rates; however, the only sub-capitation arrangements are for transportation, ambulance service, nurse triage and advice, and vision which would either not be covered by Medicare or would not have a payment differential based on Full Dual or non-Full Dual status.
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	KHS did not have any sub-capitated arrangements that exceeded the 5% or more of total medical expense threshold.

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 0.07%, or $442,101, when compared to Schedule 7. This variance is 0.06% 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 overstated by 0.09% 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 6a, lines 34–36.	Variance: RDT Provider Incentive Expense is overstated by 11.88%, or $1,800,071. This amount represents 0.16% of total medical expense. Per KHS, the variance is due to the use of accruals at the time of RDT submission as compared to the actual results known at the time of this testing.
From the listing of provider incentive payments, Mercer sampled the highest two payment amounts and one random payment. Mercer observed proof of	Variance: Detailed support for provider incentive payments in the sample test work is understated by 9.43% or $99,679. The detailed support

payments for the sampled provider incentive payments.	represents an accrual at the time of RDT submission which was less than the actual payment.
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.	KHS confirmed there are related party incentive arrangements and those payments are included in the test work above.
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.	Related party provider incentive payments were noted and the incentive arrangement terms aligned with similar arrangements for non-related parties.

Reinsurance	
Description of Procedures	**Results**
Mercer requested reinsurance supporting detail. Mercer compared the support provided to the amount reported in the RDT.	No variance reported.
Mercer recalculated reinsurance premiums, based on SFY 2021 membership as of February 2023, to compare to reported amounts.	Variance: RDT was understated by 0.00% or $7,039 due to difference in member months known at the time of RDT submission.
Mercer recalculated recoveries for a sample of five members.	No cases exceeded the reinsurance threshold.
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 reinsurance information reported.

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.	KHS reported a combination of actual and estimated settlement expense in the appropriate COS on the Settlement line of Schedule 7. To note, $7,710,735 of the settlement expense relates to Back to Care initiatives for COVID-19 for the second half of CY 2020. This amount is 97% of the total settlement expense. The COVID-19 settlements did not continue into CY 2021.
If settlement amounts are material, Mercer requested supporting documentation and performed the following procedures.	N/A. Settlements reported represent 0.79 % of total medical expense.
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, KHS 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 benchmark administrative percentage was 6.55% and KHS reported 6.43%. This differential is considered reasonable.

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.	KHS 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.	KHS has related party arrangements as defined to include any hospitals or provider organizations whose executive level staff hold a seat on the KHS Board of Directors. The related parties provide medical services under FFS arrangements representing approximately 12% of total medical expense. KHS does not have any sub-capitated arrangements with these related parties but has provider incentive payments. Per review of the incentive arrangement agreements, terms are similar to those non-related party terms.
If related party contracts are a material portion of the related medical COS, Mercer also reviewed any allocation methodologies for reasonableness.	N/A. No allocation methodologies noted.

Mercer reviews that all services included in the related party agreements are allowable for Medicaid rate setting.	All services considered allowable.
When applicable, Mercer obtained related party corporate allocation methodologies for administrative services. Where significant, Mercer recalculated the amounts for reasonableness.	N/A. No related party allocations.

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 benchmark UM/QA/CC percentage was 1.70% and KHS reported 2.80%. This difference is considered reasonable.
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 0.99%, $216,903 or 0.03% of total medical expenses. Allocated expenses are 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. 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: RDT is overstated by 0.42%, or $5,232,581.

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. No allocations 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.
Mercer requested information on the efforts to identify and recover provider overpayments and on how the recoveries are recorded in the RDT.	KHS provided the written policy for the identification and recovery of overpayments. Based on a review of that policy, KHS is not reporting any

	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 overstated by $5,232,581 or 0.42%.

Based on the procedures performed, the total amount of gross medical expenditures in the RDT was overstated by $11,957,406, or 1.53%, of total medical expenditures in the SFY 2021 RDT.

Based on the procedures performed, administrative expenditures in the SFY 2021 RDT showed no variance. However, the plan should be properly recording a portion of their global 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.

KHS reviewed this report and had the following comments:

The variances noted were due primarily to the use of estimates in the RDT submission during the SFY as compared to the actual results known at the time of audit test work. The performance of the RDT audit on a CY basis rather than a SFY basis would have allowed for more complete data to be audited based on the submission date of the RDT.

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 Recredentialing	X

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