Mercer

Government Human Services Consulting

State Fiscal Year 2023 Health Net of California Rate Development Template

Auditor's Report

California Department of Health Care Services

June 27, 2025

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) 2023 by Health Net of California (HNC). 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-ECM (SIS/UIS) — Enhanced Care Management (ECM) Summary
- 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 MCP for SFY 2023. HNC'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 are understated by 0.07%. • Eligibility: 0.05% of claim submissions had no matching eligibility totaling $1,367,765 or 0.03% of total medical expense. • Enrollment: 0.11% of claim submissions were not enrolled with the HNC on claim date of service, totaling $3,126,446 or 0.07% of total medical expense. • Encounter Completeness: 3.34% of claim submissions had no matching encounter totaling $99,071,252 or 2.16% of total medical expense. • Service Year: No variance noted. All dates of service fall within SFY 2023. • COS Map: Review of all COS showed 90%–99% match for all COS. The mismatches have been redistributed to the appropriate COS for variance reporting below and attributed to differences in provider taxonomy codes used by HNC versus DHCS. HNC is continuing its efforts to improve provider reporting of taxonomy codes for future encounter submissions. All items noted above are adjustments to the support provided and are included

Fee-For Service (FFS) Medical Expense	
Description of Procedures	**Results**
	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 3.58% • Outpatient (0.86%) • Physician 4.43% • Mental Health 30.56% • LTC 1.82% • All Other 6.39% In Total, RDT FFS expenses are overstated by 4.13%, or $105,007,714, which is 2.29% of total medical expense. • The variances above are primarily due to claims that had no matching encounter in the DHCS system. Approximately 65% of the missing encounters are due to a lack of claim identifier information provided in the FFS claims files from HNC. The Mental Health COS comprises a significant portion of the claims that are missing encounters. Based on the explanations provided by HNC, 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.	Variance: RDT Global Sub-capitation expense is overstated by 2.08%, or $4,656,799, which is 0.10% of total medical expense. The total of the detail provided was less than the amounts reported in the RDT. Per HNC, the variance is primarily due to the ongoing reconciliation of the capitation rates for the Coordinated

Global Subcontracted Payments	
Description of Procedures	**Results**
	Care Initiative (CCI) program and the UIS/SIS populations.
Mercer obtained roster information for the globally subcontracted providers and verified eligibility of members, confirmed enrollment with MCP, and analyzed claims to verify none of the FFS Claims paid should have been paid under the global arrangement.	Eligibility and enrollment were verified for 99.31% of members. The amount of global capitation paid for the ineligible members was $2,657,063.
Mercer observed proof of payments via relevant bank statements, clearinghouse documentation, or other online financial institution support for all 12 months of SFY 2023 global capitated payments.	Variance: Detailed support for global capitation expense is understated by 0.37%, or $809,752. The proof of payment information was more than the supporting detail provided for the sampled global capitated providers.
Mercer reviewed the contractual arrangement with the MCP's global subcontractor(s) and recalculated the total payment amounts using global roster information provided for all 12 months of SFY 2023 multiplied by the rates established in the contract with the subcontractor.	Variance: Proof of payment support for global capitation expense is overstated by 1.89%, or $4,146,037. The recalculated amounts were less than the global capitation amounts in the proof of payment support provided.
Mercer compared the global per member per month (PMPM) payment rates to relevant PMPM experience for non-global members for reasonableness.	Mercer found the average global PMPM to be reasonable as compared to the cost experience of the non-global membership.
If applicable, Mercer reviewed Full-Dual member global contracted PMPMs to determine whether the amount(s) are at a reduced rate as compared to the non-Full Dual category of aid (COA) groups.	Confirmed reduced rates as compared to the non-Full Dual COA groups.
Mercer reviewed the sampled global 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.	Mercer reviewed the global capitated contract with subcontractor to determine the level of administrative functions included. See Appendix A for details. Per HNC, there was no global administrative expense reported in the Schedule 1-A Data tab in the RDT. Therefore, this is an understatement of

Global Subcontracted Payments	
Description of Procedures	**Results**
	administrative expense and an equal overstatement of medical expense.

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 0.04%, or $744,658, which is 0.02% of total medical expense. 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 99.98% of members. The amount of non-global sub-capitation paid for the ineligible members is $7,289.
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 overstated by 1.26%, or $2,455,319. The proof of payment information was less than 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.	Variance: Proof of payment support for sub-capitated amounts in the sample test work is overstated by 2.24%, or $4,303,519. The recalculated amounts were less than the sub-capitation amounts in the proof of payment support provided.
If applicable, Mercer reviewed Full-Dual COA sub-capitated 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	HNC did not have any sub-capitated arrangements that exceeded the 5% or more of total medical expense threshold.

