MERCER

SCAN Health Plan

Capitation Rate Development and Certification

January 1, 2021–December 31, 2021

State of California
Department of Health Care Services
Capitated Rates Development Division
December 18, 2020

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Contents

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Executive Summary

SCAN Health Plan (SCAN) contracts with the California Department of Health Care Services (DHCS) to provide health care services to its Medicare/Medi-Cal dual eligible members age 65 years old and over in the counties of Los Angeles, Riverside and San Bernardino. SCAN receives a capitation payment from DHCS for the services provided.

DHCS contracted with Mercer Government Human Services Consulting (Mercer), as part of Mercer Health & Benefits LLC, to develop actuarially sound capitation rates for use during calendar year 2021 (CY 2021). CY 2021 encompasses the time period of January 1, 2021 through December 31, 2021.

This report describes the rate development process and provides the certification of actuarial soundness required by Title 42, Code of Federal Regulations (CFR), part 438.4 (42 CFR §438.4). This report was developed to provide the requisite rate documentation to DHCS and to support the Centers for Medicare and Medicaid Services' (CMS') rate review process. This report follows the general outline of the CMS 2020–2021 Medicaid Managed Care Rate Development Guide, which is the applicable version of the guide for the CY 2021 rating period. The rate development process included the historical practice of developing rate ranges. However, the credentialed actuaries are certifying to a final rate as federally required.

Multiple attachments are also included as part of this rate certification package. These attachments include summaries of the CY 2021 capitation rates (including the final and certified capitation rates) and capitation rate calculation sheet (CRCS) exhibits. The final capitation rates by county and category of aid (COA) groupings, including a comparison to the prior CY 2020 rating period certified rates, can be found in the attached Excel file titled *CY2021 SCAN Rates 20201218.xlsx*.

DHCS and Mercer have not just merely trended forward the previous year's rates, but have completed a comprehensive exercise of rebasing using more recent adjusted actual SCAN experience. The rebasing means that rates for various groups do not always move similarly, even with similar prospective trend forces operating on them. The new adjusted base may, and did, emerge differently than expected in the prior year's rate development.

Overall, across all populations and counties, the CY 2021 weighted lower bound capitation rate, which DHCS will pay SCAN, is projected at $366.68 per member per month (PMPM). Mercer certifies to the six separate lower bound capitation rates. This $366.68 PMPM is an approximate 3.17% increase over the corresponding CY 2020 figure. With a projected

168,576 member months, total lower bound capitation dollars are projected to be approximately $61.8 million in CY 2021.

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General Information

This section provides a brief overview of SCAN's history and an overview of the rate setting process, including the following elements:

- SCAN's history
- Covered services
- Covered populations
- Rate structure
- Federal Medical Assistance Percentage (FMAP)
- Rate methodology overview

The information provided in this section should be supplemented with the SCAN contract information for additional detail.

SCAN's History

SCAN was founded in 1977 to provide health and other services to seniors living in Long Beach, California. Today SCAN contracts with DHCS to provide health services for the dual eligible Medicare/Medi-Cal population age 65 years old and over residing in Los Angeles, San Bernardino and Riverside counties.

Covered Services

SCAN provides or arranges for all medically necessary covered services for members. Covered services are those set forth in Title 22, CCR, Chapter 3, Article 4, beginning with Section 51301 and provided in accordance with 42 CFR 438.210(a) and 42 CFR 440.230, unless otherwise specifically excluded under the terms of the contract. Covered services include, but are not limited to:

