Mercer

Government Human Services Consulting

State Fiscal Year 2023 Santa Clara Family Health Plan 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 Santa Clara Family Health Plan (SCF). 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 SCF for SFY 2023. SCF'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: 0.39% of claim submissions had no matching eligibility totaling $4,775,922 or 0.42% of total medical expense. • Enrollment: 0.15% of claim submissions were not enrolled with SCF on claim date of service, totaling $173,829 or 0.02% of total medical expense. • Encounter Completeness: 12.29% of claim submissions had no matching encounter totaling $18,438,966 or 1.61% of total medical expense. The majority of claims submitted without a corresponding encounter are attributable to differences in encounter submission guidance for Medicare-Medicaid Plans (MMP) relating to the Cal MediConnect (CMC) population. • Service Year: 0.03% of claim submissions were out of period totaling $46,377 or 0.00% of total medical expense. • COS Map: Review of all COS showed 96%–99% match for all COS. The mismatches have been redistributed to the appropriate COS for variance reporting below.

Fee-For-Service (FFS) Medical Expense	
Description of Procedures	**Results**
	All items noted above are adjustments to the support provided and are included in the variance calculations immediately below.
Mercer compared detailed lag tables for each COS grouping (Facility — Inpatient, Facility — Outpatient, Physician, Mental Health — Outpatient and BHT 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 14.01% • Outpatient 6.84% • Physician (7.85%) • Mental Health 1.10% • LTC 1.09% • All Other (8.19%) In Total, RDT FFS Expenses are overstated by 3.50%, or $14,463,795, which is 1.26% of total medical expense. • The variance is primarily due to an overestimation of the Inpatient IBNR because of a significant change to a hospital contract after the RDT submission. No additional test work 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 0.62%, or $692,444, which is 0.06% of total medical expense. The total of the detail provided was less than the amounts reported in the RDT.
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	Eligibility and enrollment were verified for 99.96% of members. The amount of global capitation paid for the ineligible members was $38,000.

Global Subcontracted Payments	
Description of Procedures	**Results**
paid should have been paid under the global arrangement.	
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 1.30%, or $1,313,269. The proof of payment information was more than the supporting detail provided for the sampled global capitated providers. The variance is primarily due to capitation retroactivity. No additional testing was deemed necessary.
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 2.67%, or $2,739,356. 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 lower when compared to the cost experience of the non-global membership. Per SCF, the variance is due to differences in population mix and risk, contracting and reimbursement structures, and insulation from utilization changes.
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 global capitated contracts to determine delegated administrative duties. Using this	Mercer reviewed the global capitated contract with subcontractor to determine the level of administrative functions

Global Subcontracted Payments	
Description of Procedures	**Results**
information, Mercer then reviewed the amount of administrative dollars reported in the RDT as compared to the delegated administrative functions.	included (see Appendix A for details). SCF identified 6.81% of the global capitation expense as administrative in the Schedule 1-A Data tab in the RDT. This amount is considered within an acceptable range for industry standards. However, this administrative expense was not removed from medical expense. Therefore, this is an understatement of 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 understated by 1.48%, or $8,586,876, which is 0.75% of total medical expense. The total of the detail provided was more than the amounts reported in the RDT. The variance is primarily due to the timing of supplemental payments made to Valle Health Plan (VHP) as well as a contract amendment retroactively increasing 1H23 capitation rates which was signed in November 2023.
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 99.92% of members. The amount of non-global sub-capitation paid for the ineligible members is $199,865.
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 understated by 0.12%, or $292,521. The proof of payment information was more than the supporting detail provided for the sampled sub-capitated providers.
Mercer reviewed the contractual arrangements, and recalculated the total	Variance: Proof of Payment support for sub-capitated amounts in the sample

