MERCER

AUDITORS REPORT

CALENDAR YEAR 2017 MOLINA HEALTHCARE RATE DEVELOPMENT TEMPLATE

November 13, 2020

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Executive Summary

Pursuant to federal requirements under Title 42 of the Code of Federal Regulations 438.602(e), the 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) [1]. DHCS contracted with Mercer Government Human Services Consulting (Mercer) to fulfill this requirement for the financial data submitted in the Medi-Cal Rate Development Template (RDT) for calendar year (CY) 2017 by Molina Healthcare (Molina). 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 Bridge rating period (July 1, 2019 – December 31, 2020). The RDT tested was the final version, including any revisions stemming from resubmissions as a result of the RDT Q&A 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 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 2017 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 calendar year reported.

The procedures and results of the test work are enumerated in Table 1 of Section 2.

[1] 42 CFR 438.602(e)

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Procedures and Results

We have 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 Molina for the CY 2017. Molina's management is responsible for the content of the RDT and responded timely to all requests for information. However, it should be noted that Molina submitted multiple versions of many of the supporting documentation files. Often, when questions arose by Mercer around these files, another file would be provided with revised information. The multiple submissions in numerous areas caused significant delays in completing the audit and resulting report.

Table 1: Procedures

Category	Description	Results
Utilization and Cost Experience	We compared summarized total net cost data from amounts reported in Schedule 1 to category of service (COS) totals from Schedule 6a and to total incurred claims by COS for Schedule 7 for consistency.	No variance.
Global Subcontracted Payments	We requested overall global capitation supporting detail. We compared the support provided to the amounts reported in Schedule 1-A, excluding supplemental payments. The total of the detail provided was more than the amounts reported in the RDT.	Variance: RDT reported capitation amounts are less than the support provided by 2.21%, or $388,818.

Category	Description	Results
	We reviewed the contractual arrangement with Molina's sole global subcontractor, Health Net. Molina was unable to provide contractual validation of the PMPM rates paid to Health Net. Molina indicated they maintain the current rates within QNext based on the capitation rates paid by DHCS. Molina subsequently provided QNext rate history for Health Net applicable to CY2017.We compared the PMPM rates in the rosters, for the applicable month of service (MOS), to the PMPM rates in QNext. In aggregate, the PMPM amounts included in the roster detail for the sampled MOS were higher than the amounts supported by Qnext rates. The Qnext rates provided did not match the rates seen in the rosters but were in line with the most recent rate sheets received from DHCS, less 7%, which aligns with contract specifications. We recalculated the roster amounts for the sampled month of service (excluding retroactivity which was immaterial to the roster totals) utilizing the Qnext rates. The sum of the recalculated amounts based on QNext rates were less than the related global capitation amounts reported in the supporting rosters provided.	Variance of roster payment amounts as compared to expected payment amounts using QNext rates for the eight sampled months was an overstatement of $1,271,876, or 10.72%. This error rate, when applied to the full twelve months, equates to an overstatement of $1,907,418.
	We selected the three highest months of payment and five randomly selected additional months of payment to obtain membership rosters for each month selected. Twenty randomly selected members from each month were checked to ensure eligibility. The same members were compared against claims included in the fee-for-service (FFS) data provided by Molina to see if both Molina and the global subcontractor paid claims.	All sampled members eligible. No FFS claims paid.
	We reviewed members included on the member roster to ensure there were no Coordinated Care Initiative members or payments provided in the step above.	None identified.
	We selected the three highest months of payment and five randomly selected additional months of payment and traced payments to proof of cash disbursement.	No variance, cash disbursement matched roster amounts.

Category	Description	Results
Member Months	We compared MCO reported member months from Schedule 1C to eligibility and enrollment information provided by the State. Our procedures are to request explanations for any member months with greater than 1% variance in total or greater than 2% variance by major category of aid.	Variance: RDT overstated by 0.41% in total.
Capitation Revenue	We discussed how capitation was recorded. Molina provided support for their revenue calculation.	RDT overstated by 1.36% based on estimated revenue calculation using the known capitation rates in place during 2017.
Interest and Investment Income	We requested interest and investment income for the MCO entity as a whole and information regarding how the income reported in Schedule 6a was allocated to the Medi-Cal line of business. Molina did not report any interest or investment income on Schedule 6a. Variance was determined based on the amount allocated to Medi-Cal as reported in Molina's internal financial statements.	Variance: RDT is understated by 100.00%, or $5,221,209.
Fee For Service Medical Expense	Using data files (paid claims files) provided by Molina, we sampled and tested transactions for each major category of service (COS) (Inpatient, Outpatient, Physician, Pharmacy, Facility-Long Term Care (LTC), and All Others) and traced sample transactions through Molina's claims processing system, the payment remittance advice, and the bank statements.	No variance observed.
	We compared detailed lag tables for each major COS (Inpatient, Outpatient, Physician, Pharmacy, Facility- (LTC), and All Others) created from the data files provided by Molina and compared the information reported in Schedule 7. We compared the paid claims amounts from Schedule 7, line 35 to total paid claims prior to the additional runout detail included in the data files, expecting no changes.	Variance: RDT overstated in total by 1.38% of total FFS claims payments reported on Schedule 7, or $12,967,431.
	We compared total final incurred amounts including incurred but not reported (IBNR) estimates from Schedule 7 to total paid amounts from all months reported in the data files 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.	Variance: RDT over/(understated): Inpatient 0.66%; Outpatient 0.31%; LTC 1.95%; Physician (3.82%); Pharmacy (0.07%); All Other 3.65%; In Total 0.50%, or $4,727,254.

