Mercer

Government Human Services Consulting

Calendar Years 2019 and 2020 Access Dental Plan Rate Development Template

Auditor's Report

California Department of Health Care Services

April 5, 2023

Contents

Section 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 Dental Managed Care Rate Development Template (RDT) for calendar year (CY) 2019 and CY 2020 by Access Dental Plan (ADP). 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 2019 and CY 2020 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 CY reported.

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

[1] 42 CFR 438.602(e)

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 Dental Managed Care RDT from ADP for CY 2019 and CY 2020. ADP'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	Mercer compared the total net cost by category of service (COS) from the "Fee-for-Service" and "Capitation" tables, for CY 2019 and CY 2020, in Schedules 1.1–1.3, to the appropriate COS on lines 6–11 of Schedule 2 for consistency.	No variance noted.
	Mercer compared the Proposition 56 Additional Payments from Schedule 1, for CY 2019 and CY 2020, to Total Prop. 56 Payments of Schedule 2 for consistency.	No variance noted.
Member Months	Mercer compared ADP 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.	Variance: CY 2019 RDT overstated by 1,296 or 0.04% in total. By category of aid, variances were overstated/(understated) as follows: • ACA Expansion (1.06%) • Non-ACA Child (0.41%) • Non-ACA Adult 4.19% CY 2020 RDT reported no variance in total. By

Category	Description	Results
		category of aid, variances were overstated/(understated) as follows: • ACA Expansion 0.15% • Non-ACA Child (0.33%) • Non-ACA Adult 0.44%
Capitation Revenue	Mercer/DHCS discussed how capitation was recorded. We compared the capitation revenue as reported on Schedule 2 to capitation paid to ADP as reported by DHCS.	No variance noted.
Fee-For-Service (FFS) Medical Expense	Mercer compared the summarized data from paid claims files provided by ADP by FFS and Proposition 56 and in total to the information reported Schedules 1.1–1.3. Per review of support provided, ADP did not include runout of $320,129 of both Dental FFS and Prop 56 expense, that accounts for the majority of the variance reported in CY 2020.	Variance: Combined FFS and Prop 56 for CY 2019 is understated by $(162,822) or (1.99%) or 0.21% of total dental services expense. Combined FFS and Prop 56 for CY 2020 is understated by $(415,625) or (9.05%) or 1.04% of total dental services expense.
	Using data files (paid claims files) provided by ADP, Mercer sampled and tested 80 transactions for all services and traced sample transactions through ADP's claims processing system, the payment remittance advice, and the bank statements. **Exceptions Noted** Complete review of paid claims files resulted in $807 of interest expense included across both reporting periods by using procedure code D9999-Unspecified	Variance: Interest payments were inappropriately included in FFS Claims data: • CY 2019: $426 • CY 2020: $381

Category	Description	Results
	adjunctive procedure. The total amount is not material; however, the interest expense should not be included in dental service expense. The amounts reported have been removed from testing and are included in the total variances reported below. Mercer was unable to verify two claims worth $230 out of the total claims sampled of $10,367, or 2.22%, due ADP being unable to provide claims images. This represents 0.0% of Total Dental Expense. The claims review uncovered multiple instances where National Provider Identifier (NPI) was not provided. ADP determined that most claims submitted via paper did not have blank NPI fields and a manual processing error occurred where NPI was not captured and recorded to the claims system. ADP has updated the process to ensure inclusion of NPI as a result of this finding. No additional testing was performed as payment was made based on provider name and the inclusion of NPI did not affect final payment.	
	Mercer reviewed the paid claims files submitted to verify control totals, verify eligibility, confirm the COS grouping was correct, and confirm the year reported was correct.	Control Totals: No variance. Eligibility: Variance of 0.06% or $7,221 of all claims from paid claims files submitted. COS Map: No variance. Service Year: No variance.
Sub-capitated Medical Expense	Mercer requested sub-capitation supporting detail. We compared the support provided to the amounts reported in Schedule 1.1–Schedule 1.3.	CY 2019: RDT Schedule 1.1–1.3 is understated by (0.31%) or ($77,274).