Sub-Capitated Medical Expense	
Description of Procedures	**Results**
payment amounts by sub-capitated provider using roster information provided by the MCP for the sampled providers.	test work is overstated by 1.02%, or $2,584,611. The recalculated amounts were less than the sub-capitation amount reported 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 amount of administrative dollars reported in the RDT as compared to the delegated administrative functions.	SCF had one sub-capitated arrangement that exceeded the 5% or more of total medical expense threshold. The arrangement with VHP accounts for approximately 46% of SCF's total medical expense. SCF pays VHP 98% of the DHCS capitation rates paid to SCF. The arrangement with VHP includes administrative functions that are outlined in Appendix A. However, none of the PMPM amounts paid to VHP were allocated to administrative expense in the RDT. Additionally, SCF did not allocate administrative dollars for any of their other sub-capitated arrangements. Therefore, this is an understatement of administrative expense and an 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 from Schedule 7 for consistency.	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.	SCF has related party sub-capitated arrangements as defined to include any hospitals or provider organizations whose executive level staff hold a seat on the SCF Board of Directors. Per review of the sub-capitated contracts, terms are similar to those non-related party terms. It should be noted that subcontractor, VHP, accounts for approximately 46% of their total medical expense and would be considered a significant relationship; however, VHP does not appear to be a related party.
If related party contracts are a material portion of the related medical COS, Mercer also reviewed any allocation methodologies for reasonableness.	Not applicable. No corporate allocations are present.
Mercer reviewed 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.	Not applicable. No related party allocations.

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 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.

Provider Incentive Arrangements	
Description of Procedures	**Results**
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.	No settlements were paid for SFY 2023.
If settlement amounts are material, Mercer requested supporting documentation and performed additional procedures if necessary.	Not applicable.

Overpayments	
Description of Services	**Results**
Mercer inquired of the MCP whether they incurred any provider overpayments and recoupment of overpayments related to SFY 2023 dates of service. If overpayments existed, Mercer requested the	Variance: RDT is understated by 103.24%, or $650,653. Per SCF, the understatement was due to differences between estimated and

Overpayments	
Description of Services	**Results**
overpayment and recoupment amounts and compared the net amounts to the RDT.	actual overpayments. Additionally, per SCF, $2,909 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 ecoupments are recorded in the RDT.	SCF provided the written policy for the identification and recovery of overpayments. Based on a review of that policy, SCF 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 1.82% or 48 deliveries. Per SCF, the delivery count variance is due to timing.
Mercer requested policies and procedures to identify delivery events and related costs, as well as any allocation methodologies.	SCF provided high-level logic used to identify delivery events and related 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 health plan by DHCS.	Variance: RDT is understated by 0.84%, or $10,282,167. The majority of the variance is due to an understatement of the base capitation revenue of $103 million, offset by the lack of reporting the MCO tax for 1H2023.

Member Months	
Description of Procedures	**Results**
Mercer compared the SCF-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 1.61% in total. Per SCF, the understatement is due to an error in reporting certain dual eligible member months in the RDT.

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 SCF 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 SCF 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	Variance: Schedule 1 is overstated by 0.22%, $107,528 or 0.01% of total medical expenses.

UM/QA/CC	
Description of Procedures	**Results**
allocation methodologies for reasonableness, if applicable.	
Mercer confirmed with MCP that UM/QA/CC costs were also 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, SCF is submitting TPL information as required by APL 21-007. No further testing was deemed necessary.
Mercer reviewed the plan's audited financial statements for 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 overstated by $10,282,167 or 0.84%.

Based on the procedures performed, the total amount of gross medical expenditures in the RDT was overstated by $9,015,492 or 0.78% 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 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 audit are determined to be immaterial and do not warrant corrective action.

Due to the low encounter completeness factor discussed in the FFS section, a review of the FFS section will be performed in approximately one year. If a 95% completion factor is not achieved, a corrective action plan may be issued.

SCF reviewed this report and agreed with the findings.

Appendix A
Administrative Duties in Subcontracted Arrangements

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

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