Mercer

Government Human Services Consulting

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, 2024 through December 31, 2024 (calendar year [CY] 2024).

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 2023–2024 Medicaid Managed Care Rate Development Guide (RDG) dated May 2023, which is applicable to contract periods beginning on or after July 1, 2023. The rate development process included the historical practice of developing rate ranges. However, this report certifies to a final rate within the developed rate ranges as federally required. A copy of the RDG titled *CA SCAN CY 2024 Rate Development Guide 2023 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 *CA SCAN CY 2024 Rates 2023 12.xlsx*. This attachment includes summaries of the CY 2024 capitation rates (including the final and certified capitation rates) and capitation rate calculation sheet (CRCS) exhibits. The rate summary exhibit includes the final CY 2024 capitation rates (e.g., lower bound) by county and category of aid (COA) groupings and a comparison to the prior CY 2023 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 Tim Washkowiak, ASA,

MAAA, who is a member 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 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 expanded 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 2024 weighted lower bound capitation rate, which DHCS will pay SCAN, is projected at $372.81 per member per month (PMPM). Mercer certifies to the 16 separate lower bound capitation rates. The projected CY 2024 weighted lower bound capitation rate PMPM of $372.81 is an approximate 0.97% decrease over the corresponding CY 2023 figure. With a projected 255,953 member months including San Diego County, total lower bound capitation dollars are projected to be approximately $95.4 million in CY 2024.

It should also be noted there may be a future amendment to this certification that could 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. The potential updates include Senate Bill (SB) 525 (Minimum Wage Increase) and Assembly Bill (AB) 2511 (Skilled Nursing Facility [SNF] Generators).

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
SNF services	Podiatry services	Home health agency services
Subacute nursing facilities limited to Medi-Cal contract facility	Inpatient (IP) hospital services for general acute care, mental illness, substance abuse, and rehabilitative services	Chiropractic services
Non-physician practitioners	Ambulatory surgical care centers	Acupuncture

Covered Services		
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 being a member, then treatment is covered. There are no changes to covered populations for the CY 2024 rating period.

As of the most current credible eligibility snapshot, there are approximately 13,151 beneficiaries enrolled in SCAN in Los Angeles County, approximately 3,333 in Riverside County, approximately 2,515 in San Bernardino County, and 90 in San Diego.

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 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.

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 CY 2022 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 2024 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 2022 time period. 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 2024 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 2024 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.

Medical Loss Ratio

Mercer confirms the capitation rate development process and resulting rates, as outlined in this certification, and supporting documentation, are reasonable, appropriate, and attainable and MCOs are assumed to reasonably achieve a medical loss ratio (MLR) greater than 85%.

The CY 2024 internal rate ranges utilize a full rebase incorporating the most complete and current data period (CY 2022). This rebase, along with the non-medical loads, detailed below by COA, result in aggregate priced-for effective MLRs greater than 85%.

By COA, the aggregate priced-for effective MLR is greater than 85%:

1) Aged/Disabled Dual:
    a) Assumed upper bound MLR: 100%–11.80% (upper bound non-medical load) = **88.20%.**
    b) Assumed lower bound MLR: 100%–8.00% (lower bound non-medical load) = **92.00%.**
2) LTC-Certified Dual:
    a) Assumed upper bound MLR: 100%–8.35% (upper bound non-medical load) = **91.65%.**
    b) Assumed lower bound MLR: 100%–4.55% (lower bound non-medical load) = **95.45%.**

For CY 2024, the State will impose remittance provisions related to this MLR. Any revenue will need to be remitted to the State up to 85% MLR, if the calculated actual MLR is less than 85% for an MCO.

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 2024 rates. Inclusion of encounter data, where appropriate, will be a future process improvement step. Services incurred in CY 2022 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		
IP 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.

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 September 5, 2023 that any services they provided in addition to those under the State Plan were not included in the RDT schedules submitted. Regarding 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.

Institution for Mental Disease

Covered benefits associated with these capitation rates do not include services associated with an Institution for Mental Disease (IMD). In addition, if a managed care member is in an IMD in a given month, the state does not pursue federal match for that individual for that month. Therefore, the only potential rate impact from a federal perspective for members utilizing an IMD for more than 15 days in a given month would be associated with the potential impact of those members experiencing significantly higher or lower costs than other non-IMD utilizing members. Within the development of the base data, it was confirmed that members in an IMD for more than 15 days in a given month did not exist, and therefore did not have an impact on the base data.

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 program, became 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

The managed care organization (MCO) voluntarily covered ILOS refers to value-added services dollars reported in the RDT that align with one of the newly covered Community Supports services. If a value-added service reported in the RDT was deemed by Mercer to align with one of the 14 Community Support services, then those dollars were included in the base data.

In Lieu of Services Documentation

For requirements outlined in CMS' communication on ILOS with SMD # 23-001, please refer to the following sources included in the certification package for CMS' convenience. The state of California calls ILOS 'Community Supports':

- For service definitions and a brief description of each ILOS in the program, please see page 9 of the DHCS Community Support Policy Guide.
- For state plan services crosswalk, please see page 62 of the DHCS Community Support Policy Guide.
- For target populations, please see page 66 of the DHCS Community Support Policy Guide.
- For the projected ILOS Cost Percentage, please refer to the *CY 2024 Prospective ILOS Cost Percentage 2023 12.pdf*
- For a review on cost effectiveness, please refer to the CA ILOS Literature Review.

Base Data Adjustments

The CY 2022 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.

San Diego County Base Data Development

Beginning January 1, 2023, SCAN began operating 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, Program of All-Inclusive Care for the Elderly, 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.