Covered Services		
Physician services	Psychology services	Durable medical equipment
Skilled nursing facility services	Podiatry services	Home health agency services
Subacute nursing facilities limited to Medi-Cal contract facility	Inpatient hospital services for general acute care, mental illness, substance abuse and rehabilitative services	Chiropractic services
Non-physician practitioners	Ambulatory surgical care centers	Acupuncture
Services for major organ transplants	Pharmaceutical services with certain prescribed and over the counter drugs	Emergency and urgently needed services
Physical, occupational and speech therapies (group and individual)	Laboratory, radiology and radioisotope services	Health education
Medical transportation	Prosthetic and orthotic supplies	Hospice services
Optometry services	Vision care including eyeglasses, contact lenses, prosthetic eyes and other eye appliances	Adult day health care
Audiology services including hearing aids	Dental services including dentures	Personal care services
Psychiatry services	Medical supplies	Renal dialysis services including hemodialysis and peritoneal dialysis

Covered Populations

When individuals become eligible for Medi-Cal, they are assigned a specific aid code. SCAN's COAs are comprised of a number of aid codes that are similar in definition or have individual beneficiaries with similar demographic characteristics or medical conditions, and are as follows:

- Aged/Disabled Dual COA — these are beneficiaries aged 65 and older (may or may not be disabled) and eligible for Medicare Part A, Part B and Part D. DHCS uses Plan Code 200, 204 and 206 to represent the Aged/Disabled rating groups of SCAN dual eligible members in Los Angeles, Riverside and San Bernardino counties, respectively.

- Long-Term Care (LTC) Certified Dual COA — these are beneficiaries aged 65 and older who have been certified eligible to reside in a LTC facility, and are eligible for Medicare Part A, Part B and Part D. These individuals have an elevated or more severe medical condition than those in the Aged/Disabled Dual COA. DHCS uses Plan Code 201, 205 and 207 to represent the LTC-Certified rating groups of SCAN dual eligible members in Los Angeles, Riverside and San Bernardino counties, respectively.

Qualified Medicare Beneficiaries (QMB) and Specified Low-Income Medicare Beneficiaries (SLMB) are not eligible for enrollment in Medi-Cal managed care plans. For both dual COAs, SCAN enrolls only Non-QMB and Non-SLMB Dual Eligibles, in other words, only Dual Eligibles who have full Medicaid benefits. SCAN does not enroll individuals with End Stage Renal Disease (ESRD); however, if an individual develops ESRD while a member, treatment is covered. There are no changes to covered populations for the CY 2021 rating period.

Currently there are approximately 9,750 beneficiaries enrolled in SCAN in Los Angeles County, approximately 2,550 in Riverside County and approximately 1,750 in San Bernardino County.

Rate Structure

SCAN is compensated through monthly capitation payments for two COA cohorts in each of the three counties:

- Aged/Disabled Dual

- LTC-Certified Dual

The capitation rates for these COAs include all applicable services under the SCAN contract.

FMAP

Some services or populations are subject to a higher FMAP than the regular California FMAP of 50%. Recognizing this, CMS requests the signing actuary to indicate the proportions or amounts of the costs that are subject to a different FMAP and show this information to the extent possible. Furthermore, if there are proposed differences among the capitation rates to covered populations, CMS requires that valid rate development standards are applied and are

not based on the rate of FMAP associated with the covered populations. This section addresses these FMAP concerns from CMS.

There are two services for which the State may receive a different FMAP than that applying on a population basis. Those services are family planning, for which the FMAP is 90%, and adult preventive services, which earns an additional 1% pursuant to section 4106(b) of the Affordable Care Act (ACA). Mercer and DHCS prepare separate memoranda that describe and document the process for estimating the proportion of any capitation rate subject to these different FMAPs. The family planning enhancement would not apply for SCAN. An adult preventive services impact would likely not be material.

The implementation of the Families First Coronavirus Response Act (H.R. 6021) provides a temporary 6.2 percentage point increase for certain populations effective beginning January 1, 2020, and extending through the last day of the calendar quarter in which the public health emergency (PHE), declared by the Secretary of Health and Human Services for Coronavirus Disease 2019 (COVID-19), including any extensions, terminates. The increased FMAP percentage applies to the regular 50% FMAP, and smaller increases apply to the Breast and Cervical Cancer Treatment Program (BCCTP) and California's Children's Health Insurance Program (CHIP) population FMAPs, both of which are not applicable for SCAN.

