

State Fiscal Year 2023 Central California Alliance for Health Rate Development Template

Auditor's Report

California Department of Health Care Services

October 23, 2025

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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 plan (MCP). 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) 2023 by Central California Alliance for Health (CCAH). Mercer designed and DHCS approved procedures to test the accuracy, truthfulness, and completeness of self reported financial data in the RDT.

Medi-Cal RDT reporting requires satisfactory immigration status (SIS) population and unsatisfactory immigration status (UIS) information to be reported separately. However, the audit testing was performed on the consolidated SIS/UIS basis, unless otherwise noted. In addition, only the direct MCP submissions at the consolidated contract/county/region levels were subject to testing, not including the global subcontracted MCP submissions.

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 (CY) 2025 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 MCP.

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

- Schedule 1 (SIS/UIS) — 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-O — Overpayments
- Schedule 1-U — Utilization Management/Quality Assurance/Care Coordination (UM/QA/CC)
- Schedules 6a — Financial Report
- Schedule 7 — Lag Payment Information
- Schedule D 1 (UIS/SIS) — Members Delivery Counts

- **Schedule D 2 (UIS/SIS) — Members Maternity Utilization and Cost Experience**

The data collected in the RDT is reported on a modified accrual (incurred) basis for SFY 2023 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 CCAH for SFY 2023. CCAH'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, eligibility, enrollment with the MCP for the claim date of service, existence of a related encounter for the claim, and that the date of service is within the reporting period. In addition, Mercer reviewed the claims for correct COS grouping and inquired about interest paid on late claims.	- Control Totals: No variance noted. - Eligibility: 0.09% of claim submissions with no matching eligibility totaling \$1,627,453 or 0.12% of total medical expense. - Enrollment: 0.06% of claim submissions were not enrolled with CCAH on claim date of service, totaling \$562,948 or 0.04% of total medical expense. - Duplicates: 0.05% of claim submissions were duplicates totaling \$441,677 or 0.03% of total medical expense. - Encounter Analysis: 0.18% of claim submissions with no matching totaling \$5,187,744.43 or 0.41% of total medical expense. - Service Year: No variance noted. All dates of service fall within SFY 2023. - Interest Paid: Per CCAH, interest payments on late claims were appropriately excluded from FFS claims expense. - COS Map: Review of all COS showed 86%–99% match for all COS. The mismatches have been redistributed to the appropriate COS for variance reporting below and attributed to a difference in classification logic used by CCAH versus DHCS. CCAH is continuing to

Fee-For Service (FFS) Medical Expense	
Description of Procedures	Results
	review DHCS logic to ensure alignment for future reporting. CCAH is continuing its efforts to improve provider reporting of taxonomy codes. All items noted above are adjustments to the support provided and are reflected in the variance calculations immediately below.
Mercer compared detailed lag tables for each COS grouping (Facility — Inpatient, Facility — Outpatient, Physician, Mental Health — Outpatient and Behavioral Health Treatment Services, Facility — LTC, and All Others) created from the paid claims data files provided by the MCP and compared this 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 MCP.	Variance: RDT FFS Expenses are over/(understated) as compared to the support provided: • Inpatient 1.37% • Outpatient 9.68% • Physician (7.16%) • Mental Health 0.31% • LTC 1.84% • All Other (1.84%) In Total, RDT FFS Expenses are overstated by 0.38.%, or \$4,909,837, which is 0.35% of total medical expense. The variance is primarily due to the exclusions of claims with no related encounter. There were \$20 million in claims reclassified from the Outpatient COS to the Physician COS, causing the large overstatement of the Outpatient COS and the corresponding understatement of the Physician COS in the RDT. This large reclassification was primarily due to the claims data requested for the audit lacking line level detail, which would further assist in properly categorizing the claims. Based on the explanations provided by CCAH and additional research performed, no additional testing was deemed necessary.

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.	Not applicable. CCAH did not have any Global Subcontractors.