Satisfactory Immigration Status/Unsatisfactory Immigration Status Considerations

The RDT-reported data encompassed all SCAN-enrolled members, including both SIS and UIS populations. The UIS and SIS data was developed and adjusted separately, and due to credibility issues with the UIS population, an acuity factor was applied to the SIS data to develop UIS base data. The final step in the base data development process was to limit the UIS population to only federal services. This subsection describes the process 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 SIS population
  - This factor represents the expected PMPM cost relativity of the UIS population compared to the SIS population. 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 SIS base data was 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 2022 member months and the original base data (UIS and SIS combined) were used as the starting point, and the RDT reported UIS member months and UIS RDT 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) was 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

RDTs were submitted by SCAN to report CY 2022 experience specific to the UIS population. The CY 2022 UIS experience in these RDT templates was reviewed and compared against the aggregate RDT-reported experience. In aggregate across the CY 2022 time period, the

UIS enrollment accounted for roughly 0.6% 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 2022 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 for federally eligible services, SFY 2021–2022 encounter data for the UIS population was utilized by analyzing both pregnancy-related and emergency services PMPM spend as a percentage of total UIS PMPM spend. 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 makes 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 each encounter or fee-for-service (FFS) claim only flagged once as either pregnancy-related or emergency. No encounters or FFS claims 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 emergency- and pregnancy-related services) can be found in Appendix A.

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 services. Then, 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 region, 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 region's data points for the same COA and COS combination. In the smoothing process, if a region-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 for pregnancy-related and emergency services, by COA and COS. These statewide federal percentages (the sum of pregnancy-related and emergency percentages) were then blended with the region-specific federal percentages to derive the federal percentages applied for each region, by COA and COS. A 50% factor was used for the region percentages and the remaining 50% factor was used for the statewide average percentages. This blend was done to introduce variation seen in the percentages by region. These final blended percentages were then applied to the UIS base data in total by region, 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.

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

The MCO experience used to develop the base data was reported net of any third-party liability; therefore, no adjustment was necessary in the capitation rate development process.

Graduate Medical Education

Regarding Graduate Medical Education (GMED) costs and along with item AA.3.9 of "Documentation Requirements for Actuarially Sound Capitation Rates, Effective Date: November 15, 2014", DHCS staff has confirmed there are no provisions in the SCAN managed care contract regarding GMED. SCAN does not pay specific rates containing GMED or other GMED related provisions. As MCO data serves as the base data for the rate ranges, GMED 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 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 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 2022 base period to CY 2024 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 *CA SCAN CY 2024 Rates 2023 12.xlsx*.

The annualized factors for combined trend and program change adjustments are approximately 3.3% 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], as shown in the following table:

Projection Trends	Annualized 2024/2022	Annualized 2027/2022
Aged	4.1%	4.2%
Disabled	5.1%	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 2024 SCAN rate development, Mercer developed trend rates for each provider type or COS separately by utilization and unit cost components. Notably, Mercer selected the same trends for the SIS and UIS populations for each COA. This was done, as it is Mercer's expectation that utilization or unit cost trends will not differ substantially between the populations on a service category basis.

Mercer reviewed and utilized multiple sources of data and information for trend development. These include recent MCO encounter and RDT data, MCO Medi-Cal-only financial statements, Medi-Cal specific hospital IP and outpatient payment data, Consumer Price Index, National Health Expenditures updates, and multiple industry trend reports including the CMS Medicaid actuarial report. Each of these data and information sources has strengths and challenges, and those strengths and challenges may change over time. Hence, no one, or combination of data and information source(s), was utilized within a

[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.

prescribed formula. Rather, each was reviewed for its potential applicability and utilized collectively with other data and information via actuarial judgement in order to inform the final trends.

The overarching trend development approach remains consistent with prior rate periods as a combination of “top down” and “bottom up” claim cost trend development. Mercer conducted historical annual trend calculations to inform directional changes of emerging trends for consolidated service categories at the major COA level. To the extent the emerging trends, along with the host of data and information described above, indicated a material increase or decrease of service utilization or unit cost; Mercer adjusted the trends established in the prior year’s rates incrementally as the new trends for the current rates in order to reflect the directional changes. This is also referenced as a “change in the change” approach for the purpose of continuity of trend assumptions between different rating periods. In addition to “bottom up” claim cost trend analysis, a considerable amount of actuarial judgement was used in the final trend development based upon Mercer’s longstanding Medi-Cal specific program knowledge and extensive experience in working with the majority of the largest Medicaid programs in the country.

After the mid-point/best estimate trends were determined, a trend range was created by adding 0.25% to each of the utilization and unit cost components as the upper bound and subtracting 0.25% as the lower bound. Trends were leveraged from the SPD/Full-Dual population covered under Medi-Cal’s mainstream rates. The specific trend levels by utilization and unit costs for each COS are displayed in columns (D) and (E) of the CRCS, respectively. 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 2022 with a midpoint of July 1, 2022. The rate period is January 1, 2024 through December 31, 2024 with a midpoint of July 1, 2024. Therefore, annual trend factors were applied for 24 months.

Note that trends for the LTC provider type are displayed as 0.0% for unit cost. Due to the relatively high level of legislatively mandated changes surrounding LTC, Mercer has handled LTC unit cost 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 2024 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 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 *CA SCAN CY 2024 Rates 2023 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 AB 1629 LTC facilities occur on January 1 of each year, while rate increases for non-AB 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.

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 October 1 of each year, and the rate increases for Hospice room and board that occur on August 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.

COVID-19 Considerations

No additional explicit adjustment was made for the COVID-19 public health emergency (PHE) within the CY 2024 SCAN rate development process. Factors contributing to this decision include:

- The final base data is developed using CY 2022 experience. For the prior rating period, CY 2021 utilization experience appeared to return towards pre-COVID-19 levels but not to a full extent. CY 2022 experience compared to CY 2021 showed less increase in utilization suggesting the 2022 period is far enough removed from the COVID-19 PHE to be an appropriate base for the CY 2024 rating period.
- SCAN has a material level of provider subcapitation. 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 the COVID-19 PHE.