Category	Description	Results
		CY 2020: RDT Schedule 1.1–1.3 is overstated by 1.42% or $352,592.
	For CY 2019 Mercer sampled membership from 26 capitation rosters across 12 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. For CY 2020 we sampled membership from 25 capitation rosters across 11 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.	CY 2019 Eligibility: 0.36% of member months were ineligible which equates to approximately $8,593 of the sample, or 0.03% of total sub-capitated medical expense. FFS claims: No variance. CY 2020 Eligibility: 0.35% of member months were ineligible which equates to approximately $10,511 of the sample, or 0.04% of the sub-capitated medical expense. FFS claims: No variance.
	Mercer reviewed a sample of the contractual arrangements with ADP's sub-capitated providers and compared per member per month (PMPM) payment details per the contract with the payment amount using roster information provided by ADP.	CY 2019 The sampled rosters are overstated by 0.02% or $416. CY 2020 No Variance
	Mercer observed proof of payments for the sampled sub-capitated providers in the previous step.	No variance noted.
Provider Incentives	Mercer reviewed incentive arrangements and observed sample calculations for	Variance

Category	Description	Results
	contractual compliance and reasonableness. Provider Incentives were reported by ADP combined with “Supplemental Claims” on Schedule 2 under Total Aggregate Write-ins for Other Dental Expenses. For CY 2019, “Provider Incentives and Supplemental Claims” were reported as $6,413,810, which included $874,970 of supplemental claims. While not an overstatement of dental expense, the supplemental claims are removed from the amount reported on Schedule 2 to isolate Provider Incentive Expense. This leaves a net of provider incentive expense reported of $5,538,840. No supplemental claims were identified in the CY 2020 support for the same line item. The CY 2019 ADP reported provider incentives totaling $5,538,840 included $2,792,166 that does not meet the criteria for incentives. The majority of the incentive expense was assigned to a program that was ultimately determined to be based solely on a calculation to attain a medical loss ratio (MLR) of 82%. In addition, some incentive documentation provided was outdated and included payments when minimum incentive criteria was not met. In CY 2020, ADP reported $10,492,617 of Provider Incentives, of which $7,158,318 was an accrual for “Provider Bonus/Incentive”. This accrual has previously been referred to as “a bonus the Plan pays to meet the MLR requirement and is based off a calculation to meet MLR requirements to avoid remittance”. Based on other procedures	For CY 2019, Schedule 2 of the RDT is overstated by $2,792,166 or 50.41% of incentive expense. This represents approximately 7.13% of total dental expense. For CY 2020, Schedule 2 of the RDT is overstated by $7,651,443 or 72.92% of reported incentive expense. This represents approximately 19.08% of total dental expense.

Category	Description	Results
	performed on Access data, these amounts have been deemed not allowable for Medicaid reporting.	
Administrative Expenses	Mercer reviewed administrative expenses as a percentage of capitation and on a PMPM basis, taking into consideration the size of the plan's membership in comparison to other Medi-Cal dental plans.	For CY 2019 ADP reported $2.30 PMPM, or 13.77% of revenue. The average of all Medi-Cal Dental Managed Care Plans is $2.44 PMPM and 15.58%. This difference is deemed reasonable. For CY 2020 ADP reported $2.19 PMPM, or 13.97% of revenue. The average of all Medi-Cal Dental Managed Care Plans is $2.43 PMPM and 16.49%. This difference is deemed reasonable.
	Mercer 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.	No variance noted.
Other Information	Mercer reviewed the audited financial statements for the plan for the CY 2019 and CY 2020 for a clean audit opinion or identification of significant deficiencies or material weaknesses.	No issues noted.
	Mercer compared reported expenses, including incurred but not reported and administrative expenses, to audited financial statements for consistency.	No material variances noted.

Section 3

Summary of Findings

Based on the procedures performed, the total amount of dental service expenditures in Schedule 1.1–1.3 and Schedule 2 were overstated by $2,552,071 or 6.52% of total dental expenditures in CY 2019 and $7,588,410 or 18.92% of total dental expenditures in CY 2020.

Based on the procedures performed, the total amount of administrative expenditures in the CY 2019 and CY 2020 RDT showed no material variance and were determined to be reasonable.

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

- Incentive programs should be developed to motivate providers to provide members with quality care, improve health outcomes, and to encourage appropriate utilization. Providers should be made aware of the programs prior to the service period in which they may earn the incentive and be provided the criteria on which to earn the incentives, including how the incentive payment will be calculated. If the incentive criteria is not attained, incentive payments should not be made. If providers do meet the predetermined criteria, payment criteria should be followed as outlined in the program details. Documentation of programs, notification of providers, and any documentation to support payments made should be adequately maintained and updated as needed on a regular basis.
- Aggregate Write-Ins on Schedule 2 include items that should have been reported on other/additional schedules or should have been isolated for clearer reporting. For example:
  - ‘Specialty Capitation’ should be reported under ‘All Other Dental Services – Capitated’ on Schedule 2 and reported under “All Other Services Capitation’ and/or ‘Full Adult Restoration Capitation’ in Data Block 1/Schedule 1.
  - ‘Full Adult Restoration Fee for Service’ should be reported under ‘All Other Dental Services — Fee-For-Service’ on Schedule 2 and was properly reported on Schedule 1.1–1.3.
  - Incentives and supplemental claims should be reported separately on both Schedule 1.1–1.3 and Schedule 2.

ADP has reviewed this report and had no comments.

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