



# AUDITORS REPORT

# CALENDAR YEAR 2017 ACCESS DENTAL PLAN RATE DEVELOPMENT TEMPLATE

February 10, 2021

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# 1

## 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)<sup>1</sup>. DHCS contracted with Mercer Government Human Services Consulting (Mercer) to fulfill this requirement for the financial data submitted in the Medi-Cal Dental Managed Care Rate Development Template (RDT) for calendar year (CY) 2017 by Access Dental Plan (Access). 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 fiscal year 2019 – 2020 rating period. The RDT tested was the latest version received during the rate setting process prior to finalizing capitation rates. If subsequent versions were received after the rate setting process, it may be noted in Table 1 below.

The key schedules subject to testing from the RDT include, but were not limited to:

- Schedules 1.1 – 1.3 Utilization and Unit Cost Reports
- Schedule 2 – Financial Report
- Schedule 2a – Financial Report – Administrative Expense Detail
- Schedule 3 – 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.

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<sup>1</sup> 42 CFR 438.602(e)

# 2

## 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 Dental Managed Care RDT from Access for the CY 2017. Access’s management is responsible for the content of the RDT and responded timely to all requests for information. The initial RDT submitted was utilized for rate setting, therefore our testing below is limited the information contained in that submission. Subsequent submissions were not tested unless noted below.

Table 1: Procedures

Category	Description	Results																								
Utilization and Cost Experience	<p>We compared the total net cost data from amounts reported in Schedules 1.1 – 1.3 to category of service (COS) totals from Schedule 2 and to total incurred claims by COS for Schedule 3 for consistency.</p> <p>Access reported Prop 56 expenses of \$1,287,395 in Schedules 1.1-1.3 and Schedule 3, but not in Schedule 2. In addition, Access recorded UM/QA/CC expenses of \$820,203 in Schedule 2, but not in Schedules 1.1-1.3 or Schedule 3. The net amount of these two amounts results in a variance of \$467,192 as reported in the results column.</p> <p>Access did not report the split of FFS, Capitation, Prop 56 and Allocated/Write-In expenses consistently across Schedules 1.1-1.3, Schedule 2 and Schedule 3 as shown in the table below:</p> <table border="1"> <thead> <tr> <th></th> <th>Schedule 1.1-1.3</th> <th>Schedule 2</th> <th>Schedule 3</th> </tr> </thead> <tbody> <tr> <td><b>Fee-For-Service</b></td> <td>\$ 3,120,353</td> <td>\$3,450,841</td> <td>\$4,158,524</td> </tr> <tr> <td><b>Capitation</b></td> <td>\$13,856,697</td> <td>\$ 26,637,937</td> <td>\$11,352,129</td> </tr> <tr> <td><b>Total Allocated Costs/Write Ins</b></td> <td>\$13,111,728</td> <td>\$820,204</td> <td>\$ -</td> </tr> <tr> <td><b>Prop 56</b></td> <td>\$1,287,396</td> <td>\$ -</td> <td>\$1,287,396</td> </tr> <tr> <td><b>Total Dental Expense</b></td> <td><b>\$31,376,174</b></td> <td><b>\$30,908,982</b></td> <td><b>\$16,798,049</b></td> </tr> </tbody> </table>		Schedule 1.1-1.3	Schedule 2	Schedule 3	<b>Fee-For-Service</b>	\$ 3,120,353	\$3,450,841	\$4,158,524	<b>Capitation</b>	\$13,856,697	\$ 26,637,937	\$11,352,129	<b>Total Allocated Costs/Write Ins</b>	\$13,111,728	\$820,204	\$ -	<b>Prop 56</b>	\$1,287,396	\$ -	\$1,287,396	<b>Total Dental Expense</b>	<b>\$31,376,174</b>	<b>\$30,908,982</b>	<b>\$16,798,049</b>	<p>Variance: None of the three key schedules tied to each other, which they should.</p> <p>Schedules 1.1-1.3 in total were greater than the amounts reported in Schedule 2 by \$467,192 or 1.49%.</p> <p>Schedules 1.1-1.3 in total were more than Schedule 3 by \$14,578,126, or 46.46%. This is primarily due to inconsistent reporting of Capitated expenses. The issue was corrected in subsequent RDT submissions received after the conclusion of the rate setting process. The revised variance showed Schedules 1.1-1.3 less than Schedule 3 by \$707,683, or 2.26%.</p>
	Schedule 1.1-1.3	Schedule 2	Schedule 3																							
<b>Fee-For-Service</b>	\$ 3,120,353	\$3,450,841	\$4,158,524																							
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Category	Description	Results
Member Months	<p>We compared MCO reported member months from Schedule 2 to eligibility and enrollment information provided by DHCS. Our procedures are to request explanations for any member months with greater than 1% variance in total.</p> <p>Access indicated that a subset of members were not accounted for in the initial RDT submission.</p>	<p>Variance: RDT understated by 165,316 or 4.20% in total. By category of aid, variances were overstated/(understated) as follows:</p> <p>ACA Expansion 25.91%; Non-ACA Child (1.98%) Non-ACA Adult (95.03%)</p> <p>The variance was corrected in subsequent RDT submissions received after the conclusion of the rate setting process. The revised variance showed an overstatement of 2,123, or 0.05% member months.</p>
Capitation Revenue	<p>We discussed how capitation was recorded. We compared the capitation revenue as reported on Schedule 2 to capitation paid to Access as reported by DHCS.</p>	<p>RDT overstated by 2.45%, or \$1,115,624.</p>
Fee For Service Medical Expense	<p>Using data files (paid claims files) provided by Access, we sampled and tested transactions for all services and traced sample transactions through Access's claims processing system, the payment remittance advice, and the bank statements.</p>	<p>No variance noted.</p>
	<p>We compared the detailed lag table for all services created from the data files provided by Access and compared to the information reported in Schedule 3. We compared the paid claims amounts from Schedule 3, line 31 to total paid claims prior to the additional runout detail included in the data file, expecting no changes. Per review of support provided, Access did not remove \$1,383,462 of refunds received from providers from FFS expenses reported in Schedule 3. This amount accounts for the majority of the overall variance noted.</p>	<p>Variance: Schedule 3 of the RDT overstated by \$1,367,685 or 32.89% of total FFS claims payments. However, as noted above, Schedules 1.1-1.3 and Schedule 2 on the RDT did not tie to Schedule 3.</p>

