MERCER

AUDITORS REPORT

CALENDAR YEAR 2017 COMMUNITY HEALTH GROUP RATE DEVELOPMENT TEMPLATE

April 7, 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 Community Health Group (CHG). 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 on Schedules 6a and 6b 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.

[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 CHG for the CY 2017. CHG'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.	0% Variance.
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 categories of service with greater than 1% variance in total or greater than 2% variance by 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 3.03% for revenue based on rates times member months.
Interest and Investment Income	We analyzed the interest and investment income schedule and the amount allocated to the Medi-Cal line of business as reported in the RDT. CHG 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.	Variance: 100% understated by $0.5 million. RDT contained no allocation for investment income to the Medi-Cal line of business.
Fee For Service (FFS) Medical Expense	Using data files (paid claims files) provided by CHG, we sampled and tested transactions for each major COS (Inpatient, Outpatient, Physician, Pharmacy, Facility-LTC, and All Others) and traced sample transactions through CHG's claims processing system, the payment remittance advice, and to 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 CHG 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. However, we identified $75 million overstated variance in Physician and Other paid claims. The overstatement in the RDT was due to the inclusion of subcapitated provider payments each month. We instructed CHG staff to move the subcapitation payments out of the paid claims section of Schedule 7 down to Subcapitation on line 36.	Variance: $75,042,215. RDT overstated by 9.82% in paid claims due to misclassification of subcapitation expenses. After correcting for the subcapitation, misclassification, the RDT was understated by 0.01%.
	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. Excluding the effect of sub-capitated physician and other expenses, the RDT was overstated by $5,111,990.	Variance: RDT over/(understated) by Inpatient: 4.31% Outpatient (4.55%) LTC 0.49%; Physician (0.57%); Pharmacy 1.17%; All Other 0.03%; In Total 0.73%.
	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. Related to the issue noted in one of the procedures above, we did identify a significant understatement of $75,139,884. The understatement was due to the inclusion of sub-capitated provider payments each month within FFS line 35 total paid claims. We instructed CHG staff to move the subcapitation payments out of the paid claims section line 35 of Schedule 7 down to Subcapitation on line 36.	Variance: $75,139,884 understated in subcapitation due to misclassification in paid claims. After correcting for the subcapitation misclassification there was no variance.

Category	Description	Results
	We sampled membership from two subcapitated 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 subcapitated provider. One member was found to have been ineligible in the month in which subcapitation was paid. A larger sample was taken and found to contain no additional ineligible members.	Variance: 1 ineligible member. 1.69% overstated.
	We reviewed subcontract agreements and payment amounts. We observed proof of payments for a sample of sub-capitated provider payments. We compared these amounts to the reported amounts in schedule 1.	Variance: Subcapitated amounts understated by 0.01%.
Reinsurance	We compared detailed reinsurance net of recoveries against reported amounts in schedule 6a by calculating the total paid for premiums and subtracting recoveries.	Variance: Net reinsurance costs in RDT overstated by 46.46%, or $1,949,628.
	We recalculated reinsurance premiums to compare to reported amounts.	Premiums calculated were equal to premiums reported.
	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 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. CHG reported a change in the allocation methodology in which the entirety of administrative expense is allocated based on time studies by department, which resulted in a lower allocation to administrative expenses to Medi-Cal business. We reviewed allocation methodologies and recalculated for reasonableness.	The benchmark administrative percentage was 5.5% and CHG reported 2.7%. Variance: RDT overstated by 17.01% compared to trial balance, or $4,195,726 due to change in allocation method.

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 CHG management via interview that UM/QA/CC costs were not also included in general administrative expenses. CHG reported a change in allocation methodologies based on time studies by department resulting in an overstatement.	Variance: RDT overstated by 1.87%, or $265,611. Benchmark costs were 1.23% of revenue vs. 1.53% reported.
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 all 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. CHG 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.	CHG identifies HACs through selected diagnosis codes. Using a grouper, DRGs exclude the select diagnosis codes and reduces payment accordingly.

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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 $7,329,528, or 0.93% 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 $4,195,726, or 3.53% 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 beyond the revised data already provided.

CHG has reviewed this report and had no comments.

Mercer (US) Inc.
2325 East Camelback Road, Suite 600
Phoenix, AZ 85016
www.mercer-government.mercer.com