Mercer

Government Human Services Consulting

State Fiscal Year 2021 Community Health Group Coordinated Care Initiative Rate Development Template

Auditor's Report

California Department of Health Care Services

July 3, 2024

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Contents

Section 1: Introduction

Pursuant to federal requirements under Title 42 of the Code of Federal Regulations 438.602(e), the State of 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), part of Mercer Health & Benefits LLC, to fulfill this requirement for the financial data submitted in the Medi-Cal rate development template (RDT) for state fiscal year (SFY) 2021 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 calendar year 2023 rating period. The RDT tested was the final version, including any revisions stemming from resubmissions as a result of the RDT Question and Answer discussion guide process with the MCO.

The key schedules subject to testing from the RDT include, but were not limited to:

- Schedule 1.1–1.3 — Utilization and Cost Experience
- Schedule 1-A — Global Subcontracted Health Plan Information
- Schedule 1-C — Base Period Enrollment by Month
- Schedule 1.1U–1.3U — UM/QA/CC
- Schedule 5 — Large Claims Report
- Schedules 6.1a-b and 6.2.3a-b — Financial Reports
- Schedule 7.1–7.3 — Lag Payment Information

The data collected in the RDT is reported on a modified accrual (incurred) basis for SFY 2021 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 SFY reported.

The procedures and results of the test work are enumerated in the Table(s) of Section 2.

Section 2: Procedures and Results

Mercer has performed the procedures enumerated in the Table(s) 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 SFY 2021. CHG's management is responsible for the content of the RDT and responded timely to all requests for information.

Table(s): Procedures

Fee-For-Service (FFS) Medical Expense		
Description of Procedures	**Results CMC**	**Results Non-CMC**
Mercer reviewed all paid claims data for each category of service (COS) to verify control totals, verify eligibility and enrollment in the Coordinated Care Initiative (CCI) Medi-Cal program, confirm the COS grouping was correct, confirm the year reported was correct, and confirm enrollment with the MCO for date of service.	• Control totals: No variance noted. • Eligibility: Verified for all members. • COS Map: Review of all COS showed 95% or higher match for all. • Service Year: CHG submitted 84 records with dates of service outside of SFY 2021. These claims, totaling $78,510, were excluded from testing.	
Mercer compared detailed lag tables for each major COS (Inpatient, Outpatient, Physician, Facility — Long-Term Care [LTC], and All Others) created from the paid claims data files provided by the MCO and compared the support to the information reported in Schedule 7. Mercer compared the paid claims amounts from Schedule 7, line 35 and the incurred but	Variance: RDT FFS Expenses are over/(understated): • Inpatient 2.63% • Outpatient (0.49%) • LTC (0.23%) • Physician (0.13%) • All Other (1.48%) In Total 0.76% or $737,690, or 0.46% of total medical expense.	Variance: RDT FFS Expenses are over/(understated): • Inpatient (12.98%) • Outpatient (0.64%) • LTC (1.46%) • Physician (3.12%) • All Other 0.35% In Total (1.96%) or ($1,735,742), or (1.88%) of total medical expense. The majority of the large variances are due to understatement of IBNR expense.

Fee-For-Service (FFS) Medical Expense		
Description of Procedures	**Results CMC**	**Results Non-CMC**
not reported (IBNR) amount from Schedule 7, line 40 to total paid claims data as provided by the MCO.		
Using data files (paid claims files) provided by the MCO, Mercer sampled and tested 60 transactions and traced them through the MCO's claims processing system, the payment remittance advice, and the bank statements.	No variance noted.	No variance noted.

Global Subcontracted Payments		
Description of Procedures	**Results CMC**	**Results Non-CMC**
Mercer requested overall global capitation supporting detail. Mercer compared the support provided to the amounts reported in Schedule 1-A.	Not applicable. CHG does not have any global capitation arrangements for their CCI population for SFY 2021.	

Sub-Capitated Medical Expense		
Description of Procedures	**Results CMC**	**Results Non-CMC**
Mercer requested overall non-global sub-capitation supporting detail. Mercer compared the support provided to the amounts reported in Schedule 1.	Variance: RDT Sub-capitated Medical Expense is overstated by 2.79% or $252,208. The total of the detail provided was less than the amounts reported in the RDT.	No variance noted.
Mercer reviewed a sample	Variance: Detailed support	Variance: Detailed support

