

Capitation Rate Development and Certification

SCAN Health Plan

State of California
Department of Health Care Services
Capitated Rates Development Division
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Section 1

Executive Summary

The State of California Department of Health Care Services (DHCS) contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefit LLC, to develop actuarially sound Medicaid capitation rates for SCAN Health Plan (SCAN) for use during the rating period of January 1, 2023 through December 31, 2023 (calendar year [CY] 2023).

Actuarially sound is being defined by Mercer as follows; Medicaid capitation rates are “actuarially sound” if, for business in the state 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 the purpose 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, cost of capital, and government mandated assessments, fees, and taxes.

Per Section 4.2 of ASOP 49, capitation rates for SCAN were developed in accordance with the Centers for Medicare & Medicaid Services (CMS) requirements and this document provides the certification of actuarial soundness required by 42 CFR § 438.4. Any proposed differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations comply with 42 CFR § 438.4(b)(1). Any differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations are based on valid rate development standards that represent actual cost differences to the covered populations, and these differences do not vary with the rate of Federal Financial Participation associated with the covered populations in a manner that increases federal costs.

This report was developed to provide the requisite rate documentation to DHCS and to support the review process performed by CMS. This report follows the general outline of the CMS 2022–2023 Medicaid Managed Care Rate Development Guide (RDG) dated April 2022, which is applicable to contract periods beginning on or after July 1, 2022. The rate development process included the historical practice of developing rate ranges. However, the credentialed actuaries are certifying to a final capitation rate within the developed rate ranges as federally required. A copy of the RDG titled *CA SCAN CY 2023 Rate Development Guide 2022 12.pdf*, with documentation references, is attached with this report.

Multiple exhibits are included as part of this rate certification package in the attached Excel file titled *CY 2023 SCAN Rates 2022 12.xlsx*. This attachment includes summaries of the CY 2023 capitation rates (including the final and certified capitation rates) and capitation rate calculation sheet (CRCS) exhibits. The rate summary

exhibit includes the final CY 2023 capitation rates by county and category of aid (COA) groupings and a comparison to the prior CY 2022 rating period certified rates.

Mercer developed this rate certification package exclusively for DHCS; subject to this limitation, DHCS may direct this rate certification package be provided to CMS. It should be read in its entirety and has been prepared under the direction of Mike Nordstrom, ASA, MAAA, Jie Savage, ASA, MAAA, and Tim Washkowiak, ASA, MAAA, who are members of the American Academy of Actuaries and meet its US Qualification Standards for issuing the statements of actuarial opinion herein.

To the best of Mercer's knowledge, there are no conflicts of interest in performing this work.

The suppliers of the data are solely responsible for its validity and completeness. Mercer has reviewed the data and information for internal consistency and reasonableness, but did not audit it. All estimates are based upon the information and data available at a point and are subject to unforeseen and random events, and actual experience will vary from estimates.

Mercer expressly disclaims responsibility, liability, or both for any reliance on this communication by third parties or the consequences of any unauthorized use or disclosure other than as mutually contemplated when Mercer was first retained to perform this work.

Certified Rate Change

Mercer has not just merely trended forward the previous year's rates, but has 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.

Beginning January 1, 2023, SCAN will expand to operate in San Diego County providing the same benefits to the members in the same eligibility groups as in the existing Los Angeles, Riverside, and San Bernardino counties.

Additionally, the State of California provides Medi-Cal coverage to certain members with unsatisfactory immigration status (UIS), referred to as the UIS population. UIS members are eligible to receive the same State Plan services as members with satisfactory immigration status (SIS), but federally eligible to only receive emergency and pregnancy-related services. Through communication with CMS, DHCS is required to set capitation rates for the UIS and SIS populations separately. Further, the capitation rates for the UIS population are required to be separated by federally eligible services (namely, emergency and pregnancy-related services) and services paid by the State alone (all other services). Within the rates being certified in this certification, the UIS and SIS populations are separated. Further, the SIS population capitation rates are being certified for all components while only the federally eligible rate component is being certified for the UIS population. The split of the UIS and SIS

populations occurs within the base data, and capitation rates are developed after this split occurs for both populations. Unless otherwise noted, all references to the UIS capitation rates are assumed to be for the federal component only.