Managed Care Adjustment

Mercer set the Managed Care Adjustment factor to 1.000 for the CY 2024 rating period. This is consistent with the CY 2023 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 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 2024 rating period was developed leveraging the CY 2023 analysis and adjustment, considering SCAN financial statement administrative performance and trends over the last several years, and SCAN projection via their RDT response. CY 2024 lower bound administration is set at 6.00% for Aged/Disabled and 2.55% for LTC-Certified. The administration percentage is applied as a percentage of the total premium for SCAN. The CY 2023 percentage for administration loading calculated to an aggregate weighted 4.12%. For the CY 2024 rates, the aggregate weighted administration loading percentage similarly calculates to 4.15%.

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

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

Withhold Arrangements

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

Risk-Sharing Mechanisms

There is one risk-sharing arrangements applicable to the SCAN CY 2024 capitation rates as detailed below.

MLR Remittance

The State will impose an 85% minimum MLR for CY 2024. The formula for calculating the Contractor's MLR is a/b, where a is the total covered benefit and service costs of the MCO, including incurred but not reported claim completion in accordance with 42 CFR 438.8(e) and b is the total capitation payments received the MCO, including any withhold payments minus taxes, licensing, and regulatory fees, in accordance with 42 CFR 438.8(f). Remittance takes place when the Contractor's MLR is below the 85% minimum requirement and is the difference (excess) between the two percentages. Further details of the MLR can be found in the SCAN contracts.

Although capitation rates are not directly affected by the minimum MLR requirement, the rates were developed in such a way that the MCOs are reasonably expected to achieve an MLR of at least 85% for CY 2024. This risk mitigation mechanism has been developed in accordance with generally accepted actuarial principles and practices.

State Directed Payments

There is one State directed payment applicable to the SCAN CY 2024 capitation rates as summarized in the table below. The following subsection in this certification amendment provides more detail around this initiative.

Skilled Nursing Facility and Workforce and Quality Incentive Program

Control Name of the State Directed Payment	Type of Payment	Brief Description	Is the Payment Included as a Rate Adjustment or Separate Payment Term?
Control Name TBD — SNF Workforce and Quality Incentive Program (WQIP)	Quality-adjusted uniform dollar increase	Uniform dollar increase for contracted services modified by quality based scores at the provider level	Separate payment term

The SNF WQIP preprint will be submitted to CMS for approval no later than December 31, 2023. The SNF WQIP is a quality-adjusted uniform dollar add-on payment for services provided by the class of network SNFs for which Medi-Cal is the primary payer, limited to a predetermined pool amount. The SNF WQIP is a separate payment term; the actual uniform dollar increase will be calculated after the end of the CY 2024 period based on actual contracted LTC services utilized within the class and actual quality scores.

The approach for developing the estimated SNF WQIP uniform dollar increases and PMPM impacts is similar to the approach utilized for the hospital directed payments. The estimated contracted share of LTC days and unit cost differentials for the SNF WQIP class were applied to the GME PMPM component of the capitation rate by rate cell for the LTC COS. These calculations produced estimated SNF WQIP contracted days, by rate cell and in total, which formed the basis for creating an estimated uniform dollar add-on payment that would total the intended directed payment target. For this estimate, Mercer assumed uniform quality performance measures across all eligible days.

The directed payment target for WQIP was $295.3 million for the entire 12-month rating period. The uniform dollar add-on payment estimate of $17.27 for LTC produced this impact of $295.3 million. The estimates on a PMPM basis by rate cell are provided in the attached spreadsheet (*CY 2024 Medi-Cal WQIP Directed Payment Summary 2023 12.xlsx*).

The methodology that will be used to allocate actual payments associated with this directed payment will be consistent with the methods discussed in this certification and the 42 CFR § 438.6(c) preprint. The final actual add-on payment will be adjusted based on facility-specific, curved WQIP performance measure scores. The directed payment outlined below is paid as separate payment terms, and the actual payments associated with these directed payments will be paid in the future. To facilitate CMS rate review for the SNF WQIP directed payment, the table below summarizes the directed payment.

Control Name of the State Directed Payment	Aggregate Amount Included in the Certification	Statement that the Actuary is Certifying the Separate Payment Term	The Magnitude on a PMPM Basis	Confirmation the Rate Development is Consistent with the Preprint	Confirmation that the State and Actuary will Submit Required Documentation at the End of the Rating Period (as applicable)
Control Name TBD — SNF WQIP	$295.3 million	The actuary certifies the incorporation of the separate payment term	See file titled *2024 Medi-Cal WQIP Directed Payment Summary 2023 12.xlsx* for the PMPM estimates	Confirmed.	Confirmed

There are no additional directed payments applicable to SCAN for CY 2024 that are unaddressed in this rate certification. There are no requirements regarding the reimbursement rates the health plan must pay to any providers unless specified in the certification as a directed payment or pass-through payment, or authorized under applicable law, regulation, or waiver.

Pass-Through Payments

There are no pass-through payments applied in SCAN CY 2024 capitation rates.

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 we 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 the Medicaid program. 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 the SCAN capitation rates, for CY 2024, January 1, 2024 through December 31, 2024, were developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medi Cal covered populations and services under the managed care 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 meet its qualification standards to certify to the actuarial soundness of these 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 MCO costs will differ from these projections. Mercer has developed these rates on behalf of DHCS 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 or reinsurance arrangements in these rates. Use of these rates for any purpose beyond that stated may not be appropriate.

MCOs are 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 MCOs for any purpose. Mercer recommends that any MCO considering contracting with DHCS 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 Tim Washkowiak at timothy.washkowiak@mercer.com.

