MERCER

AUDITORS REPORT

CALENDAR YEAR 2017 L.A. CARE RATE DEVELOPMENT TEMPLATE

August 11, 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). 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 L.A. Care (LAC). 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 RDTs 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 years' 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.

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 LAC for the CY 2017. LAC's management is responsible for the content of the RDT. During the course of the procedures, Mercer encountered numerous challenges with the responsiveness of LAC to inquiries, requests for supporting information, and/or with the accuracy of the information provided. While the overall variance results appear minimal, the detail provided in Table 1 below exemplifies the individual differences, many of which are considered significant from a rate setting perspective.

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. *Plan Response: This was stated in the RDT that the IHSS claims are not included in Schedule 7. DHCS has the payment information for these claims as L.A. Care does not adjudicate nor pay IHSS claims directly.*	No variance between Schedule 6a and Schedule 1. Schedule 7 did not include data from In-Home Support Services (IHSS) in the amount of $401,921,840, thus did not agree to Schedule 6a or Schedule 1 by 12.26%.
Global Subcontracted Payments	We reviewed the contractual arrangement with LAC's global subcontractors and tested the overall payments made to the global subcontractors by comparing results against amounts reported in Schedule 1A.	RDT overstated by 0.06%, or $1,295,795.
	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 LAC to see if both LAC and the global subcontractor paid claims. 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 variance noted.

Category	Description	Results
	We selected the three highest months of payment and five randomly selected additional months of payment and traced payments to proof of cash disbursement. RDT reported amounts are based on estimates for the incurred month of service. Payments are estimated using a rolling 12-month average of eligibility. We confirmed the tested payments did not include any pass-through or directed payments.	Actual payments exceeded sampled amounts by 2.47%, or $20,668,025.
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.	RDT overstated by 0.04%.
Capitation Revenue	We discussed how capitation was recorded. LAC records capitation revenue on an incurred basis using eligibility from the current month membership file multiplied by rates established on the most current rate sheet received from DHCS, including retroactivity.	RDT understated by 0.48% based on estimated revenue calculation using the known capitation rates in place during 2017.
Interest and Investment Income	We analyzed the interest and investment income and the amount allocated to the Medi-Cal line of business as reported in the RDT. LAC did not allocate any investment income to the Medi-Cal line of business. We expect investment income to be allocated to Medi-Cal using a predefined, consistent allocation method. Mercer estimated the allocation percentage to be 88% based on the allocation methodology used for administrative costs. *Plan Response: Confirmed.*	Variance: RDT understated by 100% or $17.3 million.
Fee For Service (FFS) Medical Expense	Using data files (paid claims files) provided by LAC, we sampled and tested transactions for each major COS (Inpatient, Outpatient, Physician, Pharmacy, Facility-LTC, and All Others) and traced sample transactions through LAC's claims processing system, the payment remittance advice, and to the bank statements. One claim was found to be incorrect in LAC's data warehouse and did not tie to the claims system due to a change in systems (from MHC to QNXT). Remittance for two claims categorized as "Other" were not found in LAC systems and not traceable to actual payments. Due to the preliminary findings, a second sample of claims were tested with no issues. *Plan Response: Two claims were IHSS claims. Claim Image, RA, and Proof of Payment are not available.*	3 variances identified out of 60 sampled claims.

Category	Description	Results
	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 LAC and compared the information reported in schedule 7 for paid claims. While interviewing LAC staff, Mercer identified that interest and penalty expense paid on the late payment of claims was included in paid claims total. Interest on the late payment of claims should be classified as administrative expense and not medical expense. Additionally, coordination of benefit (COB) recoveries by a subcontractor were not applied to paid claims or run through LAC's claims processing system. *Plan Response: Confirmed.*	Variance: RDT overstated by 0.46%, or $8,189,135 of total FFS claims payments reported in Schedule 7. Included in the variance is $1,873,403 in interest and penalties and $6,222,327 in COB recoveries.
	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. The COS definitions used to create the FFS claim files did not align with the COS mapping in schedule 7 which caused significant variances by COS, but only a 2.39% variance in total for incurred claims, including interest and penalties on late payment of claims. *Plan Response: For reporting claims in Schedule 1, we use the category of service logic provided in the RDT. In Schedule 7, the claims are rolled up into larger groups, The groupings utilized in Schedule 7 are more consistent with the groupings used for IBNR development for L.A. Care's financial statements.*	Variance: RDT over/(understated) by: Inpatient 6.65%, Outpatient 46.13%, LTC 3.06%, Physician (100.00%), Pharmacy 0.08%, All Other (31876.95)%, In Total 2.39%, or $44,484,926.
	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. The supporting documentation provided by LAC validated sample claims and the components being tested. However, the overall COS mapping of the entire major COS files did not support the way the claims were represented in the RDT, specifically Schedule 7.	No variance noted, however see note in previous test regarding the COS mapping issue.
Sub-capitated Medical Expense	We compared reported sub-capitation payments to amounts reported in schedule 7.	Variance: RDT Schedule 7 is overstated by 0.50%, or $5,171,238.

