Mercer

Government Human Services Consulting

Capitation Rate Development and Certification

SCAN Health Plan

January 1, 2022–December 31, 2022

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

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Contents

Section 1
Executive Summary

The 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[1] Medicaid capitation rates for SCAN Health Plan (SCAN) for use during the rating period of calendar year 2022 (CY 2022). CY 2022 encompasses the time period of January 1, 2022 through December 31, 2022.

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

Per Section 4.2 of ASOP 49, capitation rates for SCAN were developed in accordance with Centers for Medicare & Medicaid Services (CMS) requirements and this document provides the certification of actuarial soundness required by 42 CFR § 438.4. CMS defines actuarially sound rates as meeting the following criteria:

- Have been developed in accordance with generally accepted actuarial principles and practices. Proposed differences among capitation rates according to covered populations are based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.
- Are appropriate for the populations to be covered and the services to be furnished under the contract.
- Payments from each rate cell do not cross-subsidize payments for any other rate cell.
- Have been certified by actuaries who meet qualification standards established by the American Academy of Actuaries and the Actuarial Standards Board.

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

[1]Actuarially sound/actuarial soundness — Medicaid capitation rates are "actuarially sound" if, for 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. http://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049_179.pdf

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 describes the rate development process and provides the certification of actuarial soundness required by 42 CFR §438.4. This report was developed to provide the requisite rate documentation to DHCS and to support the CMS' rate review process. This report follows the general outline of the CMS 2021–2022 Medicaid Managed Care Rate Development Guide dated June 2021, which is applicable to contract periods beginning on or after July 1, 2021. The rate development process included the historical practice of developing rate ranges. However, the credentialed actuaries are certifying to final capitation rates within the developed rate ranges.

To the best of Mercer's knowledge, there are no conflicts of interest in performing this work. Mercer expressly disclaims responsibility, liability, or both for any reliance on this communication by third parties or the consequences of any unauthorized use.

Multiple attachments are also included as part of this rate certification package. These attachments include summaries of the CY 2022 capitation rates (including the final and certified capitation rates) and capitation rate calculation sheet (CRCS) exhibits. The final capitation rates by county and category of aid (COA) groupings, including a comparison to the prior CY 2021 rating period certified rates, can be found in the attached Excel file titled *CY2022 SCAN Rates 20211217.xlsx*.

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

Beginning with the CY 2022 rating period, some significant changes within the Medi-Cal program will occur. 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. Components of this initiative are addressed throughout the body of this report.

Overall, across all populations and counties, the CY 2022 weighted lower bound capitation rate, which DHCS will pay SCAN, is projected at $369.10 per member per month (PMPM). Mercer certifies to the six separate lower bound capitation rates. This $369.10 PMPM is an approximate 3.01% increase over the corresponding CY 2021 figure. With a projected 174,685 member months, total lower bound capitation dollars are projected to be approximately $64.5 million in CY 2022.

Future amendments to this certification may be submitted to CMS. Certain assumptions material to the rates in this certification depend on the status of the Coronavirus Disease 2019 (COVID-19) Public Health Emergency (PHE). This rate certification assumes the PHE will conclude on December 31, 2021. A future amendment may be submitted to CMS if there are material impacts to the program due to the length of the PHE.

In addition, California provides full scope coverage to beneficiaries 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). These UIS members are federally eligible to receive pregnancy and emergency related services. Capitation rates within this certification are set across the entire enrolled population, within which the UIS and SIS members are embedded together. Through communications with CMS, it has come to DHCS and Mercer's attention that these members should be separated from the population with SIS for capitation rate development purposes. If the removal of members and/or services ineligible for full scope federal funding has a material impact on these capitation rates, an amendment will be submitted accordingly.

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, and Riverside counties.

Covered Services

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

Covered Services		
Physician services	Psychology services	Durable medical equipment
Skilled nursing facility services	Podiatry services	Home health agency services
Subacute nursing facilities limited to Medi-Cal contract facility	Inpatient hospital services for general acute care, mental illness, substance	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

As part of the aforementioned CalAIM initiative, there are three major benefit/service changes effective January 1, 2022. This includes 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).

Covered Populations

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

- Aged/Disabled Dual COA — these are beneficiaries aged 65 and older (may or may not be disabled) and eligible for Medicare Part A, Part B, and Part D. DHCS uses Plan Code 200, 204, and 206 to represent the Aged/Disabled rating groups of SCAN dual eligible members in Los Angeles, Riverside, and San Bernardino counties, respectively.
- Long-Term Care (LTC) Certified Dual COA — these are beneficiaries aged 65 and older who have been certified eligible to reside in a LTC facility, and are eligible for Medicare Part A, Part B, and Part D. These individuals have an elevated or more severe medical condition than those in the Aged/Disabled Dual COA. DHCS uses Plan Code 201, 205, and 207 to represent the LTC-Certified rating groups of SCAN dual eligible members in Los Angeles, Riverside, and San Bernardino counties, respectively.

