MERCER

AUDITORS REPORT

CALENDAR YEAR 2017 HEALTH NET OF CALIFORNIA RATE DEVELOPMENT TEMPLATE

September 4, 2020

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1
Executive Summary

Pursuant to federal requirements under Title 42 of the Code of Federal Regulations 438.602(e), the 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) [1]. DHCS contracted with Mercer Government Human Services Consulting (Mercer) to fulfill this requirement for the financial data submitted in the Medi-Cal Rate Development Template (RDT) for calendar year (CY) 2017 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.

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 Bridge Year rating period (July 1, 2019 – December 31, 2020). The RDT tested was the final version, including any revisions stemming from resubmissions as a result of the RDT Q&A discussion guide process with the MCO.

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

- Schedule 1 Utilization and Cost Experience
- Schedule 1A – Global Subcontracted Health Plan Information
- Schedule 1C – Base Period Enrollment by Month
- 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 CY 2017 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 calendar year reported.

The procedures and results of the test work are enumerated in Table 1 of Section 2.

[1] 42 CFR 438.602(e)

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Procedures and Results

We have 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 HNC for the CY 2017. HNC's management is responsible for the content of the RDT and responded timely to all requests for information.

Table 1: Procedures

Category	Description	Results
Utilization and Cost Experience	We compared summarized total net cost data from amounts reported in Schedule 1 to Direct Medi-Cal category of service (COS) totals from Schedule 6a and to total incurred claims by COS for Schedule 7 for consistency.	Schedule 1 understated by 0.28%, or $9,388,588, when compared to Schedule 6a. There is no variance when Schedule 1 is compared to Schedule 7.
Global Subcontracted Payments	We requested overall global capitation supporting detail. We compared the support provided to the amounts reported in Schedule 1-A. The total of the detail provided was less than the amounts reported in the RDT.	Variance: RDT reported capitation amounts are overstated by 1.71%, or $4,786,407.
	We reviewed the contractual arrangement with HNC's global subcontractor and recalculated the total payment amount using global eligibility from the 834 data multiplied by the rates established on the most current rate sheet received from DHCS, adjusted for the global subcontracted arrangement. The recalculated amounts were less than the global capitation amount reported in the supporting detail provided.	Variance: Detailed support for global capitation amounts are overstated by 0.02%, or $39,792.
	We selected the three highest months of payment and five randomly selected additional months of payment to obtain membership rosters for each month selected. Twenty randomly selected members from each month were checked to ensure eligibility. The same members were compared against claims included in the fee-for-service (FFS) data provided by HNC to see if both HNC and the global subcontractor paid claims.	No FFS claims paid. All sampled members eligible.

Category	Description	Results
	We reviewed members included on the member roster to ensure there were no Coordinated Care Initiative members or payments provided in the step above.	None identified.
Member Months	We compared MCO reported member months from Schedule 1C to eligibility and enrollment information provided by the State. Our procedures are to request explanations for any member months with greater than 1% variance in total or greater than 2% variance by major category of aid.	Variance: RDT overstated by 0.10% in total.
Capitation Revenue	We discussed how capitation was recorded. HNC records capitation revenue on an accrual basis using eligibility from the 834 data multiplied by rates established on the most current rate sheet received from DHCS.	RDT overstated by 0.57% based on estimated revenue calculation using the known capitation rates in place during 2017.
Interest and Investment Income	We 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.	Variance: RDT is understated by 0.89%, or $255,294.
Fee For Service Medical Expense	Using data files (paid claims files) provided by HNC, we sampled and tested transactions for each major category of service (COS) (Inpatient, Outpatient, Physician, Pharmacy, Facility-Long Term Care (LTC), and All Others) and traced sample transactions through HNC claims processing system, the payment remittance advice, and the bank statements.	No variance observed.
	We compared detailed lag tables for each major COS (Inpatient, Outpatient, Physician, Pharmacy, Facility- (LTC), and All Others) created from the data files provided by HNC and compared the information reported in Schedule 7. We compared the paid claims amounts from Schedule 7, line 35 to total paid claims prior to the additional runout detail included in the data files, expecting no changes.	Variance: RDT understated in total by 0.92% of total FFS claims payments reported on Schedule 7, or $14,934,166.
	We compared total final incurred amounts including incurred but not reported (IBNR) estimates from Schedule 7 to total paid amounts from all months reported in the data files to verify the accuracy/reasonableness of IBNR for each COS. Allowable absolute value variances were deemed to be not greater than 2% for inpatient claims and 1% for all other COS.	Variance: RDT over/(understated): Inpatient 0.48%; Outpatient 0.17%; LTC 0.77%; Physician 2.52%; Pharmacy (2.27%); All Other 3.94%; In Total 0.47%, or $7,883,150.