Overall, across all populations and counties, the CY 2023 weighted lower bound capitation rate, which DHCS will pay SCAN, is projected at \$397.56 per member per month (PMPM). Mercer certifies to the 16 separate lower bound capitation rates. Excluding San Diego County, the projected CY 2023 weighted lower bound capitation rate PMPM of \$397.26 is an approximate 1.4% increase over the corresponding CY 2022 figure. With a projected 185,184 member months including San Diego County, total lower bound capitation dollars are projected to be approximately \$73.6 million in CY 2023.

It should also be noted there may be a future amendment to this certification that will be submitted to CMS to account for new payment arrangements that were pending finalization of the program parameters as of the date after which new information could no longer be accepted for this certification. Other assumptions within the rate setting will be reviewed, such as the end date of the Coronavirus Disease 2019 (COVID-19) Public Health Emergency (PHE), but will not necessarily require a capitation rate amendment, unless the certifying actuaries deem an amendment is necessary.

Section 2

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, Riverside, and San Diego (beginning January 1, 2023) 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 the contents of the table below.

| Covered Services | | |
|---|---|-----------------------------|
| Physician services | Psychology services | Durable medical equipment |
| Skilled nursing facility (SNF) 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 | Chiropractic services |

| Covered Services | | |
|---|---|--|
| | abuse, and rehabilitative 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 |

Beginning with the CY 2022 rating period, some significant changes within the Medi-Cal program are occurring. Highlights of these changes include the implementation of multiple aspects of the California Advancing and Innovating Medi-Cal (CalAIM) proposal, which is a multi-year initiative by DHCS to improve the quality of life and health outcomes for the Medi-Cal population.

As part of the CalAIM initiative, there is one major benefit/service change affecting SCAN effective January 1, 2022:

- 14 Community Supports services now allowable in the managed care contracts as “in-lieu-of” services (ILOS) in accordance with 42 CFR §438.3(e) and/or the terms and conditions of California’s Section 1115 and Section 1915(b) waivers

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, 202, 204, and 206 to represent the Aged/Disabled rating groups of SCAN dual eligible members in Los Angeles, San Diego, 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, 203, 205, and 207 to represent the LTC-Certified rating groups of SCAN dual eligible members in Los Angeles, San Diego, 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; however, if an individual develops end stage renal disease while a member, then treatment is covered. There are no changes to covered populations for the CY 2023 rating period other than SCAN's Medi-Cal expansion into San Diego County.

As of the most current credible eligibility snapshot, there are approximately 9,530 beneficiaries enrolled in SCAN in Los Angeles County, approximately 2,550 in Riverside County, and approximately 1,850 in San Bernardino County.

Rate Structure

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

- Aged/Disabled Dual
- LTC-Certified Dual

The capitation rates for these COAs are separated for the UIS and SIS populations, to satisfy CMS requirements. Capitation rates for the UIS population consist of federal eligible services only.

Federal Medical Assistance Percentage

Depending on the Medicaid managed care program, some services or populations are subject to a higher FMAP than California's regular FMAP. 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.

The rates certified in this report include only populations that receive the regular FMAP, except for individuals who do not have SIS for whom federal financial participation is available for emergency and pregnancy-related services only. For the UIS members, rate components attributed to emergency services are subject to a 50% FMAP; while rate components attributed to pregnancy-related services are subject to a 65% FMAP. Given that SCAN eligible members are aged 65 and older, the UIS capitation rates are assumed to be all for emergency services and none for pregnancy-related services.

Rates are developed for each population based on expected cost and homogeneity of risk. The FMAP for each population is not taken into account and is not a consideration. Non-benefit costs are developed using a method that does not consider FMAP for different populations. This includes the provision for underwriting gain.

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 PHE, declared by the Secretary of Health and Human Services for COVID-19, including any extensions, terminates. If the PHE were to be extended beyond December 31, 2022, the increased FMAP percentage applies to all populations in this report.

There are two services for which the State may receive a different FMAP than the population-based FMAP. 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. 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. Both the family planning and the adult preventive services enhancement impacts would likely not be material for the SCAN population.

Rate Methodology Overview

Capitation rates for SCAN were developed in accordance with rate setting guidelines established by CMS. As noted previously, the actuaries continued the historical practice of rate range development for SCAN. However, the actuaries are certifying to a rate within the developed rate range.