Qualified Medicare beneficiaries and specified low-income Medicare beneficiaries are not eligible for enrollment in Medi-Cal managed care plans. For both dual COAs, SCAN enrolls only non-qualified Medicare beneficiaries and non- specified low-income Medicare beneficiaries 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, treatment is covered. There are no changes to covered populations for the CY 2022 rating period.

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

Rate Structure

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

- Aged/Disabled Dual
- LTC-Certified Dual

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

Federal Medical Assistance Percentage

Depending on the Medicaid managed care program, some services or populations are subject to a higher FMAP than the regular California 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. 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. 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 that applying on a population basis. Those services are family planning, for which the FMAP is 90%, and adult preventive services, which earns an additional 1% pursuant to section 4106(b) of the Affordable Care Act. 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 2020 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 2022 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 operate. 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 2022 period. Then Mercer applied additional adjustments to the base data to incorporate:

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

The above approach has been utilized in the development of the CY 2022 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.

Other than an increase in mental health outpatient services utilization described later, no additional explicit adjustment was made for the COVID-19 PHE within the CY 2022 SCAN rate development process. Factors contributing to this decision include:

- The final modeled base data is developed with a weighted average of 75% adjusted CY 2019 experience with 25% adjusted CY 2020 experience. This blend implicitly factors in COVID-19 experience, where generally lower utilization but higher unit cost was observed, with the net of the two components combined being a lower CY 2020 PMPM. Although it is impossible to predict the COVID-19 SCAN CY 2022 impact, DHCS, Mercer, and SCAN, believe there will be at least some, and hence have incorporated the lower CY 2020 base data.
- SCAN has a material level of provider subcapitation. The providers contracted with SCAN were paid by SCAN; therefore, access to quality health care remains.
- Although not explicitly tied to COVID-19, annual utilization and unit cost trend rates for several service categories were each reduced by 0.5% with COVID-19 considerations partially in mind.
- DHCS and Mercer regularly review emerging financial experience for SCAN, which would include any related impacts due to COVID-19.

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 2022 rates. Inclusion of encounter data, where appropriate, will be a future process improvement step. Services incurred in CY 2019 and CY 2020 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	

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 Department of Managed Health Care. Mercer did not audit SCAN data or information, and if the data or information is materially incomplete or inaccurate, Mercer's conclusions may require revision. However, Mercer did perform alternative procedures and analyses that provide a reasonable assurance as to the aggregate data's appropriateness for use in capitation rate development. Aggregate experience

for SCAN appeared reasonable. Where appropriate, budget-neutral adjustments were made to the reported RDT data to account for unusual/unreasonable COA figures. As previously mentioned, a weighted average of adjusted CY 2019 RDT data (at 75%) and adjusted CY 2020 RDT data (at 25%) 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 15, 2021 that any services they provided in addition to those under the State Plan were not included in the RDT schedules submitted. With regard to overpayments to providers and Section 438.608(d) of the Medicaid Managed Care Final Rule, claims/financial experience provided by SCAN and utilized by DHCS and Mercer was on a net-payment basis, after any recoveries. For the remaining requirements of 438.608(d), please see the SCAN contract.

American Indian Health Service Programs

SCAN contract Exhibit A, Attachment 8, Provider Compensation Arrangements, details the American Indian Health Service Programs 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 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 managed care organization (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.

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 increase the base costs for the Aged/Disabled COA in San Bernardino County. This smoothing adjustment reduces the large deviation from aggregate experience for each COA and was made in a budget-neutral manner for the 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 2020 cost and benefit level before being blended (at a 75% weighting) with the CY 2020 RDT data.

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 2020 base period to CY 2022 contract period. Adjusted and smoothed CY 2019 data was also trended forward to CY 2020, which was then blended with CY 2020 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 *CY2022 SCAN Rates 20211217.xlsx*.

The annualized factors for combined trend and program change adjustments are approximately 3.0% 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.[2]

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

Trend

Trend is an estimate of the change in the overall utilization and cost of medical services over a finite period. Trend factors are necessary to estimate the expenses of providing health care services in a future period. As part of the CY 2022 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

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

Coordinated Care Initiative. Historical factors utilized were reviewed. Trends developed from RDT-submitted information were analyzed. SCAN projected trends were considered. Other available data/information such as current Consumer Price Index factors and California minimum wage changes were gathered. Actuarial judgment was applied to determine the final trend factors.

