MERCER

AUDITORS REPORT

CALENDAR YEAR 2017 CENTRAL CALIFORNIA ALLIANCE FOR HEALTH RATE DEVELOPMENT TEMPLATE

June 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 the Central California Alliance for Health (CCAH). 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 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 CCAH for CY 2017. CCAH'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.
Global Subcontracted Payments	We requested the information related to a contractual arrangement with a global subcontractor including the overall payments made to the global subcontractor to compare results against amounts reported in Schedule 1A.	CCAH confirmed no global subcontract arrangements.
Member Months	We compared MCO reported member months (MMs) from Schedule 1C to eligibility and enrollment information provided by the State. Our procedures are to request explanations for any MMs with greater than 1% variance in total or greater than 2% variance by major category of aid.	Variance: RDT overstated by 0.05% in total.
Capitation Revenue	We tested for reasonableness by using eligibility from the 834 data multiplied by rates established on the most current rate sheet received from DHCS.	RDT understated by 2.80% for revenue based on rates times MMs.
Interest and Investment Income	No interest and investment income was reported in the RDT. CCAH confirmed both were unintentionally omitted. The schedule and the allocation method provided by CCAH was used for testing.	Variance: RDT understated by 100.00%.
Fee For Service Medical Expense	Using data files (paid claims files) provided by CCAH, 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 CCAH 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 CCAH 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 overstated by 2.12%
	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 3.78%; LTC 0.61%; Outpatient (0.67)%; Pharmacy (0.06%; Physician (0.02)%; All Other 1.08%; In Total 1.25%.
	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 0.02%
	We sampled membership from thirteen subcontractors, verified eligibility of members and analyzed claims to verify none of the fee-for-service claims paid should have been paid by the subcapitated provider.	No variance noted.
	We reviewed subcontract agreements and recalculated payment amounts for reasonableness.	Variance: Capitation payments are overstated by 0.79% when compared to provider roster detail.
	We observed proof of payments for a sample of subcapitated provider payments.	No variance noted.

Category	Description	Results
Provider Incentive Arrangements	We reviewed incentive arrangements and observed sample calculations for contractual compliance and reasonableness.	Variance: RDT overstated by 0.69%.
Reinsurance	We requested the information related to Reinsurance Net of Recovery, including the detail of the reinsurance premium expense and a summarized list of reinsurance cases to compare results against amounts reported in Schedule 6a.	Variance: RDT is overstated by 132.24%. Reinsurance claims submitted before the deadline were paid after the submission of the RDT. The variance is not material to net revenue.
	We recalculated reinsurance premiums to compare to reported amounts.	Variance: Premium is understated by 3.58%
	We recalculated recoveries of reinsurance cases exceeding the reinsurance threshold for a sample of members.	No variance noted.
Administrative Expenses	We benchmarked administrative expenses as a percentage of capitation across all county organized health system plans and compared them 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 4.38% and CCAH reported 7.30%. Variance is largely due to erroneous reporting of two expense items in the RDT administrative line items.
	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 overstated by 2.95% compared to trial balance. Variance is largely due to erroneous reporting of two expense items in the RDT administrative line items.

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 benchmark for reasonableness. Confirmed with CCAH management via interview that UM/QA/CC costs were not also included in general administrative expenses.	No variance noted.
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 reported with the exception of Administrative Expenses, which were overstated by 2.95%. Variance is largely due to erroneous reporting of two expense items in the RDT administrative line items.

Category	Description	Results
	We inquired how hospital-acquired conditions were treated in the RDT and policies for payment.	Once CCAH is notified that a Medi-Cal member has developed a Provider Preventable Condition (PPC), CCAH staff within Quality Improvement will log the PPC event into the Quality Management/Potential Quality Issue (PQI)/PPC database, then validate that the enrollee is a Medi-Cal member during the time of service that the PPC event meets criteria. Within five working days of the discovery of the event, Quality Improvement submits a form and 7107 to the DHCS Audits and Investigations unit and notifies the PQI to the CQIW and Clinical Quality Improvement Collaborative. Claims related PPC events are marked as do not pay. If claims have already been paid, then claims department notifies in-house recoveries and overpayments for the PPC event would be recovered. Therefore, no expenses related to PPA events are included in the RDT reporting.

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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 $13,082,301 or 1.28% 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 $2,301,608, or 2.95% of total administrative expenditures in the CY 2017 RDT.

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

CCAH has reviewed this report and had no comments.

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