Category	Description	Results
	We reviewed a sample of claims from each COS to verify control totals, verify eligibility, confirm the COS grouping was correct, and confirm the year reported was correct.	Control totals: No variance noted. Eligibility: $397,116 or 0.05% of paid claims were on members with no matching Medi-Cal eligibility. COS Map: No variance noted. Service Year: No variance noted.
Sub-capitated Medical Expense	We requested overall sub-capitation supporting detail. We 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. The biggest, but not the only issue that caused this variance, was that Molina identified during the review of the internal financial statement reconciliation that they had inadvertently duplicated $6.1 million of Global Subcontracted payments to Health Net in the Sub-capitation reporting on the RDT Schedule 7 line 36. This Health Net issue included $3.4M in the Riverside RDT and $2.7M in the San Bernardino RDT. This was a one-time error and not a recurring reporting issue.	Variance: RDT reported sub-capitation amounts are overstated by 3.42%, or $9,218,939.
	We sampled membership from thirteen rosters across eleven subcontractors, verified eligibility of members and analyzed claims to verify none of the FFS claims paid should have been paid by the sub-capitated provider.	Eligibility: 3 of 280 sampled members (1.07%) came back ineligible, and were not validated by Molina. FFS claims of $30.03 or 0.00% of total FFS claims were paid on sub-capitated members claims that were not validated by Molina.

Category	Description	Results
	We reviewed a sample of the contractual arrangements with Molina's sub-capitated providers and recalculated the total payment amounts by sub-capitated provider using roster information provided by Molina. The recalculated amounts were less than the sub-capitation amount reported in the supporting detail provided. The majority of variance identified was applicable to four of the five highest sub-capitation payments, to related party "Joseph M Molina MD." Molina was unable to locate a signed contract or signed rate sheet for this vendor, therefore the full $8,280,429 of sampled payments are included as a variance. *Molina response: "Molina Healthcare (MHC) concedes that it is poor business practice to not have signed agreements outlining provider capitation rates. MHC disagrees that the $8.28M is an RDT overstatement. MHC has a document describing the terms agreed to by MHC and "Joseph M Molina." The $8.28M were incurred expenses in line with the agreed upon terms between MHC and Joseph M Molina."* Mercer did not receive documentation sufficient to conclude that the $8.28 million is an appropriate expense to include in rate setting, thus the amount remains reported as a variance. For the highest sampled sub-capitation payment identified as a "Make-Whole" payment to related party "Joseph M Molina MD" we discovered Molina had included payments applicable to the ACA Marketplace, Covered California (not a Medi-Cal line of business) within the CY2017 RDT. We therefore expanded our sampling to include all CY2017 "Make-Whole" payments to Joseph M. Molina, MD. Our analysis of the reconciliations and supporting documentation provided, identified a variance totaling $1,701,058 for payments not applicable to the CY2017 Medi-Cal line of business and RDT.	Variance: The detailed support for sub-capitated payment amounts reported in the RDT is overstated by 40.33%, or $9,981,487.
	We observed proof of payments for the sampled sub-capitated providers in the previous step.	No variance noted.
Provider Incentive Arrangements	We reviewed incentive arrangements and observed sample calculations for contractual compliance and reasonableness.	Variance: RDT is overstated by 3.89%, or $178,792.

Category	Description	Results
Administrative Expenses	We benchmarked administrative expenses as a percentage of capitation 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. Molina has an administrative services agreement with their Parent company. Administrative expense PMPM and as a % of revenue for CY2017 were considerably higher than the benchmark, despite restructuring changes to reduce the amount of administrative costs as called out by Molina for CY2017 during the RDT Discussion Guide process. In addition, as noted below in the Pharmacy section, the administrative component of the PBM fees was not appropriately recorded as an administrative cost. Therefore, reported administrative costs would be even higher if reported correctly.	The benchmark administrative PMPM was $14.69 and 5.50% of revenue across all Two-Plana and GMC plans. Molina reported $21.21 PMPM and 7.49% of revenue, primarily driven by higher than average Affiliate Administration Services (on a PMPM basis). It should be noted that Molina is near the average of Two-Plan/GMC plans from a membership perspective. Thus, the higher than average administrative percentage is not justified by membership level.
	We compared detailed line items from the plan's trial balance mapped to line items in Schedule 6a for reasonableness. We reviewed allocation methodologies and recalculated for reasonableness.	No variance noted.
Taxes	We reviewed Schedule 6a line 59 "Provision for Taxes" to determine if all taxes, including Federal, State and local income taxes were included. We observed $0 reported. Internal financials indicated income taxes were applicable to Molina. We estimated the applicable amount based on the "Total Medi-Cal" amount reported in Molina's internal financials.	Variance: RDT is understated by 100.00% or $33,373,000.
Utilization Management, Quality Assurance, Care Coordination (UM/QA/CC)	We benchmarked UM/QA/CC expenses as a percentage of revenue 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. UM/QA/CC expense PMPM and as a % of revenue for CY2017 were considerably higher than the benchmark.	The benchmark UM/QA/CC PMPM and percentage was $3.27 and 1.23% and Molina reported $7.71 and 2.72%. These costs are included in the costs allocated by the parent corporation.
	We reviewed Schedule 6b line compared detailed line items from the plan mapped to line items in Schedule 1-U for reasonableness. We reviewed allocation methodologies and recalculated for reasonableness.	No variance noted.