Sub-Capitated Medical Expense	
Description of Procedures	**Results**
amount of administrative dollars reported in the RDT as compared to the delegated 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.	HNC has related party arrangements as defined to include any hospitals or provider organizations whose executive level staff hold a seat on the HNC Board of Directors. HNC has FFS arrangements with these related parties.
If related party contracts are a material portion of the related medical COS, Mercer also reviewed any allocation methodologies for reasonableness.	HNC has one related party with payments that are 95% of the related COS expense. The related party contract does not list allocation methodologies.
Mercer reviews that all services included in the related party agreements are allowable for Medicaid rate setting.	All services included in the related party arrangements are allowable for Medicaid rate setting.
When applicable, Mercer obtained related party corporate allocation methodologies for administrative services.	Mercer reviewed the related party corporate allocation methodologies and determined that they are reasonable.

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 8.05%, or $2,362,088. However, HNC had a Shared Risk

Provider Incentive Arrangements	
Description of Procedures	**Results**
	Incentive Program pertaining to nine providers that was not tied to quality measures. Therefore, $3,161,396 was removed from the audit support provided. As a result, RDT Provider Incentive Expense is overstated by 2.72%, or $799,309, and represents 0.02% of total medical expense.
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.	HNC confirmed there were no related party provider incentive arrangements.
Mercer observed proof of payments for the sampled provider incentive payments and compared the amounts to the detailed support.	Variance: Detailed support for provider incentive payments in the sample test work is understated by 0.62% or $40,613. 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.	Variance: Schedule 7 is understated by 68.30% or $414,044. Per HNC, the understatement was due to differences between estimated and actual settlements and represents 0.01% of total medical expense.
If settlement amounts are material, Mercer requested supporting documentation and performed additional procedures if necessary.	Not applicable. The settlement amount is immaterial.

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 existed, Mercer requested the overpayment and recoupment amounts and compared the net amounts to the RDT.	Variance: RDT is understated by 223.25%, or $6,763,239. Per HNC, the understatement was due to differences between estimated and actual overpayments. Additionally, per HNC, $157,334 of the overpayments were reported as Fraud, Waste, and Abuse to the appropriate agency as required.
Mercer requested information on the efforts to identify and recoup provider overpayments and on how the recoupments are recorded in the RDT.	HNC provided the written policy for the identification and recovery of overpayments. Based on a review of that policy, HNC is appropriately excluding any provider overpayments from the RDT medical expenses. However, due to the understatement 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 6.96% or 1,023 deliveries. Per HNC, the delivery identification criteria has caused the RDT to be understated. The RDT reported delivery counts represent a lower bound on the number because HNC has developed logic that is very conservative. The maternity kick payment process has historically had more inclusive criteria to identify when a delivery has occurred. Throughout 2023, there were efforts to eliminate criteria which were found to be driving some potential false positives. Currently, the maternity kick payment process is well aligned with the more conservative RDT approach.
Mercer requested policies and procedures to identify delivery events	HNC provided high-level logic used to identify delivery events and related

Maternity	
Description of Procedures	**Results**
and related costs, as well as any allocation methodologies.	costs. The logic provided was reviewed and was deemed reasonable.

Capitation Revenue	
Description of Procedures	**Results**
Mercer compared capitation amounts reported in Schedule 6a for CY 2022 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 is overstated by 8.48%, or $524,174,813. Per HNC, the variance primarily is due to the following: Overreporting of the CCI capitation of approximately $257 million. Lack of the 1H2023 accruals for the Hospital Quality Assurance Fee Pass-through and Rate Range items totaling $256 million.

Member Months	
Description of Procedures	**Results**
Mercer compared the HNC-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 0.21% in total.

Administrative Expenses	
Description of Procedures	**Results**
Mercer benchmarked administrative expenses as a percentage of net revenue across all County Organized Health System (COHS) 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 HNC was within an acceptable range as compared to industry standards.
Mercer compared detailed line items from the plan's trial balance for	No variance noted.

Administrative Expenses	
Description of Procedures	**Results**
reasonableness when mapped to line items in Schedule 6a. If applicable, Mercer reviewed allocation methodologies for reasonableness.	

UM/QA/CC	
Description of Procedures	**Results**
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 when reviewing the results.	The UM/QA/CC percentage reported by HNC 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.	Variance: Schedule 1 is overstated by 1.64%, $786,809 or 0.02% of total medical expenses.
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, HNC 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.

Other Information	
Description of Procedures	**Results**
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 overstated by $524,174,813 or 8.48%.

Based on the procedures performed, the total amount of gross medical expenditures in the RDT was overstated by $114,872,480 or 2.50% 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 properly record a portion of their provider global and provider sub-capitation expenses as administrative in future RDT reporting; therefore, reducing their medical expense.

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

HNC reviewed this report and had the following comment — The overstatement of gross medical expenditures was primarily driven by encounters and overpayment runout.

Appendix A

Administrative Duties in Subcontracted Arrangements

Administrative Task	Molina (Global)
Quality Management	X
Quality Measure Tracking	X
Member Grievance	X
Encounter Submission	X
Claims Adjudication and Payment	X
Member Services	X
Provider Services	X
Case Management	X
Claims Processing	X
Utilization Management	X
Provider Relations and Education	X
Provider Contracting	X
Credentialing and Recredentialing	X

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