Sincerely,

Timothy Washkowiak, ASA, MAAA
Principal

Appendix A

Pregnancy-related and Emergency Service Identification Logic

This appendix details the logic and codes that were used in the identification of pregnancy-related and emergency services, which make up the federally eligible capitation rates for the UIS population. The process utilized contained logic and codes developed both by DHCS and Mercer. In this process, each encounter for the UIS population was flagged (yes or no) into different types of categorizations identified as either pregnancy-related or emergency services. After each encounter was categorized into these flags, a hierarchy was used to ensure each encounter only flagged into one category. Finally, based on the final category for each encounter, each encounter was then classified as pregnancy-related, emergency, or neither. Encounters identified as pregnancy-related or emergency were the basis of the development of the pregnancy-related and emergency percentages and the federally eligible capitation rates for the UIS population.

Below is a list of the different types of emergency and pregnancy-related categories. Additionally, an indication as to whether the categorization is emergency or pregnancy-related is also shown. Detailed codes and logic for each category are listed later in this Appendix. Note, the Rx claims are not present within the logic below since Rx services were carved out of the managed care contracts effective January 1, 2022. Additionally, the order of the categorizations below corresponds to the hierarchy used as well.

1. Labor and Delivery (Emergency) — Labor and delivery is separated out from other maternity-related services since labor and delivery is considered emergency for claiming purposes.

2. Maternity DHCS (Pregnancy-related) — The State maintains an existing set of business rules or logic/criteria it uses to identify applicable maternity-related services for FFS claiming on the UIS population. This category corresponds to this logic. Mercer reviewed the State's logic to ensure agreement that the services identified by the logic would be related to a maternity-related service. Mercer's assessment was that the logic included was a reasonable basis for the identification of the maternity services.

3. Maternity Mercer (Pregnancy-related) — Mercer maintains a set of codes and coding methodology to identify maternity-related services in encounter data for capitation rate development purposes. Mercer's coding and methodology was developed by and is continually refined by Mercer's team of clinicians and coding and data specialists.

4. Pregnancy-related "Catch All" (Pregnancy-related) — This logic identified live birth or delivery events. Using that birth/delivery event date, all encounters were pulled within SFY 2021–2022 for these members with dates of service 238 days prior to the delivery event (pregnancy-related services). The 238-day threshold (34 weeks) was selected because based on information from the National Center for Health Statistics, only 3% of

babies are born before 34 weeks of pregnancy. That means 97% of all births are at 34 weeks of pregnancy or later. This 238-day threshold is viewed as conservative because it does not account for the first few weeks of pregnancy for most births (90% of births are at 37 weeks or later). The assumption here is that virtually every service delivered during pregnancy is ultimately for the benefit of the unborn child.

5. Emergency Medical Transportation (Emergency)
6. Emergency Facility (Emergency)
7. Emergency Other (Emergency)
8. IP Admissions that Originated Through the ER (Emergency)
9. Dialysis (Emergency)
10. Emergency DHCS (Emergency) — Similar to the Maternity DHCS categorization, the State maintains existing business rules or logic/criteria is uses to identify emergency-related services for FFS claiming on the UIS population. Mercer reviewed the State's logic to ensure agreement that the services identified by the logic would be related to an emergency-related service. Mercer's assessment was that the logic included was a reasonable basis for the identification of the emergency services.

Detailed Codes and Logic

Note, in the logic provided below, overlap does occur. As noted previously, all encounters flagging into multiple categories were ultimately only flagged into one category due to the hierarchical logic applied.

1. **Labor and Delivery Criteria**

The following conditions must be satisfied for an encounter to be considered a Labor and Delivery encounter.

Criteria Set 1:

A. The encounter has one of the 25 diagnosis code fields populated with one of the following codes:

'O6010X0', 'O6010X1', 'O6010X2', 'O6010X3', 'O6010X4', 'O6010X5', 'O6010X9', 'O6012X0', 'O6012X1', 'O6012X2', 'O6012X3', 'O6012X4', 'O6012X5', 'O6012X9', 'O6013X0', 'O6013X1', 'O6013X2', 'O6013X3', 'O6013X4', 'O6013X5', 'O6013X9', 'O6014X0', 'O6014X1', 'O6014X2', 'O6014X3', 'O6014X4', 'O6014X5', 'O6014X9', 'O6020X0', 'O6020X1', 'O6020X2', 'O6020X3', 'O6020X4', 'O6020X5', 'O6020X9', 'O6022X0', 'O6022X1', 'O6022X2', 'O6022X3', 'O6022X4', 'O6022X5', 'O6022X9', 'O6023X0', 'O6023X1', 'O6023X2', 'O6023X3', 'O6023X4', 'O6023X5', 'O6023X9', 'O670', 'O678', 'O679', 'O68', 'O690XX0', 'O690XX1', 'O690XX2', 'O690XX3', 'O690XX4', 'O690XX5', 'O690XX9', 'O691XX0', 'O691XX1', 'O691XX2', 'O691XX3', 'O691XX4', 'O691XX5', 'O691XX9', 'O692XX0', 'O692XX1', 'O692XX2', 'O692XX3', 'O692XX4', 'O692XX5', 'O692XX9', 'O693XX0', 'O693XX1', 'O693XX2', 'O693XX3', 'O693XX4', 'O693XX5', 'O693XX9', 'O694XX0', 'O694XX1', 'O694XX2', 'O694XX3', 'O694XX4', 'O694XX5', 'O694XX9', 'O695XX0', 'O695XX1', 'O695XX2', 'O695XX3', 'O695XX4', 'O695XX5', 'O695XX9', 'O6981X0', 'O6981X1', 'O6981X2', 'O6981X3',