For SCAN rate development process, Mercer utilized a blend of the CY 2019 and CY 2021 data reported by SCAN in their Rate Development Template (RDT) as base data. The most recent Medi-Cal-specific financial reports submitted to Department of Managed Health Care (DMHC) at the time of the rate development were also considered. SCAN encounter data was not incorporated for the CY 2023 rates.

Inclusion of encounter data, where appropriate, will be a future process improvement step.

The RDT data used in the development of the rate ranges is data collected from SCAN separately for each county in which they operated during the CY 2019 and CY 2021 time periods. The data requested is completed by SCAN at the level of detail needed for rate development purposes, which includes membership, medical utilization, and medical cost data by COA and category of service (COS).

Adjustments were made to the selected base data to match the covered population risk and the State Plan approved benefit package for the CY 2023 period. Then Mercer applied additional adjustments to the base data to incorporate:

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

The above approach has been utilized in the development of the CY 2023 rates for SCAN. DHCS will offer the final certified lower bound rates as developed by the actuaries 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.

Section 3

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 2023 rates. Inclusion of encounter data, where appropriate, will be a future process improvement step. Services incurred in CY 2019 and CY 2021 and completed with payment lag factors were used to form the base data for SCAN rate development. The RDT data included utilization and unit cost details by COA group, by county, and by 19 COS, which are displayed in the table below.

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

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, adjustments were made to the reported RDT data, as described below. As previously mentioned, a weighted average of adjusted CY

2019 RDT data (at 50%) and adjusted CY 2021 RDT data (at 50%) forms the modeled base data.

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 July 21, 2022 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.

Base Data Adjustments

The CY 2021 SCAN-reported RDT experience was adjusted with a unit cost base data adjustment. As detailed below, this adjustment was necessary to appropriately reflect reasonable medical cost for the covered populations and services. The adjustment is explained below.

COVID-19 Temporary Unit Cost Increase Carve-Out

Due to the impact of the COVID-19 pandemic, and in accordance with DHCS policy, SCAN made enhanced payments to LTC providers during the CY 2021 time period that otherwise would not have been made. These costs, characterized as temporary and related to the PHE, consisted of a 10% per-diem increase to LTC facilities, and were included within the RDT data. All costs from the CY 2021 period identified to be omitted from the contract period were carved out. In total, approximately \$0.97 million was removed from the base data across all counties and COA groups for the LTC COS.

Data Smoothing

The aggregate experience for SCAN appeared reasonable. However, both COAs within San Bernardino County exhibited material volatility in CY 2019, which is partly due to the smaller population size. Adjustments were made to reduce the base costs for the LTC-Certified COA while simultaneously increasing 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 prior 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 payment to expected risk. The smoothed CY 2019 data is further adjusted to CY 2021 cost and benefit level before being blended (at a 50% weighting) with the CY 2021 RDT data.

San Diego County Base Data Development

Beginning January 1, 2023, SCAN will operate in San Diego County under a Medi-Cal managed care contract. Since no prior experience could be leveraged, a blend of 33.3% Los Angeles County, 50% Riverside County, and 16.7% San Bernardino County base data was used to develop base data for San Diego County for all COS except CBAS. For CBAS, a uniform blend of Los Angeles, Riverside, and San Bernardino counties utilization information was used to develop San Diego base data.

The blend percentages were chosen using actuarial judgement based on geographic proximity, cost of living factors, and review of similar Medi-Cal historical integrated dual programs in the same counties. Reviewed programs included those that span these same counties, namely the Coordinated Care Initiative (CCI), Program of All-Inclusive Care for the Elderly (PACE), and experience of full-dual members captured in mainstream Medi-Cal rates. Due to the major differences observed in CBAS utilization within various dual integrated programs in these counties as opposed to the other COS, an even blend of CBAS weighting was applied to the rates.

SIS/UIS Considerations

The RDT-reported data encompassed all SCAN-enrolled members, including both SIS and UIS populations. Up to this point in the base data development process, all data adjustments were done using combined SIS and UIS data in total. The final step in the base data development process was to split the base data out by the UIS and SIS populations at the county, COA, and COS level, and limit to only federal services for the UIS population. This subsection describes the process that was utilized.

For each county, COA and COS, the following metrics were reviewed and developed to separate the base data for the UIS and SIS populations, and further break the UIS population rates into federal and State-only components. Additionally, a description of how each metric was used to derive the base data is described as well.