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.	No variance noted. The total of the detail provided validated the amounts reported in the RDT.
Mercer selected a sample and obtained roster information for the provider payments, verified eligibility of members, and confirmed enrollment with the MCP.	Eligibility and enrollment were verified for 99.60% of members. The amount of non-global sub-capitation paid for the ineligible members is \$10,053.
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.	No variance noted. The proof of payment information validated the supporting detail provided for the sampled sub-capitated providers.
Mercer reviewed the contractual arrangements, and recalculated the total payment amounts by sub-capitated provider using roster information provided by the MCP for the sampled providers.	No variance noted. The recalculated amounts validated the sub-capitation amount reported in the supporting detail provided.
If applicable, Mercer reviewed Full Dual category of aid (COA) sub-capitated 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.	Confirmed reduced rates as compared to the non-Full Dual COA groups.
For sub-capitated arrangements 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.	CCAHC had no sub-capitated arrangement that exceeded the 5% or more of total medical expense threshold. Mercer found that the sub-capitated contract reviewed did not include administrative functions.

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 in Schedule 7.	No variance noted.

Related Party Transactions	
Description of Procedures	Results
Mercer obtained related party agreements for medical services and reviewed them 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.	CCAH has seven related party arrangements as defined to include any hospitals or provider organizations whose executive-level staff hold a seat on the Board of Directors. These related party arrangements range from 1% to 21% of the related COS expense. Per review of the agreements, the terms are similar to non-related party agreements.
When applicable, Mercer obtained related party corporate allocation methodologies for administrative services.	Not applicable.

Provider Incentive Arrangements	
Description of Procedures	Results
Mercer requested a listing of all provider incentive arrangements, by program and provider, and compared the amounts to Schedule 1.	Variance: Using the support provided, RDT Provider Incentive Expense is understated by 6.77%, or \$1,744,900. The variance is primarily due to a partial exclusion of an incentive arrangement in the RDT.
Mercer selected a sample, including related party arrangements. 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.	CCAH confirmed there are related party incentive arrangements, the terms aligned with similar arrangements for unrelated parties, and those payments were included in the test work below.
Mercer reviewed that all services included in the provider incentive	All services included in the provider incentive arrangements are allowable for Medicaid rate setting.

Provider Incentive Arrangements	
Description of Procedures	Results
arrangements are allowable for Medicaid rate setting.	
Mercer observed proof of payments for the sampled provider incentive payments and compared the amounts to the detailed support.	Variance: Detailed support for the sampled incentive payments is overstated by 0.80%, or \$61,909. The proof of payment information was less than the supporting detail provided for the sampled incentive payments.

Provider Settlements	
Description of Procedures	Results
Mercer requested settlement amounts paid by provider related to SFY 2023 dates of service and compared the amounts to Schedule 7. 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.	Not applicable. No settlements were paid for SFY 2023.

Overpayments	
Description of Procedures	Results
Mercer inquired of the MCP whether they incurred any provider overpayment and recoupment of overpayments related to SFY 2023 dates of service. If overpayments were incurred, Mercer requested the overpayment and recoupment amounts, and compared the net amounts to the RDT. For reported overpayments, Mercer requested amounts related to Fraud, Waste and Abuse and All Other.	Variance: RDT is understated by 159.95%, or \$2,222,829. Per CCAH, the understatement was due to differences between estimated and actual overpayments. Additionally, per CCAH, \$74,201 overpayments were reported as Fraud, Waste and Abuse to the appropriate agency as required in APL 23-011.
Mercer requested information on the efforts to identify and recoup provider overpayments and on how the recoupments are recorded in the RDT.	CCAHA provided a written policy for the identification and recovery of overpayments. Based on a review of that policy, CCAH is appropriately excluding any provider overpayments from the RDT medical expenses.

Overpayments	
Description of Procedures	Results
	However, due to the variance noted above, reported medical expense is overstated.

