Mercer

Government Human Services Consulting

State Fiscal Year 2021 Health Plan of San Joaquin Mainstream Rate Development Template

Auditor's Report

California Department of Health Care Services

July 8, 2024

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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 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 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 the Table(s) of Section 2.

Section 2: Procedures and Results

Mercer has performed the procedures enumerated in the Table(s) 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 SFY 2021. HPSJ's management is responsible for the content of the RDT and has responded in a timely manner to all requests for information.

Table(s): 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: 0.91% of claim submissions with no matching eligibility totaling $8,465,176 or 0.79% of total medical expense and is included in the variance noted below. • COS Map: Review of all COS showed 97% or higher match for all COS other than LTC COS, which shows 80% match. HPSJ agrees that approximately 17% (226 claims) of the mismatch should be mapped to Inpatient COS rather than LTC COS. Per HPSJ, the mismatch was caused by a system configuration error and has been corrected. • 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	Variance: RDT FFS Expenses are over/(understated) as compared to the support provided: • Inpatient 2.43% • LTC (2.15)% • Outpatient (2.49)% • Physician 0.95% • All Other (0.94%) In Total 0.61%, or $4,562,467 which is 0.42% of total medical expense.

Fee-For-Service (FFS) Medical Expense	
Description of Procedures	**Results**
paid claims data as provided by the MCO.	Per HPSJ, the variance for Inpatient COS was due to adjustments made after the RDT submission. The adjustments affected FFS paid claims as of September 2021 which resulted in full reversal or revised paid amounts, offset by an overstatement of IBNR. Per HPSJ, the variances for LTC and Outpatient shown above are due to underestimating of IBNR. LTC and Outpatient FFS expenses were underestimated mainly due to the increase in utilization of emergency room visits, the increase in cost of dialysis treatment and increase in number of oncology injections not expected or known at the time of RDT submission.
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 understated by 1.93%, or $770,491. The total of the detail provided was greater than the amounts reported in the RDT.
Mercer reviewed the contractual arrangement with the MCO's global subcontractor(s) and recalculated the total	Variance: Detailed support for global capitation expense is overstated by 0.04%, or $15,193. The recalculated amounts were

Global Subcontracted Payments	
Description of Procedures	**Results**
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.	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.	No variance noted. The proof of payment information validated the supporting detail provided for the sampled global capitated providers.
Mercer obtained roster information for the globally subcontracted providers and verified eligibility of members, confirmed enrollment with HPSJ, and analyzed claims to verify none of the FFS Claims paid should have been paid under the global arrangement.	Eligibility was verified for 99.96% of members. The amount of global capitation paid for the ineligible members is $11,458 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.	The average global PMPM is 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 to determine the level of administrative functions included. See Appendix A for details. HPSJ identified 6.50%, or $2,595,614, of the global capitation expense as administrative in the Schedule 1-A Data tab in the RDT. The

Global Subcontracted Payments	
Description of Procedures	**Results**
	amount is considered to be within an acceptable range for industry standards. The administrative component was not removed from medical expense. Therefore, this is an understatement of administrative expenses and an equal overstatement of medical expenses.
Mercer reviewed members included on the member roster to ensure there were no Coordinated Care Initiative (CCI) members or payments provided in the steps above.	Not applicable. HPSJ does not have CCI members.

Sub-Capitated Medical Expense	
Description of Procedures	**Results**
Mercer requested overall non-global sub-capitation supporting detail. Mercer compared the support provided to the amounts reported in Schedule 7.	Variance: RDT Sub-Capitated Medical Expense is understated by 4.89% or $2,672,547. The total of the detailed provided was more than the amounts reported in the RDT. However, when comparing to Schedule 1, the variance is 0.18% or $102,006. The reason for the difference between Schedule 1 and Schedule 7 is explained in the Utilization & Cost Experience section.
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 0.29% or $18,308. 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	No variance noted. The proof of payment information

Sub-Capitated Medical Expense	
Description of Procedures	**Results**
institution support for the sampled sub-capitated provider payments in the previous step.	validated 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 99.87% of members. The amount of non-global sub-capitation paid for the ineligible members is $11,255 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.	Confirmed reduced rates as compared to the non-Full Dual COA groups.
For sub-capitated arrangements accounting for 5% or more of total medical expense, Mercer reviewed the sampled sub-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.	HPSJ did not have any sub-capitated arrangements that exceeded the 5% or more of total medical expense threshold.