- UIS acuity factor compared to the total population
 - This factor represents the expected PMPM cost relativity of the UIS population compared to the total population (UIS and SIS combined). This factor was calculated separately for each county, COA, and COS. To derive the total base data PMPM across federally eligible and State-only services for the UIS population, the original combined base data were used as the starting point, and multiplied by the UIS acuity factor. This created the total base data PMPM values for the UIS population by county, COA, and COS.
 - To derive the base data for the SIS population by county, COA, and COS, the base CY 2021 member months and the original base data (UIS and SIS combined) were used as the starting point, and the base UIS member months and UIS base data were backed out of the combined base data.

- Percentage of dollars for UIS members for pregnancy-related and emergency services
 - As noted previously, only pregnancy-related and emergency services are eligible for federal match for the UIS population. As a result, it was necessary to estimate the percentage of PMPM spend for services that are pregnancy-related or emergency specific to the UIS population. Metrics were calculated to estimate the percentage of the capitation rates that are for pregnancy-related and emergency services, separately. This process was done for each county, COA, and COS. To derive the federally eligible UIS capitation rates, the percentage of PMPM spend assumed to be federally eligible (sum of pregnancy-related and emergency services percentages) were multiplied by the total UIS capitation rates. The remaining services not eligible for federal match will be funded in full by the State, and are not part of this certification.

Acuity Factor and Federal Percentage Development

Within this subsection, the data, assumptions, and methodology used to derive both the UIS acuity factors and percentage of services that are pregnancy-related and emergency are described.

Acuity Factor Development

Supplemental data request (SDR) templates were submitted by the SCAN to report CY 2021 experience specific to the UIS population. The CY 2021 UIS experience in these SDR templates was reviewed and compared against the aggregate RDT-reported experience. In aggregate across the CY 2021 time period, the UIS enrollment accounted for roughly 0.7% of total SCAN enrollment, with little variation by county and COA. Given that all SCAN beneficiaries are dually eligible for Medi-Cal and Medicare, the low membership volume of the UIS members and the inherent volatility of the limited UIS experience reported, Mercer deemed the CY 2021 UIS experience data not credible for rate setting purposes and determined it was most appropriate to apply a 1.0 acuity factor for the UIS base data development, effectively creating no differences between SCAN's SIS and UIS members from an all-services base data perspective.

Federal Percentage Development

In the development of the percentage of the UIS base data that are for federally eligible services, state fiscal year (SFY) 2020–2021 encounter data for the mainstream Medi-Cal UIS population was utilized by analyzing both pregnancy-related and emergency services PMPM spend as a percentage of total UIS PMPM spend. This mainstream data was the only source of data Mercer had available since the SCAN-reported CY 2021 UIS information was not segmented into these categories, and the SCAN encounter data has not yet been deemed reliable. As noted previously, the percentage of UIS dollars for pregnancy-related services and the percentage of UIS dollars for emergency services were analyzed and developed separately. However, the total of the two components are what make up the total federal percentage that drives the base data calculation. Within the coding logic,

various flags in the data were derived and services were flagged as either pregnancy-related or emergency using a hierarchy logic so that each encounter only flagged once as either pregnancy-related or emergency. No encounters were flagged twice in the event that a service was flagged as both pregnancy-related and emergency related. The coding logic used to derive the federal percentages (both pregnancy-related and emergency services) is consistent with the logic provided in the July 1, 2019 through December 31, 2020 mainstream Medi-Cal certification revision dated June 24, 2022.

In terms of the hierarchy used for the federal percentages, the first service flagged in the hierarchy was labor and delivery services, and these services were identified as emergency related services. Pregnancy-related services were identified next in the hierarchy and the remaining emergency services were last in the hierarchy. Using this hierarchy logic, pregnancy-related and emergency services were grouped and separated in the analysis, in order to derive the applicable pregnancy-related and emergency percentages.

The result of this was PMPM amounts by mainstream Medi-Cal Managed Care Organization (MCO), COA, and COS for the UIS population for pregnancy-related and emergency services, as a percentage of the total UIS PMPMs, separately. In the development of the percentages utilized for the federal capitation rate development, smoothing ranges were developed at the COA and COS level separately for pregnancy-related and emergency services. The smoothing ranges were developed based on a review of each MCO's data points for the same COA and COS combination. In the smoothing process, if a plan-specific percentage fell within the smoothing range, this value was accepted and used in the calculation of a statewide average percentage of total UIS dollars. This was done separately for pregnancy-related and emergency percentages. The result of this was a statewide average percentage of total UIS PMPM spend that is for pregnancy-related and emergency services, by COA and COS.

