Mercer

Government Human Services Consulting

State Fiscal Year 2021 Anthem Blue Cross Coordinated Care Initiative Rate Development Template

Auditor's Report

California Department of Health Care Services

July 15, 2024

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 Anthem Blue Cross (ABC). 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-B — Incentive Payments Arrangements
- 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 ABC for the SFY 2021. ABC'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 each COS showed a 94.15% to 100% match rate. • Service Year: No variance. All dates fall within SFY 2021.	
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	Variance: RDT FFS Expenses are over/(understated): • Inpatient 13.54% • Outpatient (83.90%) • LTC 25.63% • Physician 99.91% • All Other (224.56%) In Total 15.57% or $8,784,341, or 14.41% of total medical expense. Per	Variance: RDT FFS Expenses are over/(understated): • Inpatient (2.76%) • Outpatient (0.27%) • LTC 2.04% • Physician (0.50%) • All Other (0.90%) In Total 1.47% or $634,763, or 1.12% of total medical expense. Per ABC, the

Fee-For-Service (FFS) Medical Expense		
Description of Procedures	**Results CMC**	**Results Non-CMC**
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.	ABC, the variances above are primarily due to sub capitation expense that was incorrectly reported in the FFS section of Schedule 7. If the sub capitation is correctly reported the Physician variance would be 31.84% and the All Other variance would be (234.39%). The remaining COS were not impacted. While the adjusted overall variance would be (0.93%), the individual COS variances remain significant.	variances above are primarily due to IBNR timing differences as well as GEMT supplemental payments and Home Health Program payments that were excluded from Schedule 7.
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 observed.	

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.	ABC did not have any Global sub-contractor arrangements.	

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 7.	Variance: RDT Sub-capitated Medical Expense in Schedule 7 is understated by 100% or $9,587,061, which 15.72% of total medical expense. However, this amount was reported correctly in Schedule 1.1.	No variance noted. The total of the detail provided was equal to the amounts reported in the RDT.
Mercer reviewed a sample 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.	Variance: Detailed support for sub-capitated amounts is overstated by 2.13% or $23,132. The recalculated amounts were less than the sub-capitation amount reported in the supporting detail provided.	Variance: Detailed support for sub-capitated amounts is overstated by 2.39% or $10,774. 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	Variance: Detailed support is overstated by 16.32% or	Variance: Detailed support is overstated by 3.82% or $17,247.

Sub-Capitated Medical Expense		
Description of Procedures	**Results CMC**	**Results Non-CMC**
documentation or other online financial institution support for the sampled sub-capitated provider payments in the previous step.	$223,622. The proof of payment information was less than the supporting detail provided for the sampled, sub-capitated providers.	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 95.16% of rostered members in the sample. The amount of non-global sub-capitation paid for the ineligible members is $17,994 and is included in the variance noted above.	Eligibility was verified for 99.86% of rostered members in the sample. The amount of non-global sub-capitation paid for the ineligible members is $206 and is included in the variance noted above.
If applicable, Mercer reviewed Full Dual COA subcontracted PMPM payment rates to determine if the amount(s) are at a reduced rate as compared to the non-Full Dual COAs.	Not applicable due to all sampled providers being paid a blended capitation rate across all COAs.	Not applicable due to all sampled providers being paid a blended capitation rate across all COAs.
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	ABC had two sub-capitated arrangements that exceeded the 5% or more of total medical expense threshold. There were eight administrative functions delegated to the two sub-capitated providers and the plan did not report	ABC did not have any sub-capitated arrangements that exceeded 5% or more of the total medical expense threshold.

Sub-Capitated Medical Expense		
Description of Procedures	**Results CMC**	**Results Non-CMC**
amount of administrative dollars reported in the RDT as compared to the delegated administrative functions. If applicable, see Appendix A for detail.	administrative dollars in the RDT. Therefore, this may result in an understatement of administrative expenses and an equal overstatement of medical expenses, depending on type of functions performed.	

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 by 0.74% or $415,605, when compared to Schedule 7. Which is 0.68% of total medical expense.	Schedule 1 is understated by 0.65% or $292,292 when compared to Schedule 7. Which is 0.62% of total medical expense.

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 3.18% in total.	Variance: RDT Member Months understated by 0.23% 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. ABC does not have CMC provider incentive arrangements for SFY 2021.	No variance noted.
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.	Not applicable.	Not variance noted.