Category	Description	Results
	We 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 Molina management via interview that UM/QA/CC costs were not also included in general administrative expenses.	Confirmed.
Pharmacy	We confirmed and observed if pharmacy benefit manager (PBM) fees were recorded as administrative expenses and not included in pharmacy claims expenses in the RDT.	Variance: $23,394,033 of PBM administrative expenses were reported within the pharmacy medical expense. This amount represents 14.61% of the amount reported on the Pharmacy line of Schedule 6a.
Other Information	We reviewed the audited financial statements for the plan for the CY 2017 for a clean audit opinion or identification of significant deficiencies or material weaknesses.	No variance noted.
	We compared reported expenses, including IBNR and administrative expenses, to audited financial statements for consistency. Audited financial statements were not segregated by line of business, therefore no ability to segregate Medi-Cal. Internal financial statements however were provided by line of business and in total, and reasonably compared to the consolidated audited financial statements, therefore no additional testing performed.	No material variances noted.

Category	Description	Results
	We inquired how hospital-acquired conditions (HACs) were treated in the RDT and policies for payment.	Molina follows CMS direction in preventing payment for HACs. Molina blocks payment of claims that have the HAC DRG modifier codes per CMS guidelines unless the claim indicates that the modifier was present on admission. In compliance with CMS requirements, Molina has a policy of non-payment in all lines on business for HACs. For state Medicaid programs that have additional HAC diagnoses that are not eligible for payment, Molina will assure that payment for those events are blocked as well. Therefore, no expenses related to HACs were included in the RDT expense reporting.

Summary of Findings

Based on the procedures performed, the total amount of gross medical expenditures in the CY 2017 RDT were overstated by $49,019,502 or 3.79% of total medical expenditures in the CY 2017 RDT.

Based on the procedures performed, the total amount of gross administrative expenditures in the CY 2017 RDT were understated by $23,394,033 or (20.42%) of total administrative expenditures in the CY 2017 RDT. However, the total administrative expenses reported in the RDT were already well above the benchmark average expense level.

Based on the defined variance threshold, the results of the audit are determined to be material and warrant significant changes to the RDT reporting process. Many of the individual and overall resulting variances are considered significant from a rate setting perspective.

It should be noted that Molina had significant challenges in providing supporting documentation to support RDT reported information as noted below. The list highlights the more significant items but is not all-inclusive.

1) Five versions of the support file for the Global and Sub-capitation payment data were submitted.
2) Four versions of the support for the provider incentives payment data were submitted.
3) Two versions of the FFS data files were submitted.
4) Initial Provider Incentive Agreement submitted to support CY2017 RDT was from 2013. When questioned, Molina provided the revised 2016 Provider Incentive Agreement.
5) In response to our initial request for CY2017 internal financial statements, Molina provided 80 files that appeared to be monthly internal reports. Molina ultimately provided workable internal financial statements upon subsequent request.
6) Molina was unable to provide contractual validation of the PMPM rates seen in the supporting member rosters received for the Global sub-contractor, Health Net.
7) Molina was unable to locate signed agreements for four of the five largest Sub-capitation payment samples to related party Joseph M Molina MD.

Mercer recommends the following steps be followed to increase the validity of Molina's RDT reporting:

1) Molina should establish a clear audit trail for completion of the RDT and maintain documentation for the information submitted to the State as support for the RDT for three years or until the RDT is no longer used for rate setting.
2) Molina should report PBM Administrative Fees within Schedule 6b, line 47.20 "Pharmacy - PBM" and as part of the reported Administrative expenses section on Schedule 6a, rather than including as part of the Pharmacy expense line in the medical section.
3) Molina should allocate and report investment income across all lines of business (including Medi-Cal) and report in Schedule 6a, line 5 and line 11.
4) Molina should allocate and report provision for taxes to the Medi-Cal line of business and report on Schedule 6a, line 59.
5) Molina should clearly identify and separate out membership and related expenses from other lines of business (e.g., Covered California) when completing their RDT.

Molina has reviewed this report and had no comments.

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