'O6981X4', 'O6981X5', 'O6981X9', 'O6982X0', 'O6982X1', 'O6982X2', 'O6982X3', 'O6982X4', 'O6982X5', 'O6982X9', 'O6989X0', 'O6989X1', 'O6989X2', 'O6989X3', 'O6989X4', 'O6989X5', 'O6989X9', 'O699XX0', 'O699XX1', 'O699XX2', 'O699XX3', 'O699XX4', 'O699XX5', 'O699XX9', 'O700', 'O701', 'O7020', 'O7021', 'O7022', 'O7023', 'O703', 'O704', 'O709', 'O720', 'O721', 'O722', 'O723', 'O730', 'O731', 'O740', 'O741', 'O742', 'O743', 'O744', 'O745', 'O746', 'O747', 'O748', 'O749', 'O750', 'O751', 'O752', 'O753', 'O754', 'O755', 'O7581', 'O7582', 'O7589', 'O759', 'O76', 'O770', 'O771', 'O778', 'O779', 'O80', 'O82', 'Z370', 'Z371', 'Z372', 'Z373', 'Z374', 'Z3750', 'Z3751', 'Z3752', 'Z3753', 'Z3754', 'Z3759', 'Z3760', 'Z3761', 'Z3762', 'Z3763', 'Z3764', 'Z3769', 'Z377', 'Z379'

or

B. The encounter has one of the following procedure codes:

'59400', '59409', '59410', '59510', '59514', '59515', '59610', '59612', '59614', '59618', '59620', '59622', '59899', '01960', '01961'

or

C. The encounter has one of the following surgical procedure codes:

'10D00Z0', '10D00Z1', '10D00Z2', '10D07Z3', '10D07Z4', '10D07Z5', '10D07Z6', '10D07Z7', '10D07Z8', '10D17Z9', '10D17ZZ', '10D18Z9', '10D18ZZ', '10E0XZZ'

Criteria Set 2:

Identify the IP encounter tied to the delivery event (delivery event falls between start and end dates of service, where COS equals IP). Consider all encounters within this span of time to be Labor and Delivery encounters.

2. **Maternity DHCS**

This was taken from Business Rules 001A and 006 from SDN 17041–TSD document provided by DHCS.

Any one of the following conditions (criteria set) must be satisfied:

Criteria Set 1:

A. Any of the 25 diagnosis codes are any of the ICD–10 codes mentioned in Appendix table row code set two of DHCS SDN 17041–TSD document:

'O000' through 'O039', 'O050' through 'O069', 'O080' through 'O089', 'O0900' through 'O0993', 'O10011' through 'O16999', 'O200' through 'O2993', 'O30001' through 'O481', 'O6000' through 'O779', 'O85' through 'O9279', 'O94' through 'O9989', 'Z3400' through 'Z3493', 'Z3A00' through 'Z3A49', 'Z370' through 'Z3799', 'Z390' through 'Z392', 'A34', 'M830', 'O80', 'O82', beginning with ‘F53’, beginning with ‘Z36’, beginning with ‘O9989’, beginning with ‘Z37’

Criteria Set 2:

A. Procedure code is any of the codes mentioned in Appendix table row code set three of DHCS SDN 17041–TSD document:

'00842', '59400', '59409', '59414', '59510', '59514', '59525', '59610', '59612', '59618', '59620', '76946', '80055', '81508', '81511', '82106', '82731', '88267', '88269', 'S0190', 'S0197', 'S0199', 'Z1030', 'Z1032', 'Z1034', 'Z1036', 'Z1038', '01958' through '01965', '01967' through '01969', '59000' through '59076', '59100' through '59160', '59300' through '59350', '59831' through '59857', '59870' through '59899', '76801' through '76828', 'Z6200' through 'Z6500'

Criteria Set 3:

A. Any of the 25 surgical procedure codes are any of the below ICD–10 surgical procedure codes mentioned in Appendix table row code set four of DHCS SDN 17041–TSD document:

'10900ZA' through '10900ZD', '10903ZA' through '10903ZD', '10904ZA' through '10904ZD', '10907ZA' through '10907ZD', '10908ZA' through '10908ZD', '10D00Z0' through '10D00Z2', '10D07Z3' through '10D07Z8', '10Q00YE' through '10Q00YH', '10Q00YJ' through '10Q00YN', '10Q00YP' through '10Q00YT', '10Q00ZE' through ‘10Q00ZH', '10Q00ZJ' through '10Q00ZN', '10Q00ZP' through '10Q00ZT', '10Q03YE' through '10Q03YH', '10Q03YJ' through '10Q03YN', '10Q03YP' through '10Q03YT', '10Q03ZE' through '10Q03ZH', '10Q03ZJ' through '10Q03ZN', '10Q03ZP' through '10Q03ZT', '10Q04YE' through '10Q04YH', '10Q04YJ' through '10Q04YN', '10Q04YP' through '10Q04YT', '10Q04ZE' through '10Q04ZH', '10Q04ZJ' through '10Q04ZN', '10Q04ZP' through '10Q04ZT', '10Q07YE' through '10Q07YH', '10Q07YJ' through '10Q07YN', '10Q07YP' through '10Q07YT', '10Q07ZE' through '10Q07ZH', '10Q07ZJ' through '10Q07ZN', '10Q07ZP' through '10Q07ZT', '10Q08YE' through '10Q08YH', '10Q08YJ' through '10Q08YN', '10Q08YP' through '10Q08YT', '10Q08ZE' through '10Q08ZH', '10Q08ZJ' through '10Q08ZN', '10Q08ZP' through '10Q08ZT', '10Y03ZJ' through '10Y03ZN', '10Y03ZP' through '10Y03ZT', '10Y04ZE' through '10Y04ZH', '10Y04ZJ' through '10Y04ZN', '10Y04ZP' through '10Y04ZT', '10Y07ZE' through '10Y07ZH', '10Y07ZJ' through '10Y07ZN', '10Y07ZP' through '10Y07ZT', '0W8NXZZ', '0WQNXZZ', '10900Z9', '10900ZU', '10903Z9', '10903ZU', '10904Z9', '10904ZU', '10907Z9', '10907ZU', '10908Z9', '10908ZU', '10D17ZZ', '10D18ZZ', '10E0XZZ', '10H003Z', '10H00YZ', '10H073Z', '10H07YZ', '10J00ZZ', '10J03ZZ', '10J04ZZ', '10J07ZZ', '10J08ZZ', '10J0XZZ', '10J10ZZ', '10J13ZZ', '10J14ZZ', '10J17ZZ', '10J18ZZ', '10J1XZZ', '10J20ZZ', '10J23ZZ', '10J24ZZ', '10J27ZZ', '10J28ZZ', '10J2XZZ', '10P003Z', '10P00YZ', '10P073Z', '10P07YZ', '10Q00YV', '10Q00YY', '10Q00ZV', '10Q00ZY', '10Q03YV', '10Q03YY', '10Q03ZV', '10Q03ZY', '10Q04YV', '10Q04YY', '10Q04ZV', '10Q04ZY', '10Q07YV', '10Q07YY', '10Q07ZV', '10Q07ZY', '10Q08YV', '10Q08YY', '10Q08ZV', '10Q08ZY', '10S07ZZ', '10S0XZZ', '10T20ZZ', '10T23ZZ', '10T24ZZ', '10Y03ZE', '10Y03ZH', '10Y03ZV', '10Y03ZY', '10Y04ZV', '10Y04ZY', '10Y07ZV', '10Y07ZY', '30273H1', '30273J1', '30273K1', '30273L1', '30273M1', '30273N1', '30273P1', '30273Q1', '30273R1', '30273S1', '30273T1', '30273V1', '30273W1', '30277H1', '30277J1', '30277K1', '30277L1', '30277M1', '30277N1', '30277P1', '30277Q1', '30277R1', '30277S1', '30277T1', '30277V1', '30277W1', '3E053VJ', '3E0DXGC', '3E0E305', '3E0E33Z', '3E0E36Z', '3E0E37Z', '3E0E3BZ', '3E0E3GC', '3E0E3HZ', '3E0E3KZ', '3E0E3NZ', '3E0E3SF', '3E0E705', '3E0E73Z', '3E0E76Z', '3E0E77Z', '3E0E7BZ', '3E0E7GC', '3E0E7HZ', '3E0E7KZ',