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 overstated by 0.39%, or $3,184,415, when compared to Schedule 7. The overstatement is due to the change in CY2020 amounts reported for Settlements and IBNR in the 1H CY2021 CA RDT submission.

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 understated by 0.14% 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 1.	Variance: RDT Provider Incentive Expense is overstated by 21.96%, or $1,433,912. Variance is due to differences between estimated and actual expenses and represents 0.13% of total medical expense.
From the listing of provider incentive payments, Mercer sampled the highest two payment amounts and one random payment. Mercer observed proof of payments for the sampled provider incentive payments.	No variance noted. The proof of payment information validated the supporting detail provided for the sampled provider incentive payments.
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.	No variance noted. The proof of payment information validated the supporting detail provided for the sampled related party provider incentive payments.
If related party provider incentive payments were noted, Mercer reviewed the incentive terms to determine whether the terms align with similar arrangements	Related party provider incentive payments were noted and arrangements are in alignment with non-related parties.

Provider Incentive Arrangements	
Description of Procedures	**Results**
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.	Variance: Reported reinsurance is overstated by 147.35%, or $15,372,810. This amount is 1.44% of total medical expenses. Per HPSJ, the variance is due to underestimated reinsurance recovery amounts reported in the RDT as compared to actual recoveries received.
Mercer recalculated reinsurance premiums, based on SFY 2021 membership as of July 2022, to compare to reported amounts.	Variance: RDT was understated by 0.04% or $5,068.
Mercer recalculated recoveries for a sample of five members.	No variance noted.
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 recoveries reported based on review of the reinsurance threshold.

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.	Variance: RDT Settlements are overstated by 4.09% or $665,682. This amount is 0.06% of total medical expenses. The reported amount is a combination of actual and estimated Settlements and is reported appropriately on Schedule 7.
If settlement amounts are material Mercer requested supporting documentation and performed the following procedures.	Not applicable, immaterial.

Third-Party Liability (TPL)	
Description of Procedures	**Results**
Mercer reviewed information submitted by the MCO as 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, HPSJ 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 administrative percentage reported by HPSJ was within an acceptable range as compared to industry standards.
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.	RDT reported Administrative Expense is overstated by 0.82%, or $448,552 or 0.04% of Net Revenue.

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.	HPSJ 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.	Related party agreements for medical services were provided. The agreements were reviewed and appear reasonable when compared to non-related party agreements.
When applicable, Mercer obtained related party corporate allocation methodologies for administrative services. Where significant, Mercer reviewed the amounts for reasonableness.	Not applicable. No corporate allocations present.

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 UM/QA/CC percentage reported by HPSJ was within an acceptable range as compared to industry standards.
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.	No variance noted.
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 0.07%, or $1,192,337.

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.

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.	HPSJ received 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.	HPSJ provided the written policy for the identification and recovery of overpayments. Based on a review of that policy, HPSJ is appropriately excluding any provider overpayments from 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 $1,192,337 or 0.07%.

Based on the procedures performed, the total amount of gross medical expenditures in the RDT was overstated by $19,708,936, or 1.84% of total medical expenditures in the SFY 2021 RDT.

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

Based on the procedures performed, administrative expenditures in the SFY 2021 RDT were overstated by $448,552, or 0.82%. The resulting variance of the administrative expenditures testing is considered immaterial and corrective action is not warranted. In addition, the plan should be properly recording a portion of their global and provider sub-capitation expense as administrative, thus reducing their medical expense.

HPSJ reviewed and accepted this report.

Appendix A: Administrative Duties in Sub-contracted 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 Re-Credentialing	X

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