DHCS uses aid codes in its capitation payment system to identify qualifying COA recipients for higher FMAP. The full capitation rate for these recipients receives the higher FMAP. Mercer developed capitation rates for each population based on projected cost and homogeneity of risk. The FMAP rate for each population is not taken into account and is not a consideration.

Rate Methodology Overview

Capitation rates for SCAN were developed in accordance with rate setting guidelines established by CMS. As required by 42 CFR §438.4(b)(9), the actuaries continue certifying to a single capitation rate for each rate cell.

For SCAN rate development process, Mercer used CY 2019 data reported by SCAN in their Rate Development Template (RDT) response as base data. The most recent Medi-Cal-specific financial reports submitted to Department of Managed Health Care (DMHC), and the financial statements submitted to DHCS and available at the time of the rate development were also considered. SCAN encounter data was not incorporated for the CY 2021 rates. Inclusion of encounter data, where appropriate, will be a future process improvement step. Mercer adjusted the selected base data in a budget-neutral manner to match the covered population projected risk and the State Plan approved benefit package for CY 2021. Then Mercer applied additional adjustments to the base data to incorporate:

- Prospective and historic (retrospective) program changes not reflected (or not fully reflected) in the base data
- Trend factors to project the expenditures and utilization to the rating period
- Administration and underwriting gain loading

The above approach has been utilized in the development of the CY 2021 rates for SCAN. DHCS will offer the final certified lower bound rates as developed by the actuary to SCAN. SCAN has the opportunity and responsibility to independently review the rates offered by DHCS and to determine whether the rates are acceptable based on their individual financial requirements. The various steps in the rate development process are described in the following sections.

Other than the LTC facility fee schedule increase described later, no additional explicit adjustment was made for the COVID-19 PHE within the CY 2021 SCAN rate development process. Factors contributing to this decision include:

- SCAN has a material level of provider subcapitation. The providers contracted with SCAN were paid by SCAN; therefore, access to quality health care remains.
- Although not explicitly tied to COVID-19, annual Utilization and Unit Cost trend rates for several service categories were each reduced by 0.5% with COVID-19 considerations partially in mind.
- DHCS and Mercer regularly review emerging financial experience for SCAN, which would include any related impacts due to COVID-19.

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Data

Base Data

SCAN submitted enrollment, claims experience data, and other financial information in the prescribed RDTs. SCAN encounter data was not incorporated for the CY 2021 rates. Inclusion of encounter data, where appropriate, will be a future process improvement step. Services incurred in CY 2019 were used to form the starting base data for SCAN rate development. The RDT data included utilization and unit cost details by COA group, by county, and by 19 categories of service (COS), which are:

Category of Service		
Inpatient Hospital	Other Medical Professional	Hospice
Outpatient Facility	Mental Health — Outpatient	Multipurpose Senior Services Program (MSSP)
Emergency Room Facility	Dental Services	In-Home Supportive Services
LTC Facility	Pharmacy	Other Home- and Community-Based Services (HCBS Other)
Physician Primary Care	Laboratory and Radiology	All Other Services
Physician Specialty	Transportation	
Federally Qualified Health Center (FQHC)	Community-Based Adult Services	

Mercer reviewed the utilization and unit cost information in the RDT data at the COA group and COS detail levels for reasonableness. Mercer also reviewed the completion factors and financial statement information SCAN reported in their RDTs, and the additional Medi-Cal-specific financial statements SCAN submitted to DHCS and DMHC. Mercer did not audit SCAN data or information and if the data or information is materially incomplete or inaccurate, Mercer's conclusions may require revision. However, Mercer did perform alternative procedures and analyses that provide a reasonable assurance as to the aggregate data's appropriateness for use in capitation rate development. Aggregate experience for SCAN appeared reasonable. Where appropriate, budget-neutral adjustments were made to the base

data to account for unusual/unreasonable COA figures. Please see the Data Smoothing section below.