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. ABC did not have any reinsurance contracts 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.	No settlements were paid for SFY 2021.	ABC reported estimated settlements of $212,640 for SFY 2021. According to ABC, settlement negotiations for this period are still ongoing.

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, ABC 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 ABC was within an acceptable range as compared to industry standards.	The administrative percentage reported by ABC 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	No variance noted.	No variance noted.

Administrative Expenses		
Description of Procedures	**Results CMC**	**Results Non-CMC**
Schedule 6b. If applicable, Mercer reviewed allocation methodologies and recalculated for reasonableness.		

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.	The RDT Tax Expense is understated by 34.42% or $7,012,085 when compared to the Audited Financial Statements. The Audited Financial Statements contain Medi-Cal and non-Medi-Cal information. The plan was unable to provide detailed support for Medi-Cal only Tax Expense reported in the RDT.	

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.	ABC had no related parties as defined by the Financial Accounting Standard Board who provided medical services to Medi-Cal members. In addition, the plan did not have any board members that held executive level positions with any hospitals or provider organizations who provided services to their Medi-Cal members.	

Related Party Transactions		
Description of Procedures	**Results CMC**	**Results Non-CMC**
When applicable, Mercer obtained related party corporate allocation methodologies for administrative services. Where significant, Mercer recalculated the amounts for reasonableness.	Mercer reviewed the related party administrative corporate allocation methodology with Elevance Health, ABC's parent company. The allocation methodology appears reasonable.	

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 COHS 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 UM/QA/CC percentage reported by ABC was within an acceptable range as compared to industry standards.	The UM/QA/CC percentage reported by ABC was within an acceptable range as compared to industry standards.
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.	Confirmed with the MCO 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–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: Using a straight average methodology, the variance for SFY 2021 is overstated at $13,851,677 or 40.88%. ABC acknowledges that the RDT capitation revenue is overstated.	Variance: Using a straight average methodology, the variance for SFY 2021 is understated at $2,516,791 or 4.38%.

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.	ABC did not report any interest or investment income in the RDT. Per ABC, interest and investment income was not allocated at the county level and therefore it was not disclosed in Schedule 6a. For reference, ABC's Audited Financial Statements reported $27.9 million as investment income for all lines of business.	

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.	ABC received a clean audit opinion.	
Mercer compared reported expenses, including IBNR and administrative expenses, to audited financial statements for consistency.	No material variances noted.	
Mercer requested information on the efforts to identify and recover provider overpayments and on how the recoveries are recorded in the RDT.	ABC provided the policy for the identification and recovery of overpayments. Based on a review of that policy, ABC is appropriately excluding 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 overstated by $13,851,677 or 40.88%. ABC acknowledges that the RDT capitation revenue is overstated. ABC should ensure accurate reporting of capitation revenue in future RDT reporting.

Based on the procedures performed, the total amount of gross medical expenditures in the CMC RDT were understated by $13,130 or 0.02% of total medical expenditures in the SFY 2021 RDT. As noted in the Fee-For-Service and Sub-capitated Medical Expense sections, sub-capitated expense was not reported consistently among Schedules 1.1 and 7.1 in the RDT. ABC should properly report Sub-capitated Medical Expense in both Schedules.

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

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

Anthem Blue Cross 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 understated by $2,516,791 or 4.38%. ABC should ensure accurate reporting of capitation revenue in future RDT reporting.

Based on the procedures performed, the total amount of gross medical expenditures in the Non-CMC RDT were overstated by $826,367 or 1.75% of total medical expenditures in the SFY 2021 RDT. ABC should prepare to properly record a portion of their provider sub-capitation expense as administrative expense in future RDT reporting, thus reducing medical expense.

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

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

Anthem Blue Cross reviewed and accepted this report.

Appendix A: Administrative Duties in CMC Subcontracted Arrangements

Administrative Task	Northern California Physicians Medical Network IPA	Physicians Medical Group of San Jose IPA
Quality Management	X	X
Quality Measure Tracking		
Member Grievance	X	X
Encounter Submission		
Claims Adjustment and Payment		
Member Services	X	X
Provider Services	X	X
Case Management	X	X
Claims Processing		
Utilization Management	X	X
Provider Relations and Education	X	X
Provider Contracting		
Credentialing and Re-Credentialing	X	X

Mercer Health & Benefits LLC

2325 East Camelback Road, Suite 600

Phoenix, AZ 85016

www.mercer-government.mercer.com

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