Mercer

Government Human Services Consulting

State Fiscal Year 2021 Anthem Blue Cross Mainstream Rate Development Template

Auditor's Report

California Department of Health Care Services

July 1, 2024

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

Table(s): 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: 0.09% of claim submissions with no matching eligibility totaling $120,862 or 0.01% of total medical expense and is included in the variance noted below. • COS Map: Review of each COS showed 83%–99% match. Discrepancies were reconciled and no further testing required. There was a bucketing issue pertaining to FQHC providers; however, the plan is continuously working to revise COS mapping logic. • Service Year: No variance noted. All dates of service fall within SFY 2021.
Mercer compared detailed lag tables for each major COS (Inpatient, Outpatient, Physician, Facility — 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 not reported (IBNR)	Variance: RDT FFS Expenses are over/(understated) as compared to the support provided: • Inpatient 1.03% • Outpatient 0.47% • LTC 0.58% • Physician (0.43%) • All Other 0.66%

Fee-For-Service (FFS) Medical Expense	
Description of Procedures	**Results**
amount from Schedule 7, line 40 to total paid claims data as provided by the MCO.	In Total 0.72% or $9,029,689, which is 0.43% of total medical expense.
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. 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**
Mercer requested 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 0.81% or $3,709,886, which is 0.18% of total medical expense. The total of the detail provided was more than the amounts reported in the RDT.
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-capitation expense is understated by 0.69% or $78,042, or 0.02% of total sub-capitation expense. 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-	No variance noted.

Sub-Capitated Medical Expense	
Description of Procedures	**Results**
capitated provider payments in the previous step. The proof of payment information validated 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 MCO.	Eligibility was verified for 99.91% of rostered members in the sample. The amount of non-global sub-capitation paid for the ineligible members is $6,713 and is included in the variance noted above.
If applicable, Mercer reviewed Full-Dual COA subcontracted PMPM payment rates to determine whether the amount(s) are at a reduced rate as compared to the non-Full Dual COAs.	Confirmed reduced rates as compared to the non-Full Dual COA groups.
For sub-capitated arrangements accounting for 5% or more of total medical expense, 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.	ABC had one sub-capitated arrangement that exceeded the 5% or more of total medical expense threshold. There were four administrative functions delegated to the sub-capitated provider and the plan did not report administrative dollars in the RDT. Therefore, this may result in an understatement of administrative expenses and an equal overstatement of medical expenses, depending on the type of functions performed.

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 for Schedule 7 for consistency.	Schedule 1 is overstated by 0.10% or $1,632,956, when compared to Schedule 7. This variance is 0.08% of total medical expense.

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 are overstated by 0.13% 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.	Variance: RDT Provider Incentive Expense is overstated by 25.50% or $2,634,091. The overstatement was due to differences between estimated and actual expenses and represents 0.13% 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.	No variance noted. The proof of payment information validated the supporting detail provided for the sampled provider incentive payments.
Mercer reviewed the listing of provider incentive payments for any payments to related parties. If the review of the provider incentive payment listing showed payments to related parties, and the sample selection in the previous step did not include related party arrangements, Mercer selected the two	ABC had no related parties as defined by the Financial Accounting Standard Board. 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.

Provider Incentive Arrangements	
Description of Procedures	**Results**
highest related party provider incentive payments. Mercer observed proof of payments for the sampled related party provider incentive payments.	
If related party provider incentive payments were noted, Mercer reviewed the incentive terms to determine whether the terms align with similar arrangements for non-related parties.	Not applicable.

Reinsurance	
Description of Services	**Results**
Mercer reviewed the reinsurance contract and compared the amount on the RDT to the requested supporting schedule.	ABC did not have any reinsurance contracts during SFY 2021.

Settlements	
Description of Procedures	**Results**
Mercer inquired of the MCO if they incurred any settlement amounts with providers related to SFY 2021 dates of service. If settlements exist, 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.	ABC reported estimated settlements of $1,650,911 for SFY 2021. According to ABC, settlement negotiations for this period are still ongoing. This potential settlement amount was not reflected as a medical expense in the RDT submission. Therefore, the medical expenses in the RDT for inpatient hospital services may be understated by this amount, which equals 0.08% of total medical expense.

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, ABC 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 and Geographic Managed Care plans and compared to the amount reported in Schedule 6a, 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.
Mercer compared detailed line items from the MCO's trial balance mapped to line items in Schedule 6a and Schedule 6b for reasonableness. Mercer reviewed allocation methodologies and reviewed for reasonableness.	The RDT administrative expense is understated by 1.66% or $2,712,631, or 0.12% of Net Revenue. The allocation methodology was deemed reasonable.

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, Mercer 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, and 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**
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.
When applicable, Mercer obtained related party corporate allocation methodologies for administrative services. Where significant, Mercer reviewed 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**
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 UM/QA/CC percentage reported by ABC was within an acceptable range as compared to industry standards.
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.	Confirmed with ABC's management that UM/QA/CC costs were not also included in general administrative expenses.

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 MCO by DHCS.	Variance: RDT is understated by 1.56%, or $35,292,205.

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.	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**
Mercer reviewed the plan'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 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

Based on the procedures performed, the total amount of capitation revenue for the SFY 2021 RDT was understated by $35,292,205, or 1.56%.

Based on the procedures performed, the total amount of gross medical expenditures in the RDT was overstated by $9,151,727 or 0.30% of total medical expenditures in the SFY 2021 RDT.

Based on the procedures performed, administrative expenditures in the SFY 2021 RDT were understated by $2,712,631 or 1.13%. In addition, the plan should prepare for properly recording a portion of their provider sub-capitation expense as administrative expense in future RDT reporting, thus reducing their medical expense.

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

ABC reviewed and accepted this report.

Appendix A: Administrative Duties in Subcontracted Arrangements

Administrative Task	River City Medical Group
Quality Management	X
Quality Measure Tracking	
Utilization Management	X
Case Management	X
Member Services	
Member Grievance	X
Claims Processing	
Claims Adjudication and Payment	
Encounter Submission	
Provider Services	
Provider Contracting	
Provider Relations and Education	
Credentialing and Recredentialing	

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