MERCER

AUDITORS REPORT

CALENDAR YEAR 2017 ANTHEM BLUE CROSS RATE DEVELOPMENT TEMPLATE

August 5, 2020

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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 Anthem Blue Cross (ABC). 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 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.

[1] 42 CFR 438.602(e)

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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 ABC for the CY 2017. ABC'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.	No variance noted.
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 overstated by 0.10% in total.
Capitation Revenue	We discussed how capitation was recorded. ABC 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 understated by 0.71% 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 and information regarding how the income provided in Schedule 6a was allocated to the Medi-Cal line of business.	No material variance noted.
Fee For Service Medical Expense	Using data files (paid claims files) provided by ABC, we sampled and tested transactions for each major category of service (COS) (Inpatient, Outpatient, Physician, Pharmacy, Facility-Long Term Care (LTC), and All Others) and traced sample transactions through ABC claims processing system, the payment remittance advice, and the bank statements.	No variance observed.

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 ABC 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 0.53% or $7,654,785.
	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.	Variance: RDT over/(understated): Inpatient 1.49%; Outpatient 3.41%; LTC 1.62%; Physician 1.11%; Pharmacy 0.00%; All Other 1.90%; In Total 1.34%.
	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.
Sub-capitated Medical Expense	We requested overall sub-capitation supporting detail. We compared the support provided to the amounts reported in Schedule 7. The total of the detail provided was greater than what is reported in the RDT.	Variance: RDT reported sub-capitated amounts are understated by 0.16% or $658,864.This amount is 0.03% of total medical expenses.
	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 sub-capitated provider.	No variance noted.
	We reviewed a sample of the contractual arrangements with ABC's sub-capitated providers and recalculated the total payment amounts by sub-capitated provider using roster information provided by ABC. The recalculated amounts were less than the sub-capitation amount reported in the supporting detail provided.	Variance: Detailed support for sub-capitated amounts is overstated by 0.84% or 140,478. This amount is 0.01% of total medical expenses. The net impact of the two sub-capitation variances noted in this section is an overstatement of 0.03% of total medical expenses.

Category	Description	Results
	We observed proof of payments for the sampled sub-capitated providers in the previous step.	No variance noted.
Provider Incentive Arrangements	We reviewed incentive arrangements and observed sample calculations for contractual compliance and reasonableness.	Variance: RDT is understated by 0.14% or $15,373.
Administrative Expenses	We benchmarked administrative expenses as a percentage of capitation across all Two-Plan/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 ABC reported 5.47%.
	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.	Variance: RDT is understated by 1.23% or $1,592,880.
Utilization Management, Quality Assurance, Care Coordination (UM/QA/CC)	We compared UM/QA/CC costs as a percentage of net revenue across all Two-Plan/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 1.23% and ABC reported 2.08%.
	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 ABC management via interview that UM/QA/CC costs were not also included in general administrative expenses. However, the support provided by ABC was less than the amount reported in the RDT Schedule 1-U.	Variance: RDT is understated by 2.17% or $1,068,392.
Pharmacy	We confirmed and observed pharmacy benefit manager fees were recorded as administrative expenses and not included in pharmacy claims expenses in the RDT.	No variance noted.
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 audited financial statements for consistency.	No material variances noted.

Category	Description	Results
	We inquired how hospital-acquired conditions (HACs) were treated in the RDT and policies for payment.	ABC screens for HACs by looking at all claims with diagnosis codes related to provider preventable conditions (PPCs). The compliance department reports these claims to DHCS via the online portal. Payment may or may not be impacted by the presence of the provider preventable condition diagnosis codes, depending on the specifics of the claim and contractual arrangement with the provider. If ABC was required to pay claims based on contracted terms, claims costs will be included in the RDT. For future reporting, ABC should exclude the cost of claims paid where PPCs existed for HACs, regardless of contractual terms.

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Summary of Findings

Based on the procedures performed, the total amount of gross medical expenditures in the RDT were overstated by $18,377,717 or 0.93% of total medical expenditures in the CY 2017 RDT.

Based on the procedures performed, administrative expenditures in the CY 2017 RDT were understated by $1,592,880 or 1.23%.

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

ABC reviewed this report and had no comments.

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