The base data utilized did not include any Disproportionate Share Hospital payments or any adjustments for FQHC or Rural Health Clinic (RHC) reimbursements. A requirement under 42 CFR 438.4 is that all payment rates under the contract be based only upon services covered under the State Plan to Medicaid-eligible individuals. SCAN communicated on August 12, 2020 that any services they provided in addition to those under the State Plan were not included in the RDT schedules submitted. With regard to overpayments to providers and Section 438.608(d) of the Medicaid Managed Care Final Rule, claims/financial experience provided by SCAN and utilized by DHCS and Mercer was on a net-payment basis, after any recoveries. For the remaining requirements of 438.608(d), please see the SCAN contract.

American Indian Health Service Programs

SCAN contract Exhibit A, Attachment 8, Provider Compensation Arrangements, details the American Indian Health Service Programs (AIHSP) reimbursement required, as it does for FQHCs and RHCs. Applicable base data has been captured per contractual requirements. Any AIHSP costs would be contained within the underlying base data component in the capitation rate development process. This certification does not include development or certification of an Indian Health capitation rate.

Share of Cost

Share of cost members (recipients who establish eligibility for Medi-Cal by deducting incurred medical expenses) are part of SCAN managed care population but share of cost amounts are not included in the development of the rates. Beneficiaries with a share of cost must meet their share of cost obligation first to be certified as Medi-Cal eligible. Medical expenses reported by SCAN are costs after any share of cost obligations have been met.

Third-Party Liability

Medicaid is the payer of last resort. RDT and independent financial statement data were net of any third-party liability data, and so no base data adjustment was necessary.

Graduate Medical Education

DHCS staff has confirmed that there are no provisions in the SCAN contract regarding graduate medical education (GME). SCAN does not pay specific rates that contain GME or other GME-related provisions. GME expenses are not part of the capitation rate development process.

In Lieu of Services

There were no in lieu of services included in the CY 2021 rates since none were part of the underlying base costs and will not be included in the CY 2021 contract. In lieu of services will continue to be monitored in future base data and rating periods.

Retrospective Eligibility Services

SCAN is not required to cover retrospective eligibility periods for their enrollees. These periods are covered in the Medi-Cal fee-for-service (FFS) program. Since MCO data serves as the base data for the rate development, retrospective eligibility periods are not part of the capitation rate development process. No adjustments are necessary.

Data Smoothing

As discussed above, the aggregate CY 2019 experience for SCAN appeared reasonable. However, both COAs within San Bernardino County exhibited material volatility, which is partly due to the smaller population size. Based on reviewing the relativity of CY 2019 RDT data to CY 2018 RDT data, adjustments were made to reduce the base costs for the LTC-Certified COA while simultaneously increase the base costs for the Aged/Disabled COA in San Bernardino County. This smoothing adjustment reduces the large deviation from aggregate experience for each COA and was made in a budget-neutral manner for the CY 2021 rating period. No dollars were gained or lost in the process. In Mercer's opinion, this approach provides for an incrementally increased match of CY 2021 payment to expected risk.

4
Projected Benefit Costs and Trends

The adjusted base data (described in Section 3) was projected to the rating period. The adjustments used to produce the projected benefit trended costs are described within this section and are listed below:

- Trends from CY 2019 base period to CY 2021 contract period
- Program changes

These adjustments by county and COA group are shown within the various rows and columns of the CRCS exhibits in the attached Excel file titled *CY2021 SCAN Rates 20201218.xlsx*.

