MERCER
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June 26, 2026
California Department of Health Care Services

State Fiscal Year 2024 Blue Shield of California Rate Development Template

Auditor's Report

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 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) 2024 by Blue Shield of California (BSH). 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) 2026 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 2024 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 BSH for SFY 2024. BSH'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.	• Control Totals: No variance noted. • Eligibility: 0.10% of claim submissions with no matching eligibility totaling $481,445 or 0.07% of total medical expense. • Enrollment: 0.05% of claim submissions were not enrolled with BSH on claim date of service, totaling $189,379 or 0.03% of total medical expense. • Duplicates: None noted. • Encounter Completeness: 9.56% of claim submissions with no matching encounter totaling $33,227,184 or 4.65% of total medical expense. Most of these claims could not be submitted to DHCS due to known data quality issues. DHCS requests that Mercer follow up with BSH in one year to verify that improvements have been made in their encounter completeness factor. • Service Year: No variance noted. All dates of service fall within SFY 2024. • Interest Paid: Per BSH, interest payments on late claims were appropriately excluded from FFS claims expense. • COS Map: Review of all COS showed 80%–96% match for all COS. The mismatches have been

Fee-For Service (FFS) Medical Expense	
Description of Procedures	Results
	redistributed to the appropriate COS for variance reporting below and are attributed to a difference in classification logic used by BSH versus DHCS, primarily related to taxonomy codes and procedure code logic. 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 9.95% • Outpatient 9.78% • Physician 14.57% • Mental Health 8.18% • LTC 2.30% • All Other (4.78%) In Total, FFS encounter data are understated by 6.05%, or $33,333,298 which is 4.67% of total medical expense. Per BSH, the variance is primarily due to claims that have not been submitted as encounters. As of the report date, BSH has not corrected the data quality issues but is researching these encounters to ensure future acceptance in the DHCS system. Based on the explanations provided by BSH, 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. BSH 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.	Variance: RDT non-global sub-capitation expense is overstated by 0.05%, or $61,725, which is 0.01% of total medical expense The total of the details provided were less than 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 99.99% of members. The amount of non-global sub-capitation paid for the ineligible members is $82,812.
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 sampled sub-capitated providers is understated by 0.05%, or 11,579. The proof of payment information was more than 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.	Variance: Proof of payment support for sub-capitated amounts in the sample test work is overstated by 0.38%, or $89,771. The recalculated amounts were less than sub-capitation amount reported in the supporting detail provided.
If applicable, Mercer reviewed Full Dual COA sub-capitated per member per month (PMPM) payment rates to determine whether the amount(s) are at	Confirmed reduced rates as compared to the non-Full Dual COA groups.

Sub-Capitated Medical Expense	
Description of Procedures	**Results**
a reduced rate as compared to the non-Full Dual COAs.	
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.	BSH had one sub-capitated arrangement that exceeded the threshold of 5% or more of total medical expense. Mercer found that the sub-capitated contract reviewed did include administrative functions that are outlined in Appendix A. However, none of the sub-capitated amounts paid were allocated to the administrative expense in the RDT. Additionally, BSH did not allocate administrative dollars for any of their other sub-capitated arrangements. Therefore, this is an understatement of administrative expense and equal overstatement of medical expense.

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.	Variance: Schedule 1 is understated by 0.01%, or $54,163, when compared to Schedule 7.

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.	BSH has no related party arrangements as defined to include any hospitals or provider organizations whose executive level staff hold a seat on BSH Board of Directors.

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 overstated by 11.77%, or $962,046. This amount represents 0.13% of total medical expense. Per BSH, the variance is due to 2024 incentive amounts being based on estimates that had not been paid out at the time of the submission.
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.	BSH confirmed there are no related party incentive arrangements.
Mercer observed proof of payments for the sampled provider incentive payments and compared the amounts to the detailed support.	No variance noted.

Provider Settlements	
Description of Procedures	**Results**
Mercer requested settlement amounts paid by provider related to SFY 2024 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.	Variance: Schedule 7 is understated by 100%, or $1,880,261. This amount represents 0.26% of total medical expense. Per BSH, this variance is due to two types of settlements happening after the RDT was submitted; a capitation settlement related to a rate increase for a provider and three FFS settlements involving two hospitals.
If settlement amounts are material, Mercer requested supporting documentation and performed additional procedures if necessary.	Not applicable. The settlement amounts are immaterial.