'3E0E7NZ', '3E0E7SF', '3E0E805', '3E0E83Z', '3E0E86Z', '3E0E87Z', '3E0E8BZ', '3E0E8GC', '3E0E8HZ', '3E0E8KZ', '3E0E8NZ', '3E0E8SF', '4A0H74Z', '4A0H7CZ', '4A0H7FZ', '4A0H7HZ', '4A0H84Z', '4A0H8CZ', '4A0H8FZ', '4A0H8HZ', '4A0HX4Z', '4A0HXCZ', '4A0HXFZ', '4A0HXHZ', '4A0J72Z', '4A0J74Z', '4A0J7BZ', '4A0J82Z', '4A0J84Z', '4A0J8BZ', '4A0JX2Z', '4A0JX4Z', '4A0JXBZ', '4A1H74Z', '4A1H7CZ', '4A1H7FZ', '4A1H7HZ', '4A1H84Z', '4A1H8CZ', '4A1H8FZ', '4A1H8HZ', '4A1HX4Z', '4A1HXCZ', '4A1HXFZ', '4A1HXHZ', '4A1J72Z', '4A1J74Z', '4A1J7BZ', '4A1J82Z', '4A1J84Z', '4A1J8BZ', '4A1JX2Z', '4A1JX4Z', '4A1JXBZ'

Criteria Set 4:

A. Claim type is one of the following:

   i. Claim Type 04 = Outpatient

   ii. Claim Type 05 = Medical

and

B. The provider type is not ‘009’ (Lab/Radiology)

and

C. The encounter has any one of the following CPT or CPSP (Comprehensive Perinatal Services Program) procedure codes:

   ‘59000’ through ‘59025’, ‘59030’ through ‘59051’, ‘59070’ through ‘59076’, ‘59100’ through ‘59151’, ‘59200’, ‘59400’, ‘59412’, ‘59300’ through ‘59325’, ‘59425’ through ‘59426’, ‘59510’, ‘59610’, ‘59618’, ‘59812’ through ‘59830’, ‘59870’ through ‘59899’, ‘S0197’, ‘Z1032’, ‘Z1034’, ‘Z1036’, ‘Z6200’ through ‘Z6204’, ‘Z6206’, ‘Z6210’, ‘Z6306’, ‘Z6300’ through ‘Z6304’, ‘Z6400’ through ‘Z6412’, ‘Z6500’

3. **Maternity Mercer**

The following codes are first checked for abortions, which will overwrite a delivery event as NULL if they fall within any of the coding ranges below:

A. Procedure codes ‘59812’, ‘59813’, ‘59814’, ‘59815’, ‘59816’, ‘59817’, ‘59818’, ‘59819’, ‘59820’, ‘59821’, ‘59822’, ‘59823’, ‘59824’, ‘59825’, ‘59826’, ‘59827’, ‘59828’, ‘59829’, ‘59830’,‘59840', '59841', '59850', '59851', '59852', '59855', '59856', '59857', '59866', 'X7724', 'X7726', 'Z0336', '01964', '01966', 'S0190', 'S0191', 'S0199', 'Z2004'

or

B. Diagnosis codes beginning with ‘O040’, ‘O070’, 'O0480', 'Z332', 'Z0371', 'Z0372', 'Z0373', 'Z0374', 'Z0375', 'Z0376', 'Z0377', 'Z0378', 'Z0379'

or

C. IP claim type code with the following IP surgical codes: '10A07ZX', '10A07ZZ', '10A08ZZ', '10A00ZZ', '10A03ZZ', '10A04ZZ', '10A07Z6', '10A07ZW', '3E0E3TZ', '3E0E7TZ', '3E0E8TZ'

Any of the following conditions (criteria set) must be satisfied for an encounter to be considered a Maternity Mercer encounter (note this logic is only applied when the beneficiary's sex is female and the beneficiary's age is between age 12 through 55, inclusive).

