MERCER

AUDITORS REPORT

CALENDAR YEAR 2017 HEALTH PLAN OF SAN JOAQUIN RATE DEVELOPMENT TEMPLATE

July 1, 2020

Contents

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) [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 Health Plan of San Joaquin (HPSJ). 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 Year 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 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)

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 RDT from HPSJ for the CY 2017. HPSJ's management is responsible for the content of the RDT and responded timely to all requests for information.

Table 1: Procedures

Category	Description	Results
Utilization and Cost Experience	We compared summarized total net cost data from amounts reported in Schedule 1 to Direct Medi-Cal category of service (COS) totals from Schedule 6a and to total incurred claims by COS for Schedule 7 for consistency.	Variance: 0.00%.
Global Subcontracted Payments	We reviewed the contractual arrangement with HPSJ's global subcontractor and tested the overall payments made to the global subcontractor by comparing results against amounts reported in Schedule 1A. HPSJ was in negotiations with Kaiser, their global subcontractor, during the time of their RDT submission and anticipated a reduction, and thus recorded global expenses accordingly.	Variance: RDT understated by 27.51%, or $6.3 million, when compared to support provided by HPSJ. This amount is 0.62% of Capitation revenue.
	We selected the three highest months of payment and five randomly selected additional months of payment to obtain membership rosters for each month selected, and verify payment.	Variance: RDT understated by 0.11%.
	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 HPSJ to see if claims were paid by both HPSJ and the global subcontractor.	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.	No CCI members on the rosters and no claims identified for CCI members.

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 understated by 0.02% in total.
Capitation Revenue	We discussed how capitation was recorded. HPSJ records capitation revenue on an accrual basis using eligibility from the 834 data multiplied by rates established on the most current rate sheet received from DHCS.	RDT overstated by 0.75% for revenue 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. We compared reported interest and investment income amounts to the amounts on Schedule 6a, Lines 5 and 11.	No variance observed.
Fee For Service Medical Expense	Using data files (paid claims files) provided by HPSJ, we sampled and tested transactions for each major COS (Inpatient, Outpatient, Physician, Pharmacy, Facility-Long Term Care (LTC), and All Others) and traced sample transactions through HPSJ 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 HPSJ 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 understated in total by 0.19%.
	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 categories of service.	Variance: RDT over/(understated): Inpatient (0.11%); LTC (0.30%); Outpatient 0.06%; Pharmacy 0.03%; Physician (1.72%); All Other 8.48%; In Total (0.01%).

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: Verified for all members selected. COS Map: No variance noted. Service Year: No variance noted.
Subcapitated Medical Expense	We compared reported subcapitation payments to amounts reported in Schedule 7.	Variance: RDT understated by 1.23%
	We sampled membership from three subcontractors, verified eligibility of members and analyzed claims to verify none of the FFS claims paid should have been paid by the subcapitated provider.	No variance noted.
	We reviewed subcontract agreements and verified rates for payment. We observed proof of payments for a sample of subcapitated provider payments.	Payment amounts were 0.08% less than the support provided for the subcapitated amounts.
Provider Incentive Arrangements.	We reviewed incentive arrangements and observed sample calculations for contractual compliance and reasonableness.	Variance: RDT overstated by 19.77%, or $2.0 million. This amount is only 0.002% of Capitation revenue, thus is considered immaterial.
Reinsurance	We recalculated reinsurance premiums to compare to reported amounts.	Variance: RDT is understated by 3.93%.
	We recalculated recoveries for a sample of members.	No variance noted.
Administrative Expenses	We benchmarked administrative expenses as a percentage of capitation across All Two-Plan and 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 5.50% and HPSJ reported 4.03%. Excluding the $1.8 million overstatement mentioned below, HPSJ administrative expenses are 3.86% of capitation.

Category	Description	Results
	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. There was an error in the formulas used to consolidate the trial balance information used in the RDT submission which double counted one line item.	Variance: RDT overstated by 4.39%, or $1.8 million, compared to trial balance.
Utilization Management, Quality Assurance Care Coordination (UM/QA/CC)	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 HPSJ management via interview that UM/QA/CC costs were not also included in general administrative expenses.	No variance noted.
	We compared UM/QA/CC costs as a percentage of revenue to benchmark for reasonableness.	The benchmark UM/QA/CC percentage was 1.23% and HPSJ reported 1.29%.
Pharmacy	We confirmed and observed pharmacy benefit manager fees were recorded as administrative expenses and not included in pharmacy claims expenses in the RDT.	Confirmed
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 internal financial statements for consistency.	No material variances reported.

Category	Description	Results
	We inquired how hospital-acquired conditions, or Provider Preventable Conditions (PPC), were treated in the RDT and policies for payment.	At HPSJ, hospital acquired conditions are identified by a review of clinical documentation by Prior Authorization, Concurrent Review, Case Management and Quality on a monthly basis. Once a condition has been identified as hospital acquired, a potential quality improvement (PQI) is completed and sent to the Quality Improvement department for further investigation. HPSJ does not withhold payment as their contracts do not support a withhold. Hospitals and physicians are required to report to DHCS and HPSJ.

3
Summary of Findings

Based on the procedures performed, the total amount of gross medical expenditures in the RDT were understated by $5,453,739 or 0.59% of total medical expenditures in the CY 2017 RDT.

Based on the procedures performed, the total amount of gross administrative expenditures in the RDT were overstated by $1,796,540 or 4.39% of total administrative expenditures in the CY 2017 RDT.

Based on the defined variance threshold, the results of the audit of medical expenditures are determined to be immaterial and do not warrant corrective action.

The result of the administrative expenditures audit is above the defined threshold, however was due to a formula error and thus does not warrant corrective action. However, HPSJ should consider enhanced peer review of information submitted as part of the RDT process to ensure accuracy.

HPSJ has reviewed this report and had no comments.

Mercer (US) Inc.
2325 East Camelback Road, Suite 600
Phoenix, AZ 85016
www.mercer-government.mercer.com