Category	Description	Results
	<p>We compared total final incurred amounts including incurred but not reported (IBNR) estimates from Schedule 3 to total paid amounts from all months reported in the data file to verify the accuracy/reasonableness of IBNR for all services. Comparison of the FFS data submitted to Schedule 3 reported amounts indicated an understatement of 0.39% or \$16,177. However, per support information received, we identified Access did not remove \$1,383,462 of refunds related to 2017 DOS received from providers from FFS expenses, resulting in an overstatement reported in Schedule 3.</p>	<p>Variance: Due primarily to refunds received from providers, the RDT is overstated by 32.88% of total FFS claims payments reported on Schedule 3, or \$1,367,285. However, as noted above, Schedules 1.1-1.3 and Schedule 2 on the RDT did not tie to Schedule 3.</p>
	<p>We reviewed a sample of claims from the FFS data files submitted to verify control totals, verify eligibility, confirm the COS grouping was correct, and confirm the year reported was correct.</p>	<p>Control totals: No variance noted.                      Eligibility: Variance of 0.02% or \$810 of all sampled claims.                      COS Map: No variance noted.                      Service Year: No variance noted.</p>
<p>Sub-capitated Medical Expense</p>	<p>We requested overall sub-capitation supporting detail. We compared the support provided to the amounts reported in Schedule 3.</p>	<p>Variance: RDT Schedule 3 is understated by 122.80% or \$13,940,356.</p> <p>The variance was corrected in subsequent RDT submissions received after the conclusion of the rate setting process. The revised variance showed an overstatement of \$90,453, or 0.34%.</p>

Category	Description	Results
	<p>We sampled membership from 49 primary capitation rosters across 12 subcontractors, and 25 specialty capitation rosters across 2 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.</p>	<p>Eligibility:                      Variance: No variance on primary capitation rosters.                      Specialty capitation rosters resulted in 2,556 members, or 0.30% of sampled rosters ineligible for the months of service sampled. Access noted that most were due to retro-eligibility and that the contracts did not require/allow them to recoup for retro-active activity.                      FFS claims: No variance.</p>
	<p>We reviewed a sample of the contractual arrangements with Access’s sub-capitated providers and recalculated the total payment amounts by sub-capitated provider using roster information provided by Access. Access was unable to provide contractual validation of the Child Specialty Capitation rates paid to related party Access Dental Centers (the sole GMC Specialty Cap provider). However, Access provided an email dated November 2013 to support the roster rates. Per Access, the GMC Child rate changes in 2013 were communicated through emails, and were still effective in 2017.</p>	<p>No variance noted.</p>
	<p>We observed proof of payments for the sampled sub-capitated providers in the previous step.</p>	<p>No variance noted.</p>