The annualized factors for combined trend and program change adjustments are approximately 2.8% for the Aged/Disabled COA and 4.0% for the LTC-Certified COA, both at the lower bound. These factors compare favorably (are lower than) versus analysis of the annual Aged and Disabled Per Enrollee expenditure projections found in the 2018 CMS Medicaid Actuarial Report.[1]

Projection Trends	2021/2020	Annualized 2027/2020
Aged	4.7%	4.3%
Disabled	4.6%	5.0%

Trend

Trend is an estimate of the change in the overall utilization and cost of medical services over a finite period. Trend factors are necessary to estimate the expenses of providing health care services in a future period. As part of the CY 2021 SCAN rate development, Mercer developed trend rates for each provider type or COS separately by utilization and unit cost components. Mercer reviewed and used multiple sources of data and information for the

[1] https://www.cms.gov/files/document/2018-report.pdf, Page 68.

development of the prospective trend factors. Trends were leveraged from the similar population covered under Medi-Cal's Coordinated Care Initiative. Historical factors utilized were reviewed. Trends developed from RDT-submitted information were analyzed. SCAN projected trends were considered. Other available data/information such as current Consumer Price Index factors and California minimum wage changes were gathered. Actuarial judgment was applied to determine the final trend factors.

Specific to the negative (residual) utilization trends for inpatient hospital and pharmacy, page 48 of the 2018 CMS Medicaid actuarial report.[2] The report provides the following examples:

Persons with Disabilities			
COS	2019 (over 2018)	2020 (over 2019)	2021 (over 2020)
Inpatient Hospital	-9.3%	-8.1%	-7.0%
Prescription Drugs	-4.1%	-3.6%	-3.0%

Mercer did not use negative utilization trend factors as aggressive as these did since there clearly were many sources (some of it conflicting/contradictory) of inpatient and pharmacy/prescription drug experience and projections. However, in our opinion, these annual CMS Medicaid reports provide excellent data and information around trends and their directionality.

The average annual trend factors were applied from the midpoint of the base data period to the midpoint of the rate period. For all COA groups, the CY 2019 base data reflects the period of CY 2019 with a midpoint of July 1, 2019. The rate period is January 1, 2021 to December 31, 2021 with a midpoint of July 1, 2021. Therefore, annual trend factors were applied for 24 months.

Note that trends for the LTC provider type are displayed as 0.0% for both utilization and unit cost. Due to the relatively high level of legislatively mandated changes surrounding LTC, Mercer has handled LTC trends through the Program Changes section of the report.

Program Changes

Program change adjustments recognize the impact of benefit or eligibility changes that took place during or after the base data period. The program changes incorporated in the development of the rates were based on information provided by DHCS staff. The program changes detailed below were viewed to have a material impact on capitation rates and were reviewed, analyzed, and evaluated by Mercer with the assistance of DHCS. The next several

[2] See footnote 1, page 48.

subsections described the program change adjustments that were explicitly accounted for within the CY 2021 capitation rates.

Program change adjustments are developed based on a “utilization per 1,000” or a “unit cost” basis. These adjustments are reflected in the CRCS exhibits. The various program changes are calculated at the COA and COS level. Multiple program changes may be reflected within a final percentage represented in a given COA and COS field. A summary showing the impact by county and COA group can be found within the program change charts in the attached Excel file titled *CY2021 SCAN Rates 20201218.xlsx*. Per DHCS, there are no current known amendments that will be provided to CMS in the future.

LTC Rate Changes

As noted in the trend subsection, trend factors were not developed for the LTC COS. In lieu of a trend adjustment, rate increases for LTC services are entirely handled through a program change adjustment and are based on legislatively mandated annual FFS rate increases. In general, managed care payment levels have trended closely with FFS payment trend levels for these services and it was deemed reasonable and appropriate to use the FFS rate increases in the managed care rate setting process. Historically, rate increases for all LTC facilities typically occurred August 1 of each year. Beginning in CY 2021, rate increases for AB 1629 LTC facilities occur January 1 of each year, while rate increases for non-AB 1629 LTC facilities will continue to occur on August 1 of each year. The LTC rate increase factors are developed separately for each county (or rating region) within Medi-Cal managed care. To calculate the adjustment factors for each county, costs and rate increases by the different LTC facility types are analyzed by county/region and a final adjustment factor is developed using this information.