Criteria Set 1:

A. The encounter has any of the 25 diagnosis codes with the codes '082', '07582'

or

B. The encounter has any procedure code with the codes '59510' through '59515', '59620' through '59622', 59525, 59618, 01961, 01968

Criteria Set 2:

A. The encounter has any of the 25 surgical codes with codes:

'10D07Z3', '10D07Z4', '10D07Z5', '10D07Z6', '10D07Z8', '10D07Z7', '10D00Z0', '10D00Z1', '10D00Z2', '10D17ZZ', '10D18ZZ', '10D00Z0', '10D17Z9', '10D18Z9', '10E0XZZ'

or

B. The encounter has any of the 25 diagnosis codes with the codes:

'O80'. 'O703', 'O704', 'O709'

or

C. The encounter has a procedure code with the codes:

'59400' through '59410', '59610' through '59614', '59898' through '59899', '01967', '01960', '57022'

Criteria Set 3:

A. The encounter has any of the 25 diagnosis codes with the codes:

'O6010X0', 'O6010X1', 'O6010X2', 'O6010X3', 'O6010X4', 'O6010X5', 'O6010X9', 'O6012X0', 'O6012X1', 'O6012X2', 'O6012X3', 'O6012X4', 'O6012X5', 'O6012X9', 'O6013X0', 'O6013X1', 'O6013X2', 'O6013X3', 'O6013X4', 'O6013X5', 'O6013X9', 'O6014X0', 'O6014X1', 'O6014X2', 'O6014X3', 'O6014X4', 'O6014X5', 'O6014X9', 'O6020X0', 'O6020X1', 'O6020X2', 'O6020X3', 'O6020X4', 'O6020X5', 'O6020X9', 'O6022X0', 'O6022X1', 'O6022X2', 'O6022X3', 'O6022X4', 'O6022X5', 'O6022X9', 'O6023X0', 'O6023X1', 'O6023X2', 'O6023X3', 'O6023X4', 'O6023X5', 'O6023X9', 'O670', 'O678', 'O679', 'O68', 'O690XX0', 'O690XX1', 'O690XX2', 'O690XX3', 'O690XX4', 'O690XX5', 'O690XX9', 'O691XX0', 'O691XX1', 'O691XX2', 'O691XX3', 'O691XX4', 'O691XX5', 'O691XX9', 'O692XX0', 'O692XX1', 'O692XX2', 'O692XX3', 'O692XX4', 'O692XX5', 'O692XX9', 'O693XX0', 'O693XX1', 'O693XX2', 'O693XX3', 'O693XX4', 'O693XX5', 'O693XX9', 'O694XX0', 'O694XX1', 'O694XX2', 'O694XX3', 'O694XX4', 'O694XX5', 'O694XX9', 'O695XX0', 'O695XX1', 'O695XX2', 'O695XX3', 'O695XX4', 'O695XX5', 'O695XX9', 'O6981X0', 'O6981X1', 'O6981X2', 'O6981X3',

'O6981X4', 'O6981X5', 'O6981X9', 'O6982X0', 'O6982X1', 'O6982X2', 'O6982X3', 'O6982X4', 'O6982X5', 'O6982X9', 'O6989X0', 'O6989X1', 'O6989X2', 'O6989X3', 'O6989X4', 'O6989X5', 'O6989X9', 'O699XX0', 'O699XX1', 'O699XX2', 'O699XX3', 'O699XX4', 'O699XX5', 'O699XX9', 'O700', 'O701', 'O7020', 'O7021', 'O7022', 'O7023', 'O740', 'O741', 'O742', 'O743', 'O744', 'O745', 'O746', 'O747', 'O748', 'O749', 'O750', 'O751', 'O752', 'O753', 'O754', 'O755', 'O7581', 'O7589', 'O759', 'Z370', 'Z372', 'Z373', 'Z3750', 'Z3751', 'Z3752', 'Z3753', 'Z3754', 'Z3759', 'Z3760', 'Z3761', 'Z3762', 'Z3763', 'Z3764', 'Z3769', 'Z379', 'O770', 'O771',
'O711', 'O713', 'O714', 'O715', 'O716', 'O717', 'O7181', 'O7182', 'O7189', 'O719', 'O8802', 'O8812', 'O8822', 'O8832', 'O8882', 'O9812', 'O9822', 'O9832', 'O9842', 'O9852', 'O9862', 'O9872', 'O9882', 'O9892', 'O9902', 'O9912', 'O99214', 'O99284', 'O99314', 'O99324', 'O99334', 'O99344', 'O99354', 'O9942', 'O9952', 'O9962', 'O9972', 'O99814', 'O99824', 'O99834', 'O99844', 'O9A12', 'O9A22', 'O9A32', 'O9A42', 'O9A52'

Criteria Set 4:

A. The encounter has a procedure code from ‘59000’ through ‘59899’.

or

B. The encounter has a revenue code of ‘720’, ‘0720’, ‘721’, ‘0721’, ‘722’, ‘0722’, ‘724’, ‘0724’, ‘729’, ‘0729’, ‘112’, ‘0112’, ‘122’, ‘0122’, ‘132’, ‘0132’, ‘142’, ‘0142’, ‘152’, ‘0152’, ‘232’, ‘0232’.

or

C. The encounter has any of the 25 diagnosis codes with the codes:

‘O720','O721','O722'

or

D. The encounter has any 25 surgical procedure codes with the codes:

'0UJD7ZZ', '0JCB0ZZ', '0JCB3ZZ', '0US90ZZ', '0US94ZZ', '0US9XZZ', '10H003Z', '10H00YZ', '10P003Z', '10P00YZ', '10P073Z', '10P07YZ', '10S07ZZ', '10900ZC', '10903ZC', '10904ZC', '10907ZC', '10908ZC', '0U7C7ZZ', '10D07Z7', '10J07ZZ', '3E053VJ', '10D17ZZ', '10D18ZZ'

Criteria Set 5:

