MERCER

AUDITORS REPORT

Calendar Year 2017 Contra Costa Health Plan Rate Development Template

May 20, 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 Contra Costa Health Plan (CCHP). 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 2019-2020 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 CCHP for the CY 2017. CCHP'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 observed.
Global Subcontracted Payments	We reviewed the contractual arrangement with CCHP's global subcontractor and tested the overall payments made to the global subcontractor by comparing results against amounts reported in Schedule 1A.	Variance: RDT overstated by 9.30%.
	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 CCHP to see if claims were paid by both CCHP and the global subcontractor.	No FFS claims paid. All sampled members eligible.
	We reviewed members included on the member roster to ensure there were no Coordinated Care Initiative members or payments provided in the step above.	None identified.
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 group.	Variance: RDT understated by 0.03% in total.

Category	Description	Results
Capitation Revenue	We discussed how capitation was recorded. CCHP records capitation revenue on the latest known capitation rate received from DHCS multiplied by enrollment.	RDT overstated by 0.26% for revenue based on estimated revenue calculation using the known capitation rates in place during 2017.
Interest and Investment Income	No interest and investment income was reported in the RDT. This was confirmed with CCHP. Mercer therefore utilized the same allocation methodology as presented in the County of Contra Costa Comprehensive Annual Financial Report for FY2017.	Variance: RDT understated by 100.00%.
Fee For Service Medical Expense	Using data files (paid claims files) provided by CCHP, 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 CCHP claims processing system, the payment remittance advice, and the bank statements.	No variance observed.
	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 CCHP 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 0.16%.
	We compared total final incurred amounts including incurred but not reported estimates from Schedule 7 to total paid amounts from all months reported in the data files to verify the accuracy/reasonableness of Incurred But Not Reported (IBNR) for each COS. Allowable absolute value variances were deemed to be not greater than 2% for inpatient claims and 1% for all other categories of service	Variance: RDT over/(understated): Inpatient 0.77%; LTC 0.27%; Outpatient (0.34%); Pharmacy 0.02%; Physician (0.59%); All Other 0.68%; In Total 0.28 %.
	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	CCHP does not have sub-capitated relationships. No testing performed.	N/A.

Category	Description	Results
Provider Incentive Arrangements.	We reviewed incentive arrangements and observed sample calculations for contractual compliance and reasonableness.	No variance observed.
Reinsurance	CCHP does not have reinsurance, but leverages the support of the County funds as needed.	N/A.
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 CCHP reported 3.40%.
	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 reviewed for reasonableness.	Variance: RDT understated by 0.11% compared to trial balance.
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. Confirmed with CCH management via interview that UM/QA/CC costs were not also included in general administrative expenses.	No significant variance noted.
	We compared UM/QA/CC costs as a percentage of revenue to benchmarks for reasonableness.	The benchmark UM/QA/CC percentage was 1.23% and CCHP reported 0.85%.
Pharmacy	We confirmed and observed pharmacy benefit manager fees were recorded as administrative expenses and not included in pharmacy claims expenses in the RDT.	Confirmed.
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.	Confirmed.
	We compared reported expenses, including IBNR and administrative expenses, to internal financial statements for consistency.	No material variances noted.

Category	Description	Results
	We inquired how hospital-acquired conditions were treated in the RDT and policies for payment.	Per CCHP, for Provider Preventable Conditions (PPC), hospitals send the health plan a copy of the form filled out online with DHCS. The Plan Quality Management (QM) Unit monitors likely PPCs through a report using claims information. When an event cannot be matched with a form received, QM follows up with the facility to determine if it is a PPC. If determined a PPC, the facility will provide a copy of the form submitted to DHCS. The plan pays for the treatment of these conditions. Expenditures for these conditions are not segregated and are reported in the Inpatient Facility COS in the CY 2017 RDT.

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Summary of Findings

Based on the procedures performed, the total amount of gross medical expenditures were overstated by $9,417,770 or 1.62% of total medical expenditures in the CY 2017 RDT.

Based on the procedures performed, the total amount of gross administrative expenditures were understated by $23,412, or 0.11% 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.

CCHP has reviewed this report and had no comments.

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