Mercer

Government Human Services Consulting

State Fiscal Year 2021 Community Health Group Mainstream Rate Development Template

Auditor's Report

California Department of Health Care Services

December 8, 2023

Contents

Section 1

Executive Summary

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 included, but were not limited to:

- Schedule 1 — Utilization and Cost Experience
- Schedule 1-A — Global Subcontracted Health Plan Information
- Schedule 1-C — Base Period Enrollment by Month
- Schedule 1-U — UM/QA/CC
- 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 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 Table 1 of Section 2.

Section 2

Procedures and Results

Mercer has 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 SFY 2021. CHG's management is responsible for the content of the RDT and has responded in a timely manner to all requests for information.

Table 1: Procedures

Fee-For-Service (FFS) Medical Expense	
Description of Procedures	**Results**
Mercer reviewed all paid claims data for each category of service (COS) to verify control totals, verify eligibility and enrollment in the Mainstream 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: 0.06% of claim submissions with no matching eligibility totaling $471,825 or 0.05% of total medical expense and is included in the variance noted below. • COS Map: Review of all COS showed 96% or higher match for all COS except for the Other COS at 87%. The review of encounter data to determine cause of non-matching claims in the Other COS showed non-matching claims were included in the Physician COS indicating CHG did not allocate the professional component of facility claims correctly. CHG reviewed and corrections were made for future RDT reporting. Service Year: CHG submitted data outside dates of service requested and were not included in our analysis.
Mercer compared detailed lag tables for each major COS (Inpatient, Outpatient, Physician, Facility — LTC, and All Others) created from the paid claims	Variance: RDT FFS Expenses are over/(understated): • Inpatient 3.18%

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 not reported (IBNR) amount from Schedule 7, line 40 to total paid claims data as provided by the MCO. Allowable absolute value variances were deemed to be not greater than 2% for inpatient claims and 1% for all other categories of service.	• Outpatient 0.49% • LTC (0.40%) • Physician 0.86% • All Other (1.72%) In Total 1.25% or $8,237,280, which is 0.83% of total medical expense. Per CHG, to address variances observed, COS mapping logic was reviewed, and corrections were made for future RDT submissions.
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.

Global Subcontracted Payments	
Description of Procedures	**Results**
Mercer requested global capitation supporting detail.	N/A. CHG does not have any global capitation arrangements.

Sub-Capitated Medical Expense	
Description of Procedures	**Results**
Mercer requested overall non-global sub-capitation supporting detail. Mercer compared the support provided to the amounts reported in Schedule 7.	Variance: RDT Sub-capitated Medical Expense is understated by 4.13% or $3,012,587. The total of the detail provided was greater than the amounts reported in the RDT due to an error in pulling CapDetail in January 2021 and accounting adjusting entries made to the wrong line of business.

Mercer reviewed a sample of the five highest provider payments and 10 random payments, reviewed the related contractual arrangements, and recalculated the total payment amounts by sub-capitated provider using roster information provided by the MCO.	Variance: Detailed support for sub-capitated amounts is understated by 1.16% or $85,042. The recalculated amounts were more 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 the sampled sub-capitated providers is understated by 4.13% or $323,800. The proof of payment information was more 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 and confirmed enrollment with the MCO.	Eligibility was verified for 99.59% of members. The amount of non-global sub-capitation paid for the ineligible members is $5,479 and is included in the variance noted above.
If applicable, Mercer reviewed Full Dual category of aid (COA) subcontracted per member per month (PMPM) payment rates to determine whether the amount(s) are at a reduced rate as compared to the non-Full Dual COAs.	The sub-capitation agreements do not delineate between Full Dual and non-Full Dual COA rates, and therefore Full Dual PMPMs are not appropriately reduced as compared to the non-Full Dual PMPMs. In the contracts where Dual members are covered, the contracted PMPM is weighted across all COAs and therefore medical expense may be over or understated based on the actual member mix versus the member mix assumed in the contracted PMPM development.
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 of administrative dollars reported in the RDT as compared to the delegated administrative functions.	CHG did not have any sub-capitated arrangements that exceeded the 5% or more of total medical expense threshold.

Utilization and Cost Experience	
Description of Procedures	**Results**
Mercer compared summarized total net cost data from amounts reported in Schedule 1 to Total Incurred Claims by COS from Schedule 7.	Schedule 1 is overstated when compared to Schedule 7 by 0.08% or $613,415.
Member Months	
Description of Procedures	**Results**
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 0.16% in total.
Provider Incentive Arrangements	
Description of Procedures	**Results**
Mercer requested a listing of all provider incentive arrangements, by provider and by month, and compared the amounts to Schedule 1, lines 34–36.	Variance: RDT Provider Incentive Expense is understated by 1.55% or $23,504. This represents 0.00% of total medical expense.
From the listing of provider incentive payments, Mercer sampled the highest two payment amounts and one random payment. Mercer observed proof of payments for the sampled provider incentive payments. The proof of payment information validated the supporting detail provided for the sampled provider incentive payments.	No variance noted.