Maternity	
Description of Procedures	Results
Mercer compared total delivery counts reported in Schedule D-1 with the support information provided by DHCS for the same period.	Variance: The delivery count reported in the RDT is overstated by 0.82% or 52 deliveries.
Mercer requested policies and procedures to identify delivery events and related costs, as well as any allocation methodologies.	CCAH provided detail-level logic from their processing system used to identify delivery events and related costs. Allocation methodologies were not utilized in their processes.

Capitation Revenue	
Description of Procedures	Results
Mercer compared capitation amounts reported in Schedule 6a for SFY 2023 with the Capitation Management System (CAPMAN) file received from DHCS for the same period. The CAPMAN file contains all amounts paid to the MCP by DHCS.	Variance: RDT Capitation Revenue is understated by 2.61%, or \$41,159,805. The majority of the variance is due to an understatement of the base capitation revenue of \$196 million. Offset by the lack of reporting the MCO tax for 1H23 and an understatement of incentive payments in the RDT due to timing.

Member Months	
Description of Procedures	Results
Mercer compared the MCP-reported member months from Schedule 1-C to eligibility and enrollment information provided by DHCS. 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 understated by 0.04% in total.

Administrative Expenses	
Description of Procedures	Results
Mercer benchmarked administrative expenses as a percentage of net revenue across all Two-Plan/Geographic Managed Care (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 CCAH was within an acceptable range compared to industry standards.
Mercer compared detailed line items from the MCP's trial balance for reasonableness when mapped to line items in Schedule 6a. If applicable, Mercer reviewed allocation methodologies for reasonableness.	No variance noted.

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 CCAH was within an acceptable range compared to industry standards.
Mercer requested the trial balance for UM/QA/CC expense to be compared to Schedule 1. Mercer also reviewed allocation methodologies for reasonableness, if applicable.	Variance: Schedule 1 is overstated by 3.49%, or \$817,731. This amount represents 0.06% of total medical expense. Per CCAH, the variance is due to an allocation methodology that was utilized to allocate the expenses for fiscal year reporting for RDT purposes.
Mercer confirmed with the MCP that UM/QA/CC costs were not included in general administrative expenses.	Confirmed.

Other Information	
Description of Procedures	Results
Mercer reviewed information submitted by the MCP as to how third-party liability (TPL) is identified and reported. Per DHCS All Plan Letter (APL) 21-007, the MCP 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, CCAH is submitting TPL information as required by APL 21-007. No further testing was deemed necessary.
Mercer reviewed the MCP's audited financial statements covering SFY 2023 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.

Section 3

Summary of Findings

Based on the procedures performed, the total amount of capitation revenue for the SFY 2023 RDT was understated by \$41,159,805 or 2.61%.

Based on the defined variance threshold, the results of the capitation revenue audit are determined to be material, but explanations were accepted as reasonable and do not warrant corrective action.

Based on the procedures performed, the total amount of gross medical expenditures in the RDT were overstated by \$1,821,748 or 0.13% of total medical expenditures in the SFY 2023 RDT.

Based on the procedures performed, there was no variance noted for administrative expenditures in the SFY 2023 RDT. However, the plan should prepare to properly record a portion of their provider sub-capitation expenses as administrative in future RDT reporting, therefore reducing their medical expense.

CCAH reviewed this report and had the following comments:

In response to the total capitation revenue understatement noted in the audit summary findings, while the variance was determined to be material, the explanation was accepted as reasonable, and no corrective action was required. To reiterate, the understatement is primarily due to an updated rate package that was received after the submission of the SFY 2023 RDT.

For CY 2023 rates, CCAH utilized the January 2023 rate package to calculate capitation revenue, which was the most recent available at the time of our March 2024 resubmission. In May 2024, an amended rate package was received, which was our final CY 2023 rates. This rate package updated the rates and included the MCO tax, which contributed to the \$41,159,805 (2.61%) understatement in reported capitation revenue for SFY 2023.



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