Of the various mainstream Medi-Cal COA groups, the seniors and persons with disabilities/full-dual (SPD/Full-Dual) COA group is most representative of SCAN's covered populations. As such, the statewide SPD/Full-Dual federal percentages (the sum of pregnancy-related and emergency services percentages) were then applied to the SCAN UIS base data in total by county, COA, and COS to derive the UIS base data for federal services only. Remaining services for the UIS population are included in the State-only rates that are not part of this certification.

American Indian Health Service Programs

The SCAN contract details the American Indian Health Service Programs reimbursement required, as it does for FQHCs and RHCs. Applicable base data has been captured per contractual requirements. Any American Indian Health Service Programs 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 the 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 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.

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.

Mental Health Parity and Addiction Equity Act

With regard to the Mental Health Parity and Addiction Equity Act, DHCS staff has confirmed that there are no provisions in the SCAN managed care contract in violation of Mental Health Parity and Addiction Equity Act.

Section 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 the modeled CY 2021 base period to CY 2023 contract period. Adjusted and smoothed CY 2019 data was also trended forward to CY 2021, which was then blended with CY 2021 actual data.
- 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 *CY 2023 SCAN Rates 2022 12.xlsx*.

The annualized factors for combined trend and program change adjustments are approximately 3.7% for the Aged/Disabled COA and 4.1% 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 | Annualized 2023/2021 | Annualized 2027/2021 |
|-------------------|----------------------|----------------------|
| Aged | 4.2% | 4.2% |
| Disabled | 4.9% | 5.1% |

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 2023 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 development of the prospective trend factors. Trends were leveraged from the similar population covered under Medi-Cal's CCI program. 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

¹ Office of the Actuary, Centers for Medicare & Medicaid Services, United States Department of Health and Human Services. 2018 Actuarial Report, On the Financial Outlook for Medicaid. Available at: <https://www.cms.gov/files/document/2018-report.pdf>, page 68.

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, see page 48 of the 2018 CMS Medicaid actuarial report.² The report provides the following examples:

| Persons with Disabilities | | | |
|---------------------------|------------------|------------------|------------------|
| COS | 2021 (over 2020) | 2022 (over 2021) | 2023 (over 2022) |
| Inpatient Hospital | -7.0% | -5.9% | -4.7% |
| Prescription Drugs | -3.0% | -2.4% | -1.9% |

Mercer did not use negative utilization trend factors as aggressive as these 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 modeled base data period to the midpoint of the rate period. For all COA groups, the modeled base data reflects the period of CY 2021 with a midpoint of July 1, 2021. The rate period is January 1, 2023 through December 31, 2023 with a midpoint of July 1, 2023. 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 subsections described the program change adjustments that were explicitly accounted for within the CY 2023 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 county, COA, and COS level. Multiple program changes may be reflected within a final percentage represented in a given

² See footnote 1, page 48.

county, 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 *CY 2023 SCAN Rates 2022 12.xlsx*.

Long-Term Care 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 handled through a program change adjustment and are based on legislatively mandated annual FFS rate increases. In general, managed care payment levels have aligned closely with FFS payment 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, FFS rate increases for all LTC facilities typically occurred August 1 of each year. Beginning CY 2021, rate increases for Assembly Bill 1629 LTC facilities occur on January 1 of each year, while rate increases for non-Assembly Bill 1629 LTC facilities continue to occur on August 1 of each year.

The LTC rate increase factors are developed separately for each county. To calculate the adjustment factors for each county, costs and rate increases by the different LTC facility types are analyzed by county/region, and the final adjustment factor is developed using this information. LTC rate change factors also reflect the 10% fee schedule increase for Intermediate Care Facility for Developmentally Disabled (ICF-DD), Freestanding subacute (SA) Facilities, and SNF — Level B that will be included as part of the cost-base rates during the CY 2023 rating period. During the PHE, all LTC facilities were subject to a 10% payment level increase. DHCS has made a policy decision to extend the 10% increase to these specific facilities regardless of the end date of the PHE.