Sub-Capitated Medical Expense		
Description of Procedures	**Results CMC**	**Results Non-CMC**
of the five highest provider payments, 10 random payments, reviewed the related contractual arrangements, and recalculated the total payment amounts by sub-capitated provider using roster information provided by MCO.	for sub-capitated amounts is overstated by 1.31% or $12,793. The recalculated amounts were less than the sub-capitation amount reported in the supporting detail provided.	for sub-capitated amounts is overstated by 1.15% pr $871. The recalculated amounts were less than the sub-capitation amount reported in the supporting detail provided.
Mercer observed proof of payments via relevant bank statements, clearinghouse documentation or other online financial institution support for the sampled sub-capitated provider payments in the previous step.	Variance: Detailed support for sub-capitated amounts is overstated by 1.46% or $80,850. The proof of payment information was less than the supporting detail provided for the sampled, sub-capitated providers.	Variance: Detailed support for sub-capitated amounts is overstated by 0.08% or $65. The proof of payment information was less than the supporting detail provided for the sampled, sub-capitated providers.
Mercer obtained roster information for the sampled provider payments and verified eligibility of members, confirmed enrollment with the MCO, and validated PMPM amounts paid by member.	Eligibility was verified for 99.99% of rostered members in the sample. The amount of non-global sub-capitation paid for the ineligible members is $100 and is included in the variance noted above.	Eligibility was verified for 99.98% of rostered members in the sample. The amount of non-global sub-capitation paid for the ineligible members is $18 and is included in the variance noted above.
For sub-capitated arrangements 5% or more of total medical expense or major COS, Mercer reviewed the sampled sub-capitated contracts to determine delegated administrative duties. Using this information, Mercer then reviewed the amount	CHG did not have any sub-capitated arrangements that exceeded the 5% or more of total medical expense threshold.	

Sub-Capitated Medical Expense		
Description of Procedures	**Results CMC**	**Results Non-CMC**
of administrative dollars reported in the RDT as compared to the delegated administrative functions.		

Utilization and Cost Experience		
Description of Procedures	**Results CMC**	**Results Non-CMC**
Mercer compared summarized total net cost data from amounts reported in Schedule 1 to Total Incurred Claims by COS for Schedule 7.	Schedule 1 is overstated when compared to Schedule 7 by 1.57% or $1,651,620.	Schedule 1 is overstated when compared to Schedule 7 by 0.86% or $766,616.

Member Months		
Description of Procedures	**Results CMC**	**Results Non-CMC**
Mercer compared MCO-reported member months from Schedule 1-C to eligibility and enrollment information provided by the State. Mercer's procedures are to request explanations for any member months with greater than 0.5% variance in total or greater than 1.0% variance by major COA.	Variance: RDT Member Months overstated by 0.12% in total.	Variance: RDT Member Months understated by 0.05% in total.

Provider Incentive Arrangements		
Description of Procedures	**Results CMC**	**Results Non-CMC**
Mercer requested a listing of all provider incentive arrangements, by provider, by month and compared the amounts to Schedule 1.	Not applicable. CHG did not pay provider incentives for their CCI population for SFY 2021.	

Reinsurance		
Description of Procedures	**Results CMC**	**Results Non-CMC**
Mercer reviewed the reinsurance contract and compared the amount on the RDT to the requested supporting schedule.	Not applicable. CHG did not have reinsurance arrangements for their CCI population for SFY 2021.	

Settlements		
Description of Procedures	**Results CMC**	**Results Non-CMC**
Mercer inquired of the MCO whether they incurred any settlement amounts with providers related to SFY 2021 dates of service. If settlements existed, Mercer noted whether the amounts are actual, or estimates based on the status of the settlements and where the amount(s) are reported in the RDT.	Not applicable. No settlements were paid for SFY 2021.	

Third-Party Liability (TPL)		
Description of Procedures	**Results CMC**	**Results Non-CMC**
Mercer reviewed information submitted by the MCO as to how TPL is identified and reported. Per DHCS All Plan Letter (APL) 21-007, the MCO is not required to collect TPL; however, they are required to report to DHCS service and utilization information for covered services related to TPL.	Per review of the support provided and confirmation with DHCS, CHG is submitting TPL information as required by APL 21-007. No further testing necessary.	

Administrative Expenses		
Description of Procedures	**Results CMC**	**Results Non-CMC**
Mercer benchmarked administrative expenses as a percentage of net revenue across all Two-Plan/GMC plans and compared to the amount reported in the RDT, taking into consideration the membership size of the plan when reviewing the results.	The administrative percentage reported by CHG for CMC was within an acceptable range as compared to industry standards.	The administrative percentage reported by CHG for non-CMC was within an acceptable range as compared to industry standards.
Mercer compared detailed line items from the plan's trial balance for reasonableness when mapped to line items in Schedule 6a and/or Schedule 6b. If applicable, Mercer reviewed allocation methodologies and recalculated for reasonableness.	No variance noted.	No variance noted.

Taxes		
Description of Procedures	**Results CMC**	**Results Non-CMC**
Mercer reviewed to ensure proper reporting of federal, State, and local taxes on line 59 of Schedule 6a. If no taxes were reported on Schedule 6a, we confirmed the organization is not subject to taxes.	Not applicable. CHG is not subject to federal and state income taxes.	