In addition, DHCS implemented a 10% fee increase for LTC facilities effective for the duration of the PHE, declared by the Secretary of Health and Human Services for COVID-19, beginning March 1, 2020. The underlying assumption is that this increase will be applicable for six months of the CY 2021 rating period.

Hospice Rate Increase — Retro and Prospective Combined

Similar to the LTC COS, unit cost trend factors were not developed for the Hospice COS. Instead, Hospice price increases are handled through a program change adjustment and are based on legislatively mandated annual FFS rate increases. In general, managed care payment levels have trended closely with FFS payment trend levels for these services and it was deemed reasonable and appropriate to use the FFS rate increases in the managed care rate setting process. There are two components to the Hospice rate increase: the rate increases for Hospice services, and the rate increases for Hospice room and board. To calculate the adjustment factor applied in the capitation rates, the rate increase for Hospice

services is weighted with the rate increase for Hospice room and board. One adjustment factor is developed at a statewide level across all populations.

Optional Benefits Restoration

Effective January 1, 2020, DHCS restored certain adult optional benefits including vision (excluding lens fabrication), audiology, speech therapy, incontinence creams and washes and podiatry. These benefit changes are either already covered under SCAN's Medicare Advantage contract, or under LTC. The sole exception is the incontinence creams and washes for the Aged/Disabled COA. The incontinence creams and washes adjustment was developed based on a review of DHCS historical FFS data as well as SCAN supplied information.

Managed Care Adjustment

Mercer set the Managed Care Adjustment factor to 1.000 for the CY 2021 rating period. This is consistent with the CY 2020 rating period.

DHCS and Mercer have retained the factor as a placeholder for potential future use around utilization and/or unit cost efficiency/effectiveness, or other appropriate, adjustments.

5
Projected Non-Benefit Costs

The projected costs as described through Section 4 represent benefit costs. This section describes the components of the rate that are not directly related to benefit costs, which include the following:

- Administration
- Underwriting Gain

Capitation rates appropriately include provisions for the administrative expenses that SCAN incurs as it operates under the risk contract requirements, as well as for SCAN's risk and cost of capital.

Administration

The administration loading for the CY 2021 rating period was developed leveraging the CY 2020 analysis and adjustment, considering SCAN financial statement administrative performance and trends over the last several years, and SCAN projection via their RDT response. CY 2021 lower bound administration for Aged/Disabled was set at 6.50% and LTC-Certified at 2.95%. The administration percentage is applied as a percentage of the total premium for SCAN. While the CY 2020 percentages were already relatively aggressive at an aggregate weighted 4.73%, we believed there was opportunity for slight further reductions for CY 2021. The corresponding aggregate weighted CY 2021 percentage is 4.36%. The actuaries consider the CY 2021, 4.36% aggregate administration percentage to be reasonable, appropriate and attainable.

Underwriting Gain

The underwriting gain load was established at a 1.5%-3.5% range across SCAN, with 1.5% being the lower bound value. The percentage range is 0.5% lower at both bounds than the values used in the prior rating period, and is consistent with overall Medi-Cal MCO at-risk program capitation rate development. Mercer has implicitly and broadly considered the cost of capital within our rating assumptions. Mercer has concluded that the assumptions surrounding the underwriting gain, as well as income that SCAN generates from investments, are sufficient to cover at least the minimum cost of capital needs for a typical health plan.

6
Special Contract Provisions Related to Payment

This section describes the following contract provisions that would impact the capitation rates and the final net payments to SCAN under the SCAN contract:

- Incentive arrangements
- Withhold arrangements
- Risk-sharing mechanisms
- Pass-through payments
- Delivery system and provider payment initiatives

None of the items above explicitly appears within the CRCS exhibits, but was considered within the rate development process, if applicable.

Incentive Arrangements

No incentive or bonus arrangements between DHCS and SCAN are in place. Hence, this subsection is not applicable to the CY 2021 rate certification.

Withholding Arrangements

No withhold arrangements between DHCS and SCAN are in place. Hence, this subsection is not applicable to the CY 2021 rate certification.