Hospice Rate Increase

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 aligned closely with FFS payment 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 that occur on August 1 of each year, and the rate increases for Hospice room and board that occur on October 1 of each year. To calculate the adjustment factor applied in the capitation rates, the rate increases for Hospice services are weighted with the rate increases for Hospice room and board. One adjustment factor is developed at a statewide level across all populations.

CalAIM Community Supports

Under the CalAIM initiative, a Community Supports program was implemented effective January 1, 2022. Within the Community Supports program, select services, many of which were previously provided under the Whole Person Care (WPC)

program, will be available under managed care. The following 14 pre-approved Community Supports services will be available under Medi-Cal managed care, effective January 1, 2022:

1. Housing Transition/Navigation Services
2. Housing Deposits
3. Housing Tenancy and Sustaining Services
4. Short-Term Post-Hospitalization Housing
5. Recuperative Care (Medical Respite)
6. Respite Services
7. Day Habilitation Program
8. Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities
9. Community Transition Services/Nursing Facility Transition to a Home
10. Personal Care and Homemaker Services
11. Environmental Accessibility Adaptations
12. Meals/Medically Tailored Meals
13. Sobering Centers
14. Asthma Remediation Services

Managed Care Organization Voluntarily Covered In Lieu of Services Adjustment

The “MCO Voluntarily Covered ILOS Adjustment” specifically adjusts for value-added services dollars reported in the RDT that align with one of the newly covered Community Supports services. These were services voluntarily provided by the MCOs within the base data period that were removed within the “Value-Added Services Adjustment” base data adjustment. If a value-added service reported in the RDT was deemed by DHCS and Mercer to align with one of the 14 Community Support services, then those dollars were carved into the rates in the form of a program change adjustment. No voluntarily covered Community Supports services were applicable or reported in SCAN CY 2019 and CY 2021 RDTs, therefore no base data adjustment or program change adjustment was made.

Whole Person Care Adjustment

This adjustment specifically adjusts for expenses for services that were provided under the WPC entities that align with one of the newly covered Community Supports services. Because these services were provided within the WPC program, anticipated managed care experience was not appropriately reflected in the base

data. This adjustment corrects for this understatement. To develop the WPC adjustment, two data sources were utilized:

1. Costs reported by the WPC entities, reported at the county level for CY 2020
2. List of WPC utilizers for CY 2020, provided by DHCS

Costs for any WPC services deemed to align with any of the 14 Community Supports services were assigned to MCOs according to each MCO's share of the WPC membership within a given county/region. Similarly, each MCO's costs were assigned to COAs based on the COAs of the MCO's WPC members. These costs were further assigned to COS based on a Community Support/COS allocation developed by DHCS and Mercer.

The WPC utilizers in Los Angeles County include SCAN members. Costs assigned to the SCAN members by COA in the proper COS (Inpatient Hospital, Outpatient Facility, Emergency Room, LTC, Physician Primary Care, and Physician Specialty) were used as a basis to develop utilization adjustments.

COVID-19 Considerations

No additional explicit adjustment was made for the COVID-19 PHE within the CY 2023 SCAN rate development process. Factors contributing to this decision include:

- The final modeled base data is developed with a weighted average of 50% adjusted CY 2019 experience with 50% adjusted CY 2021 experience. Comparing to CY 2020 experience, where generally lower utilization but higher unit cost was observed (with the net of the two components combined being a lower PMPM), due to COVID-19 impact, utilization in CY 2021 appeared to return towards pre-COVID-19 levels but not to a full extent. This blend implicitly factors in an adjustment to account for COVID-19 utilization suppression in the modeled base data.
- SCAN has a material level of provider sub capitation. The providers contracted with SCAN were paid by SCAN; therefore, access to health care remains.
- DHCS and Mercer regularly review emerging financial experience for SCAN, which would include any related impacts due to COVID-19.

Managed Care Adjustment

Mercer set the Managed Care Adjustment factor to 1.000 for the CY 2023 rating period. This is consistent with the CY 2022 rating period.

However, 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.

Section 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 2023 rating period was developed leveraging the CY 2022 analysis and adjustment, considering SCAN financial statement administrative performance and trends over the last several years, and SCAN projection via their RDT response. CY 2023 lower bound administration was 6.25% for Aged/Disabled and 2.75% for LTC-Certified. The administration percentage is applied as a percentage of the total premium for SCAN. The CY 2022 percentage for administration loading was set at an aggregate weighted 4.42%. For the CY 2023 rates, that aggregate weighted administration loading percentage was similarly set at 4.12%.