Related Party Transactions		
Description of Procedures	**Results CMC**	**Results Non-CMC**
Mercer obtained related party agreements for medical services and reviewed to determine whether the terms are at fair market value. Mercer compared the terms (e.g., PMPM or other payment rate amounts) to other similar non-related party terms for reasonableness.	Not applicable. No related party medical services provided.	
When applicable, Mercer obtained related party corporate allocation methodologies for administrative services. Where significant, Mercer recalculated the amounts for reasonableness.	Although not a corporate allocation, CHG has consulting services provided by a related party. The amount paid for SFY 2021 was approximately 0.30% of total administrative expenses. The arrangement appears to have been appropriately disclosed and approved by CHGs management and Board of Directors.	No related party expenses reported for the Non-CMC population.

UM/QA/CC		
Description of Procedures	**Results CMC**	**Results Non-CMC**
Mercer benchmarked UM/QA/CC expenses as a percentage of total medical expense across all Two-Plan/GMC plans and compared to the amount reported on Schedule 1-U, taking into consideration the membership size of the plan under review when reviewing the results.	The benchmark UM/QA/CC percentage reported by CHG for non-CMC was within an acceptable range as compared to industry standards.	The benchmark UM/QA/CC percentage reported by CHG for non-CMC was within an acceptable range as compared to industry standards.
Mercer compared detailed line items from the plan mapped to line items in Schedule 1-U for reasonableness. Mercer reviewed allocation methodologies and recalculated for reasonableness.	Variance: Schedule 1-U is overstated by 3.12% or $284,196, or 0.14% of total medical expense. The primary reason for the differential is due to the allocation methodology employed to report the UM/QA/CC expense across programs in the RDT versus the support provided.	Variance: Schedule 1-U is overstated by 3.12% or $26,869, or 0.02% of total medical expense. The primary reason for the differential is due to the allocation methodology employed to report the UM/QA/CC expense across programs in the RDT versus the support provided.
Mercer 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. Mercer confirmed with the MCO that UM/QA/CC costs were not also included in general administrative expenses.	Confirmed with the CHG management that UM/QA/CC costs were not also included in general administrative expenses.	

Capitation Revenue		
Description of Procedures	**Results CMC**	**Results Non-CMC**
Mercer compared capitation amounts reported in Schedule 6a for calendar year 2020 plus January 2021 – January 2021 (1H2021) with the Capitation Management System (CAPMAN) file received from DHCS for the same period. The CAPMAN file contains all amounts paid to the MCO by DHCS.	Variance: Using a straight average methodology, the variance for SFY 2021 is understated by 2.20%, or $3,156,067.	Variance: Using a straight average methodology, the variance for SFY 2021 is overstated at 0.37%, or $94,973.

Interest and Investment Income		
Description of Procedures	**Results CMC**	**Results Non-CMC**
Mercer 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.	Support provided did not segregate between CMC and non-CMC, therefore Mercer tested in total across all CCI. Interest income is overstated 29.35%, or $299.717. This amount is 0.03% of total Net Revenue.	

Other Information		
Description of Procedures	**Results CMC**	**Results Non-CMC**
Mercer reviewed the MCO's audited financial statements for SFY 2021 for a clean audit opinion or identification of significant deficiencies or material weaknesses.	Mercer confirmed a clean audit opinion.	
Mercer compared reported expenses, including IBNR and administrative expenses, to audited financial statements for	Audited financial statements did not segregate the lines of business, therefore Mercer tested in total across Mainstream and CCI. Administrative expense showed a variance of approximately 8.04%, or $3,044,982. However, in total, medical and administrative expense combined	

Other Information		
Description of Procedures	**Results CMC**	**Results Non-CMC**
consistency.	showed only a variance of 1.74%, therefore, a classification difference existed between the RDT and the audited financial statements. No further testing deemed necessary.	
Mercer requested information on the efforts to identify and recover provider overpayments and on how the recoveries are recorded in the RDT.	CHG provided the written policy for the identification and recovery of overpayments. Based on a review of that policy, CHG is appropriately not reporting any provider overpayments in the RDT medical expenses.	

Section 3: Summary of Findings CMC

Based on the procedures performed, the total amount of Capitation Revenue for the CMC SFY 2021 RDT was understated by $ 2,104,045 or 2.20%.

Based on the procedures performed, the total amount of gross medical expenditures in the RDT were overstated by $2,925,714 or 1.81% of total medical expenditures in the CMC SFY 2021 RDT.

Based on the procedures performed, there was no variance noted in administrative expenditures in the CMC SFY 2021 RDT.

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

CHG reviewed and accepted this report.

Section 4: Summary of Findings Non-CMC

Based on the procedures performed, the total amount of Capitation Revenue for the Non-CMC SFY 2021 RDT was overstated by $ 63,315 or 0.37%.

Based on the procedures performed, the total amount of gross medical expenditures in the RDT were understated by $942,247 or 1.02% of total medical expenditures in the Non-CMC SFY 2021 RDT.

Based on the procedures performed, there was no variance noted in administrative expenditures in the Non-CMC SFY 2021 RDT.

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

CHG reviewed and accepted this report.

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