Mercer reviewed the listing of provider incentive payments for any payments to related parties.	Confirmed there were no provider incentive payments made to related parties.

Reinsurance	
Description of Procedures	**Results**
Mercer requested reinsurance supporting detail. Mercer compared the support provided to the amount reported in the RDT.	No variance noted.
Mercer recalculated reinsurance premiums, based on SFY 2021 membership as of February 2023, to compare to reported amounts.	Variance: RDT was understated by 0.04% or $5,719.
Mercer recalculated recoveries for a sample of five members.	No variance noted.
Mercer compared the amount of reinsurance recoveries as compared to the information in Schedule 5 for reasonableness.	Reported amounts in Schedule 5 are consistent with reinsurance recoveries reported based on review of the reinsurance threshold.

Settlements	
Description of Procedures	**Results**
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 were actual, or estimates based on the status of the settlements and where the amount(s) were reported in the RDT.	No settlements were paid for SFY 2021.

Third-Party Liability (TPL)	
Description of Procedures	**Results**
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**
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 benchmark administrative percentage was 6.25% of Net Revenue and CHG reported 2.55%. The differential is primarily driven by Compensation and Affiliate Administration Services expense.
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.	The RDT Administrative Expense is overstated by 1.22%, or $268,459, or 0.03% of Net Revenue.

Taxes	
Description of Procedures	**Results**
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.	Mercer confirmed the plan is not subject to federal and state income taxes.

Related Party Transactions	
Description of Procedures	**Results**
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.	N/A. 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 2.64% of total administrative expenses. The arrangement appears to have been appropriately disclosed and approved by CHG's management and Board of Directors.
UM/QA/CC	
Description of Procedures	**Results**
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 when reviewing the results.	The benchmark UM/QA/CC percentage was 1.67% and CHG reported 1.34%. This difference is considered reasonable.
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 understated by 74.20%, $9,657,841 or 0.97% of total medical expenses. The original submission of Schedule 1-U of the RDT was understated in error and corrected for future RDT submissions. However, those submissions were not part of the calendar year 2023 capitation rate development.

Mercer interviewed financial management to determine how healthcare 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.

Capitation Revenue	
Description of Procedures	**Results**
Mercer compared capitation amounts reported in Schedule 6a for calendar year 2020 plus January 2021–June 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 health plan by DHCS.	Variance: RDT is understated by 0.17% or $2,220,626. Using a straight average methodology, the variance for SFY 2021 is estimated at $1,480,418 and remains 0.17%. Per discussion with CHG, the majority of this variance is due to timing of payments versus timing of RDT submission.

Interest and Investment Income	
Description of Procedures	**Results**
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.	No variance noted.

Other Information	
Description of Procedures	**Results**
Mercer reviewed the plan's audited financial statements 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 consistency.	No material variances noted in total. Administrative expense showed a variance of approximately 28%, or $6 million. However, in total, medical and administrative expense showed only a variance of 0.08%, or $700,000, therefore likely a classification difference 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

Based on the procedures performed, the total amount of capitation revenue for the SFY 2021 RDT was understated by $1,480,418 or 0.17%.

Based on the procedures performed, the total amount of gross medical expenditures in the RDT was overstated by $5,808,886 or 0.59% of total medical expenditures in the SFY 2021 RDT.

Based on the procedures performed, administrative expenditures in the RDT were overstated by $268,459 or 1.22%.

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

CHG reviewed this report and had the following comments:

Management has reviewed the audit results of the State Fiscal Year (SFY) 2021 Mainstream Rate Development Template (RDT) submitted by Community Health Group. We would like to express our sincere appreciation for the opportunity to provide the underlying support for the test work conducted and hope the findings support the base data development process for the organization's capitation rates related to calendar year 2023.

We are pleased that the audit report noted only immaterial variances and do not warrant corrective action, and we would like to thank the Department of Health Care Services (Department) and the Mercer Government Human Services Consulting team for its diligence and flexibility throughout the audit process.

Our goal is to continue to develop and maintain a collaborative working relationship with the Department and appreciate every opportunity to demonstrate our commitment to our partnership, maintaining the financial integrity of the managed care system, and strengthening the health care delivery system for the communities that we serve.

We recognize the significance of your role in ensuring transparency and accuracy in financial reporting, and your findings affirm our commitment to maintaining the highest standards of accountability. We take pride in the positive outcome of this audit, which reflects the collective efforts of our entire organization in upholding the principles of good governance.

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