Category	Description	Results
	We reviewed a sample of claims from each COS to verify control totals, verify eligibility, confirm the COS grouping was correct, and confirm the year reported was correct.	Control totals: No variance noted. Eligibility: Verified for all members selected. COS Map: No variance noted. Service Year: No variance noted.
Sub-capitated Medical Expense	We requested overall sub-capitation supporting detail. We compared the support provided to the amounts reported in Schedule 7. The total of the detail provided was less than the amounts reported in the RDT.	Variance: RDT reported sub-capitation amounts are overstated by 0.16%, or $2,154,477.
	We sampled membership from three subcontractors, verified eligibility of members and analyzed claims to verify none of the FFS claims paid should have been paid by the sub-capitated provider.	No variance noted.
	We reviewed a sample of the contractual arrangements with HNC's sub-capitated providers and recalculated the total payment amounts by sub-capitated provider using roster information provided by HNC. The recalculated amounts were less than the sub-capitation amount reported in the supporting detail provided.	Variance: Detailed support for sub-capitated amounts is overstated by 1.75%, or $1,372,921.
	We observed proof of payments for the sampled sub-capitated providers in the previous step. The proof of payment information was less than the supporting detail provided for the sampled sub-capitated providers.	Variance: Detailed support for the sampled sub-capitated providers is overstated by 4.47%, or $3,599,915.
Provider Incentive Arrangements	We reviewed incentive arrangements and observed sample calculations for contractual compliance and reasonableness.	Variance: RDT is understated by 2.36%, or $983,838.
Reinsurance	We reviewed the reinsurance contract and compared the amount on the RDT to the requested supporting schedule.	Variance: Reported reinsurance premium is understated by 100.0%, or $1,729,826. This amount is just 0.05% of total medical expenses.

Category	Description	Results
	We recalculated reinsurance premiums, based on 2017 membership as of April 2019, to compare to reported amounts.	Variance: Although the plan did not report reinsurance premiums on the RDT, premium support was provided. We calculated reinsurance premiums using the provided contract and member months. Reinsurance premium as shown on the support was overstated by 13.62%, or $235,572. The recalculated amount is included in the overall variance reported in the prior line item.
	We recalculated recoveries for a sample of members.	No cases exceeded the reinsurance threshold.
Administrative Expenses	We benchmarked administrative expenses as a percentage of capitation across all Two-Plan/GMC plans and compared to the amount reported in Schedule 6a, taking into consideration the membership size of the plan under review when reviewing the results.	The benchmark administrative percentage was 5.50% and HNC reported 7.14%, primarily driven by higher than average Outside Services (on a PMPM basis). It should be noted that HNC is one of the larger Two-Plan/GMC plans from a membership perspective. Thus, the higher than average administrative percentage is even more of an outlier.
	We compared detailed line items from the plan's trial balance mapped to line items in Schedule 6a for reasonableness. We reviewed allocation methodologies and recalculated for reasonableness.	No variance noted.
Utilization Management, Quality Assurance, Care Coordination (UM/QA/CC)	We benchmarked UM/QA/CC expenses as a percentage of revenue across all Two-Plan/GMC plans and compared to the amount reported on Schedule 6a, taking into consideration the membership size of the plan under review when reviewing the results.	The benchmark UM/QA/CC percentage was 1.23% and HNC reported 0.42%.
	We compared detailed line items from the plan mapped to line items in Schedule 1-U for reasonableness. We reviewed allocation methodologies and recalculated for reasonableness.	Variance: Schedule 1-U is understated by 19.98%, $3,440,108 or 0.10% of total medical expenses.

Category	Description	Results
	We interviewed financial management to determine how health care quality improvement activities such as care coordination are isolated from general administrative expenses in the general ledger. Confirmed with HNC management via interview that UM/QA/CC costs were not also included in general administrative expenses.	Confirmed.
Pharmacy	We confirmed and observed pharmacy benefit manager fees were recorded as administrative expenses and not included in pharmacy claims expenses in the RDT.	No variance noted.
Other Information	We reviewed the audited financial statements for the plan for the CY 2017 for a clean audit opinion or identification of significant deficiencies or material weaknesses.	No variance noted.
	We compared reported expenses, including IBNR and administrative expenses, to audited financial statements for consistency.	No material variances noted.
	We inquired how hospital-acquired conditions (HACs) were treated in the RDT and policies for payment.	HNC's Medical Management Health Care Services Unit (MMHCS) performs monthly potentially preventable conditions (PPCs)/HACs screening and reviewing of claims and encounter data. MMHCS reviews and evaluates reported PPCs, including provider submitted online copies of the DHCS Forms, aggregate claims data, encounter data, and referred Potential Quality of Care Referral Forms indicative of PPCs. MMHCS will complete and submit the online DHCS "Medi-Cal PPC Reporting Form" to the DHCS Audits and Investigations (A&I) Division. The reported amounts are not excluded from the RDT results. HNC should exclude these costs in future reporting.

Summary of Findings

Based on the procedures performed, the total amount of gross medical expenditures in the RDT were overstated by $4,529,905 or 0.06% of total medical expenditures in the CY 2017 RDT.

Based on the procedures performed, administrative expenditures in the CY 2017 RDT showed no variance, apart from being higher than the benchmark for Two-Plan and GMC plans.

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

HNC reviewed this report and had no comments.

Mercer (US) Inc.
2325 East Camelback Road, Suite 600
Phoenix, AZ 85016
www.mercer-government.mercer.com