Category	Description	Results
Provider Incentives	<p>We reviewed incentive arrangements and observed sample calculations for contractual compliance and reasonableness.</p> <p>Access paid a “Provider Bonus/Incentive” which was described as “a bonus the Plan pays to meet the medical loss ratio (MLR) requirement. Only providers of LAPHP program were eligible for the payments in 2017.”</p> <p>We received calculation support showing a loss ratio of 68% which was utilized to determine the actual CY2017 incentive payment amount of \$1,255,000. This amount is less than the amount reported in RDT Schedules 1.1-1.3 and Schedule 2 of \$1,333,777. However, Access did not provide validation of the incentive agreements. At least a portion of the amounts appear to be paid to related parties. In addition, they also did not provide support to show that the effective dates of such agreements were in place prior to the determination that the MLR ratio was not met. Therefore, considering the full amount reported in the RDT as a variance.</p>	<p>Variance: Schedule 1.1-1.3 of the RDT overstated by \$1,205,289 or 44.90% of reported incentive expense. This represents approximately 3.90% of total dental expense.</p>
Administrative Expenses	<p>We reviewed administrative expenses as a percentage of capitation and on a PMPM basis, taking into consideration the dynamics of the plan and the membership size when reviewing the results.</p>	<p>Access reported \$1.49 PMPM, or 12.87% of revenue and the average of all Medi-Cal Dental Managed Care Plans is \$2.01 PMPM and 17.43%. So, the results are within an expected and acceptable range.</p>
	<p>We compared detailed line items from the plan’s trial balance mapped to line items in Schedule 2a for reasonableness. We reviewed allocation methodologies and recalculated for reasonableness.</p>	<p>No variance noted.</p>
Other Information	<p>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.</p>	<p>No variance noted.</p>



Category	Description	Results
	<p>We compared reported expenses, including IBNR and administrative expenses, to audited financial statements for consistency.</p> <p>Audited financial statements were not by line of business and included Health Net as a whole, therefore no ability to segregate Medi-Cal only. However, internal financial statements were provided and reasonably compared to the reported RDT amounts.</p>	<p>No material variances noted.</p>

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## Summary of Findings

Please note that some of the issues noted in this summary section were partially corrected in a subsequent RDT submission. However, as the later RDT submissions were not received by DHCS in time for use in rate development, we have not considered those in the issues quantified below. Based on the procedures performed, the total amount of dental service expenditures in Schedule 3 were understated by \$12,005,552 or 38.84% of total dental expenditures in the CY 2017 RDT.

Based on the procedures performed, the total amount of administrative expenditures in the CY 2017 RDT showed no variance.

Based on the defined variance threshold, the results of the audit are determined to warrant the following recommendations for future RDT reporting by Access:

- The member month reporting process should be reviewed to ensure accurate reporting in the future.
- Access should align the COS mapping methodologies per the RDT instructions consistently across all relevant schedules of the RDT.
- Likewise, the total dental expenses should be equal across all RDT schedules.
- Schedules 1.1-1.3 and Schedule 2 - Reported \$0 of Prop 56 expenses for CY17, while Schedule 3 reported \$1.2M of Prop 56 expenses for CY2017. Per Access response "The 2017 Prop 56 claims were paid in 2018 so the Plan did not include the payment amount in the 2017 financial statement (i.e. Schedule 2)." Expenses reported in Schedule 2, and all RDT schedules, should be on an "incurred" basis and not reported based on a paid date basis.
- UM/QA/CC expenses were not included in Schedule 1.1 – 1.3. Per RDT instructions, these costs should be included and appropriately labeled in the total costs that flow to Schedules 1.1-1.3.
- Capitation expenses should be reported consistently across all schedules.
- Schedules 1.1-1.3 included "Supplemental Claims / IBNR Change" totaling \$1,880,496 in the initial submission. However, Schedule 3 lines 34 & 35 for IBNR reported \$0. Additionally, the reconciliation received between Schedule 2 and Schedule 3 indicated that the "Change in IBNR" for CY 2017 was only \$36,529. IBNR, and all amounts impacting multiple schedules, should be reported consistently across all relevant schedules.
- Access should have eligibility and provider payment (including sub-capitation) systems in place to effectively handle retro-eligibility changes.

Access has reviewed this report and had no comment.

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