Category	Description	Results
	We sampled membership from two sub-capitated providers on site and verified eligibility of members for the month of payment. In addition, we analyzed claims to verify none of the FFS claims paid should have been paid by the sub-capitated provider.	No variance noted.
	We reviewed subcontract agreements and recalculated payment amounts for reasonableness.	No variance noted.
	We requested proof of payments for a sample of sub-capitated provider payments.	Variance: RDT overstated by 0.26%, or $162,411 based on proof of payment.
Provider Incentive Arrangements	We reviewed incentive arrangements and observed sample calculations for contractual compliance and reasonableness. *Plan Response: The variances between the RDT reported amounts and the amounts in this file for all 3 types of incentives are due to timing. The amounts in the RDT reflected estimated preliminary amounts. The amounts provided in this file reflect final amounts.*	Variance: RDT Overstated by $1,336,134, or 4.51%.
Reinsurance	We compared detailed reinsurance net of recoveries against reported amounts in schedule 6a by calculating the total paid for premiums and subtracting recoveries. The amount reported on schedule 6a ties only to the recoveries and does not appear to subtract premiums. LAC reported the reinsurance premiums as UM/QA/CC.	RDT understated by 79.88%, or $565,126.
	We recalculated reinsurance premiums from rates identified in the reinsurance contract to compare to reported amounts. The projected reinsurance premium calculated by Mercer is $565,126, but the amount reported in the RDT was $401,394 as stated above.	RDT understated by 40.79%, or $163,732
	We recalculated recoveries for a sample of members and compared to actual recoveries received.	No variance noted.
Administrative Expenses	We benchmarked administrative expenses as a percentage of capitation for all Two-Plan and GMC plans and compared to the amount reported in schedule 6a. We compared detailed line items from the plan's trial balance mapped to line items in 6a.	The benchmark administrative percentage was 5.5% and LAC reported 5.0%. LAC is one of the largest Two-Plan/GMC plans. Variance: RDT overstated by 0.07%.

Category	Description	Results
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. We compared UM/QA/CC costs as a percentage of revenue to benchmarks for reasonableness. We confirmed with LAC management via interview that UM/QA/CC costs were not also included in general administrative expenses. However, we identified reinsurance premiums improperly classified as UM/QA/CC.	Benchmark costs were 1.23% of revenue and LAC reported 0.33%. RDT Overstated by 2.30% or $401,394 for this line item. Amount should be included in Reinsurance Net of Recovery, line 37 of Schedule 6a.
Pharmacy	We confirmed and observed pharmacy benefit manager fees were recorded as administrative expenses and not included in pharmacy claims expenses.	No variance noted.
Other Information	We reviewed 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. LAC provided detail regarding reconciling items regarding variances between Generally Accepted Accounting Principles and RDT instructions.	Variances between the audited financial statements and the RDT are consistent with variances noted in other tests.
	We inquired how hospital-acquired conditions (HACs) were treated in the RDT and policies for payment.	LAC uses claims software that will not include diagnoses in the APR-DRG calculation if the “present on admission” flag is not “yes”. Additionally, claims audit staff review claims with diagnosis codes that are hospital acquired conditions where the POA flag is either “no” or missing. Therefore, no costs for HACs are included in the RDT expense reporting.

3 Summary of Findings

Based on the procedures performed, the total amount of gross medical expenditures in the RDT were overstated by $52,124,361 or 0.92% 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 understated by $1,675,669, or -0.56% of total administrative expenditures in the CY 2017 RDT.

As mentioned previously, the overall variance results appear minimal. However, the individual differences exemplify the reporting challenges encountered during this review. Many of the individual resulting variances are considered significant from a rate setting perspective.

It also should be noted that LAC had significant challenges in providing the payment validation for both sampled global capitation and sub-capitation payments made to relevant contractors. LAC identified that CCI was included in the initial cash disbursement support file.

Based on the defined variance threshold, the overall results of the audit are determined to be immaterial and do not warrant corrective action. However, Mercer recommends the following corrective actions to increase the validity of targeted LAC RDT reporting:

- LAC 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.
- LAC should report reinsurance premiums in Schedule 6a, line 37: Reinsurance Net of Recovery instead of Schedule 1-U, line 12.
- LAC should remove interest and penalties from medical expenses from claims reported in Schedule 7 and adjust claims expenses for COB recoveries.
- LAC should adhere to category of service mapping specifications for RDT reporting for consistency.
- LAC should allocate and report investment income to the Medi-Cal line of business and report in Schedule 6a, line 5 and line 11.
- LAC should review payment terms with global subcontracted vendors to avoid overpayments and unproductive use of cash.

LAC has reviewed this report and had no comments.

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