A. The encounter has one of the following procedure codes:

'59425', '59426', 'X8170', 'Z1000', 'Z1008', 'Z1016', 'Z1018', 'Z1020', 'Z1022', 'Z1030', 'Z1032', 'Z1034', 'Z1036', 'Z2008', 'Z2502', 'Z2503', 'Z6410', 'Z6412'

Criteria Set 6:

A. The encounter has a procedure code with the codes ‘59430’, ‘Z1004’, ‘Z1012’, ‘Z1026’, ‘Z1038’

4. **Pregnancy-related “Catch All”**

The following conditions must be satisfied for an encounter to be considered a Pregnancy-related encounter:

A. Identify deliveries for members using the following criteria:

ii. Cesarean birth: Mercer Maternity Criteria 1 (from above).

iii. Vaginal birth: Mercer Maternity Criteria 2 (from above).

iv. Unspecified birth: Mercer Maternity Criteria 3 (from above).

or

i. A member must be included in Maternity Kick Payments file provided by DHCS, which is a file that lists each member who gave birth and the birth month for each member.

All encounters 238 days prior to the delivery event are considered Pregnancy-related encounters.

5. **Emergency Medical Transportation**

The below condition must be satisfied for an encounter to be considered an Emergency Medical Transportation encounter.

A. The encounter has any one of the following procedure codes:

'A0225','A0427','A0429','A0433','A0434'

6. **Emergency Facility**

The following conditions must be satisfied for an encounter to be considered an Emergency Facility encounter:

A. EDS claim type is 04 Outpatient and Emergency Indicator equals YES.

and

B. Federally Qualified Health Center National Provider Identifier is not equal to 1.

7. **Emergency Other**

Any of the following conditions must be satisfied for an encounter to be considered an Emergency Other encounter:

A. Place of service code is 0 ER.

or

B. The encounter has any one of the following procedure or revenue codes:

‘0450’, ‘0451’, ‘0452’, ‘0459’, ‘450’, ‘451’, ‘452’, ‘459’, ‘99281’ through ‘99288’.

8. **Inpatient Admissions that Originated Through the Emergency Room**

The following condition must be satisfied for an encounter to be considered an Emergency IP encounter:

A. A member has both an ER and IP encounter (using COS) with the same date of service.

9. **Dialysis**

The following condition must be satisfied for an encounter to be considered a Dialysis encounter:

A. The encounter has any one of the following procedure codes:

ii. '90935', '90937', '90940', '90945', '90947', '90951', '90952', '90953', '90954', '90955', '90956', '90957', '90958', '90959', '90960', '90961', '90962', '90963', '90964', '90965', '90966', '90967', '90968', '90969', '90970', '90999', '99512', 'G0257', '0692T', 'S9335', 'S9339'

B. Any member who had an encounter with one of the above procedure codes must also have been diagnosed with end-stage renal disease, acute kidney failure, or stage 5 chronic kidney disease using the following diagnosis codes: ‘N170’, ‘N171’, ‘N172’, ‘N178’, ‘N179’, ‘N185’, ‘N186’

10. **Emergency DHCS**

This was taken from Business Rule 005 from SDN 17041 — TSD document provided by DHCS.

Any one of the below conditions must be satisfied for an encounter to have emergency service(s) for claiming FFP.

A. The provider type is not ‘009’ (Lab/Radiology)

and

B. The claim type is either 05 or 06

and

C. The emergency indicator (C54-CLM-EMERG-IND) in CP-F-54 file is ‘Y.’

or

A. The claim type is either 04 or 06 and emergency indicator (C54-CLM-EMERG-IND) in CP-F-54 file is ‘Y’

or

A. The claim type is 03 and the emergency indicator (C54-CLM-EMERG-IND) in File CP-F-54 is ‘Y’

or

A. The claim type is 03

and

B. Claim form code (C54-CLM-FORM-CODE-0273) in CP-F-54 file is SPACE

and

C. The claim admit type(C54-IN-ADMIT-TYPE) in CP-F-54 file is either 1,3, 4, 6

or

A. The claim type is 03

and

B. Claim form code (C54-CLM-FORM-CODE-0273) in CP-F-54 file is 'U'

and

C. The claim admit type (C54-IN-ADMIT-TYPE) in CP-F-54 file is 1.

or

A. The claim type is either 04, 05, 06 and the encounter procedure codes is any of the codes mentioned in Appendix table row code set 6 of DHCS SDN 17041–TSD document:

ii. '15271' through '15278', '20527', '26341', '27267', '27268', '29582' through '29584', '32421', '32422', '32550', '32551', '33258', '43753', '46930', '49082' through '49084', '51100' through '51102', '51797', '59030', '59050', '59070', '59072', '59074', '59076', '59100', '59120', '59121, '59130', '59135', '59136', '59140', '59150', '59151', '59160', '59300', '59350', '59409', '59414', '59514', '59525', '59612', '59620', '59812', '59820', '59821', '59830', '59897', '60300', '62370', '64633' through '64636', '67041' through '67043', '67113', '67229', '68816', '88720', '88740', '88741', '90918' through '90990', '91100', '91105', '91110', '92071', '92072', '92950', '92953', '92970', '92971', '92975', '92977', '92978', '92979', '92980', '92981', '92982', '92984', '92987', '92990', '92995', '92996', '93651', '93652', '93998', '94002', '94003', '94656', '94657', '94728', '94729', '95885', '95887', '95938', '95939', '99281' through '99285', '99291', '99292', '99295', '96360', '96361', '96365' through '96376', '96379', '99296', '99297', '99464', '99477', 'C1830', 'C1886', 'C8929', 'C8930', 'Q4100' through 'Q4114', 'Q4122' through 'Q4130', 'S5000', 'S5001', 'Z1002', 'Z1010', 'Z1024', 'Z6000' through 'Z6042', 'Z7502', 'Z7504', 'Z7506', 'Z7508', 'Z7510', 'Z7610', 'Z7612'.

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