Overpayments	
Description of Procedures	**Results**
Mercer inquired of the MCP whether they incurred any provider overpayment and recoupment of overpayments related to SFY 2024 dates of service. If overpayments existed, 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 5.99%, or $168,370. Per BSH, this variance was due to overpayments that were identified after the RDT submission and is immaterial to total medical expense. Additionally, none of the overpayments identified were attributed to Fraud, Waste, and Abuse.
Mercer requested information on the efforts to identify and recoup provider overpayments and on how the recoupments are recorded in the RDT.	BSH provided a written policy for the identification and recovery of overpayments. Based on a review of that policy, BSH is appropriately excluding any provider overpayments from the RDT medical expenses. 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 understated by 11.45% or 171 deliveries. Per BSH, the variance is primarily due to deliveries known subsequent to the final RDT submission.
Mercer requested policies and procedures to identify delivery events and related costs, as well as any allocation methodologies.	BSH provided high-level logic used to identify delivery events and related costs. The logic was reviewed and was deemed reasonable. However, BSH should review the reason behind the lag in discovering maternity events as the variance above represents deliveries known after an RDT submission more than nine months following the end of SFY 2024.

Capitation Revenue	
Description of Procedures	**Results**
Mercer compared capitation amounts reported in Schedule 6a for SFY 2024 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 5.48%, or $44,326,161. The majority of the variance is due to timing differences of revenue known at the time of RDT submission as compared to final capitation revenue paid.

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 overstated by 0.13% in total.

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 administrative percentage reported by BSH was within an acceptable range as 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 BSH was within an acceptable range as 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.	No variance noted.
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, BSH 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 2024 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 2024 RDT was understated by $44,326,161, or 5.48%. Based on the defined variance threshold, the results of the capitation revenue audit are determined to be material. The majority of the variance is due to timing differences of revenue known at the time of RDT submission as compared to final capitation revenue paid. No corrective action is warranted.

Based on the procedures performed, the total amount of gross medical expenditures for the SFY 2024 RDT was overstated by $32,332,468, or 4.53% of total medical expenditures. Based on the defined variance threshold, these results are determined to be material. The variance is primarily driven by medical expenses that were not supported by an encounter, as noted in the FFS section.

Due to discrepancies in BSH's encounter data provided for analysis discussed in the FFS section, DHCS requests that Mercer follow up with BSH in one year to verify that improvements have been made in their encounter completeness factor. If the issue persists, a corrective action plan may be issued.

Based on the procedures performed, there was no variance noted for administrative expenditures in the SFY 2024 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.

BSH reviewed this report and had the following comments:

1. Capitation Revenue Understatement of $44.3 Million

BSH reported revenue consistent with Schedule 6a instructions, which requires reporting on an incurred basis. At the time of the RDT submission, revenue was calculated using the best available information, with incurred defined as cash receipts plus outstanding amount owed (i.e., total earned).

We believe the reported amounts appropriately reflect revenue earned during the reporting period and are consistent with the prescribed reporting framework.

2. Medical Expenditure Overstatement of $33.3 Million

BSH's reported FFS claims are not overstated in the SFY23-24 RDT. Our FFS claims submission control total matches our financial records with immaterial variances.

We acknowledge that some encounters have not been accepted by DHCS due to data deficiencies. We are actively addressing this issue and expect the amount to decrease in future RDT submissions, although it may not be fully eliminated.

While we acknowledge it would be ideal for encounters to be 100% complete, we do not believe that our claims reported in RDT are overstated.

Appendix A

Administrative Duties in Subcontracted Arrangements

Administrative Duties	Integrated Health Partners of Southern California
Quality Management	
Quality Measure Tracking	
Member Grievance	
Encounter Submission	X
Claims Adjudication and Payment	X
Member Services	X
Provider Services	X
Case Management	
Claims Processing	
Utilization Management	X
Provider Relations and Education	
Provider Contracting	X
Credentialing and Recredentialing	X

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