Underwriting Gain

The underwriting gain load was established at a 2.0%–4.0% range for SCAN, with 2.0% being the lower bound value applied as a percentage of the total premium for the certified SCAN rates. The percentage 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 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.

Section 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
- State directed payments
- Pass-through payments

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

Incentive Arrangements

Housing and Homelessness Incentive Program

As part of the State's overarching home- and community-based services spending plan, the State implemented the Housing and Homelessness Incentive Program (HHIP) during CY 2022 which provides incentive payments to MCOs for the achievement of specified metrics and milestones. The total maximum incentive funding that may be earned across all participating MCOs over the full duration of the program is \$1.3 billion. The HHIP has no effect on the development of capitation rates.

The purpose of HHIP is to address homelessness. MCOs would be able to earn incentive payments for making investments and progress in addressing homelessness and keeping people housed. MCOs would have to meet specified metrics in order to receive available incentive payments. As a condition of participations, MCOs would be expected to develop, in partnership with local public health jurisdictions, county behavioral health, public hospitals, county social services, and local housing departments, and submit a Local Homelessness Plan to DHCS. The Local Homelessness Plan must include, among other elements:

- A housing and services gaps/needs assessment;
- Mapping the continuum of services with focus on homelessness prevention, interim housing (particularly for the aging and/or disabled population), rapid re-housing (families and youth), and permanent supportive housing;

- Available services, how referrals will be made, how other local, state, and federal funding streams will be leveraged, and how progress will be tracked towards goals; and
- How CalAIM services are integrated into homeless system of care.

The HHIP will be for a fixed period of two program years (PYs):

- PY 1 will be January 1, 2022 through December 31, 2022, which aligns with California's CY 2022 rating period.
- PY 2 will be January 1, 2023 through December 31, 2023, which will align with California's CY 2023 rating period.

The enrollees covered by the HHIP include, but are not limited, to: aging adults, individuals with disabilities, individuals with serious mental illness and/or substance use disorder (SUD) needs at risk for, or transitioning from incarceration, hospitalization, or institutionalization, families, individuals reentering from incarceration, homeless adults, chronically homeless individuals, persons who have/had been deemed (felony) incompetent to stand trial, Lanterman-Petris Short Act designated individuals, and veterans.

The providers covered by HHIP include but are not limited to public health departments, county behavioral health, public hospitals, and others.

Additional detail regarding the HHIP is available through the managed care contract, APL 22-007 and any subsequent revisions, and similar instructions issued to MCOs.³

Withhold Arrangements

There are no withhold arrangements between DHCS and SCAN in place.

Risk-Sharing Mechanisms

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

State Directed Payments

There are no state directed payments applied in SCAN CY 2023 capitation rates in this certification.

Pass-Through Payments

There are no pass-through payments applied in SCAN CY 2023 capitation rates.

³ All Plan Letter 22-007. Available at <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-007.pdf>

Section 7

Certification of Final Rates

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

In preparing the capitation rates described, Mercer has used and relied upon enrollment, eligibility, claim, reimbursement level, benefit design, and financial data and information supplied by DHCS, its MCOs, and its vendors. DHCS, its MCOs, and its vendors are solely responsible for the validity and completeness of this supplied data and information. Mercer has reviewed the summarized data and information for internal consistency and reasonableness, but did not audit it. In Mercer'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.

Mercer certifies that SCAN capitation rates for the CY 2023 rating period, January 1, 2023 through December 31, 2023, 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 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.

DHCS understands that Mercer is 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, Mercer recommends that DHCS secure 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.

To the best of Mercer's knowledge, there are no conflicts of interest in performing this work.

DHCS agrees to notify Mercer within 30 days of receipt of this report if it disagrees with anything contained in this report or is aware of any information or data that would affect the results of this report that has not been communicated or provided to Mercer or incorporated herein. The report will be deemed final and acceptable to DHCS if nothing is received by Mercer within such 30 day period.

If you have any questions on the above certification document or attachments, please feel free to contact Mike Nordstrom at mike.nordstrom@mercer.com, Jie Savage at jie.savage@mercer.com, or Tim Washkowiak at timothy.washkowiak@mercer.com.

Sincerely,



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