Risk-Sharing Mechanisms

There are no risk-sharing arrangements between DHCS and SCAN in place.

Pass-Through Payments

There are no pass-through payments applied in SCAN CY 2021 capitation rates.

Delivery System and Provider Payment Initiatives

There are no delivery system or provider payment initiatives applied in SCAN CY 2021 capitation rates.

7
Certification and Final Rates

This certification assumes items in the Medicaid State Plan and Waiver, as well as the SCAN contract, have been approved by CMS.

In preparing the capitation rates described, the actuaries have used and relied upon enrollment, eligibility, claim, reimbursement level, benefit design and financial data and information supplied by DHCS and its vendors. DHCS and its vendors are solely responsible for the validity and completeness of this supplied data and information. The actuaries have reviewed the summarized data and information for internal consistency and reasonableness, but did not audit it. In the actuary's opinion, it is appropriate for the intended rate-setting purposes. However, if the data and information are incomplete or inaccurate, the values shown in this report and associated exhibits may differ significantly from values that would be obtained with accurate and complete information; this may require a later revision to this report.

Because modeling all aspects of a situation or scenario is not possible or practical, Mercer may use summary information, estimates, or simplifications of calculations to facilitate the modeling of future events in an efficient and cost-effective manner. Mercer may also exclude factors or data that are immaterial in our judgment. Use of such simplifying techniques does not, in our judgment, affect the reasonableness, appropriateness or attainability of the results for SCAN. Actuarial assumptions may also be changed from one certification period to the next because of changes in mandated requirements, program experience, changes in expectations about the future, and other factors. A change in assumptions is not an indication that prior assumptions were unreasonable, inappropriate or unattainable when they were made.

The actuaries certify that SCAN capitation rates for the CY 2021 rating period, January 1, 2021 through December 31, 2021, were developed in accordance with generally accepted actuarial practices and principles, and are appropriate for the Medi-Cal covered populations and services under the SCAN contract. Capitation rates are "actuarially sound" if, for the business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees and taxes. The undersigned actuaries are members of the American

Academy of Actuaries and meets its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

Capitation rates developed by Mercer are actuarial projections of future contingent events. All estimates are based upon the information and data available at a point in time, and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely, and potentially wide range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use. Actual SCAN costs will differ from these projections. Mercer has developed these rates to demonstrate compliance with the CMS requirements under 42 CFR §438.4 and in accordance with applicable law and regulations. There are no stop loss, reinsurance, withhold or incentive arrangements assumed in these rates. Use of these rates for any purpose beyond that stated may not be appropriate.

SCAN is advised that the use of these rates may not be appropriate for their particular circumstance, and Mercer disclaims any responsibility for the use of these rates by SCAN for any purpose. Mercer recommends that as SCAN considers contracting with DHCS, SCAN should analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to these rates before deciding whether to contract with DHCS.

The actuaries are not engaged in the practice of law, or in providing advice on taxation matters. This report, which may include commenting on legal or taxation issues or regulations, does not constitute and is not a substitute for legal or taxation advice. Accordingly, the actuaries recommend that DHCS secures the advice of competent legal and taxation counsel with respect to any legal or taxation matters related to this report or otherwise.

This certification report assumes the reader is familiar with the Medi-Cal program, Medi-Cal eligibility rules, and actuarial rating techniques. It has been prepared exclusively for DHCS and CMS, and should not be relied upon by third parties. Other readers should seek the advice of actuaries, or other qualified professionals competent in the area of actuarial rate projections, to understand the technical nature of these results. Mercer is not responsible for, and expressly disclaims liability for, any reliance on this report by third parties.

If you have any questions on the above certification document or attachments, please feel free to contact Mike Nordstrom at +1 602 522 6510 or Jie Savage at +1 206 257 8539.

Sincerely,

Michael E. Nordstrom, ASA, MAAA
Partner

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Attachments

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