Specific to the negative (residual) utilization trends for inpatient hospital and pharmacy, see page 48 of the 2018 CMS Medicaid actuarial report.[3] The report provides the following examples:

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

Mercer did not use negative utilization trend factors as aggressive as these 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 2020 with a midpoint of July 1, 2020. The rate period is January 1, 2022 to December 31, 2022 with a midpoint of July 1, 2022. 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

[3] See footnote 1, page 48.

change adjustments that were explicitly accounted for within the CY 2022 capitation rates.

Program change adjustments are developed based on a “utilization per 1,000” or a “unit cost” basis. These adjustments are reflected in the CRCS exhibits. The various program changes are calculated at the COA and COS level. Multiple program changes may be reflected within a final percentage represented in a given COA and COS field. A summary showing the impact by county and COA group can be found within the program change charts in the attached Excel file titled *CY2022 SCAN Rates 20211217.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, 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.

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 will be 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 through the CalAIM proposal:

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

MCO Voluntarily Covered ILOS Adjustment

ILOS are medically appropriate and cost-effective alternatives to State Plan services or settings that will be authorized in the MCO contracts effective January 1, 2022. 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 ILOS services were reported in SCAN 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 2019
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.

Mental Health Outpatient Services Acuity

Acuity changes may occur as new needs develop and treatment becomes warranted. Based on national evidence that the COVID-19 pandemic is having a material impact on mental health needs, Mercer is forecasting an uptick in behavioral health related services relative to the modeled CY 2020 base data time period, including services to treat the mild to moderate mental health conditions covered by managed care. CY 2022 capitation rates include additional costs for this increase, modeled as a 5% increase in the projected mental health outpatient services.

Managed Care Adjustment

Mercer set the Managed Care Adjustment factor to 1.000 for the CY 2022 rating period. This is consistent with the CY 2021 rating period.

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

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 2022 rating period was developed leveraging the CY 2021 analysis and adjustment, considering SCAN financial statement administrative performance and trends over the last several years, and SCAN projection via their RDT response. CY 2022 lower bound administration was 6.50% for Aged/Disabled and 2.95% for LTC-Certified. The administration percentage is applied as a percentage of the total premium for SCAN. The CY 2021 percentage for administration loading was set at an aggregate weighted 4.36%. For the CY 2022 rates, that aggregate weighted administration loading percentage was similarly set at 4.42%

Underwriting Gain

The underwriting gain load was established at a 2.0%–4.0% range across SCAN, with 2.0% being the lower bound value. The percentage range is 0.5% higher at both bounds than the values used in the prior rating period, and is consistent with overall Medi-Cal MCO at-risk program capitation rate development. Mercer has implicitly and broadly considered the cost of capital within our rating assumptions. Mercer has concluded 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 was considered within the rate development process, if applicable.

Incentive Arrangements

COVID-19 Vaccination Incentive Program

COVID-19 vaccination incentive payments are being utilized to encourage vaccinations among Medi-Cal's beneficiaries. The new program to boost COVID-19 vaccination rates will allow Medi-Cal MCOs to earn incentive payments for activities that are designed to close vaccination gaps with their enrolled members, based upon lessons learned so far in the pandemic. MCOs provide case and care management services for Medi-Cal members and are well positioned to provide enhanced coordination services, partner with primary care providers, and conduct outreach for vaccine distribution to their members. The vaccination incentive program will also encourage significantly expanded outreach in underserved communities.

Funding will incentivize outreach programs and activities by MCOs and their providers, particularly primary care providers and pharmacies, as well as engagement with trusted community organizations, such as food banks, advocacy groups, and faith-based organizations.

The vaccination incentive program runs from September 2021 through February 2022. The funding for these incentives that will be paid in accordance with 42 CFR §438.6(b) will not exceed $250 million across all applicable managed care contracts and certifications. The total incentive payments under each contract and certification

will not exceed 5% of the capitation payments. The vaccination incentive program has no effect on the development of capitation rates.

Additional detail regarding the vaccination incentive program is available through the managed care contract, All Plan Letter 21-010, and any subsequent revisions, and similar instruction issued to MCOs.[4]

Housing and Homeless Incentive Program

As part of the state's overarching home- and community-based services spending plan, the state will implement the Housing and Homeless 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 period years:

- Period year 1 will be January 1, 2022 through December 31, 2022, which aligns with California's CY 2022 rating period.

[4] All Plan Letter 21-010 and supplemental Attachment A are available at https://www.dhcs.ca.gov/Documents/COVID-19/APL-21-010-Vaccine-Incentive.pdf and https://www.dhcs.ca.gov/Documents/COVID-19/APL-21-010-Attachment-A-Vaccination-Incentive-Program-Outcome-Metrics.pdf, respectively.

- Period year 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 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, associated All Plan Letters, and similar instructions issued to MCOs.

Withholding Arrangements

No withhold arrangements between DHCS and SCAN are in place. Hence, this subsection is not applicable to the CY 2022 rate certification.

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 2022 capitation rates.

Pass-Through Payments

There are no pass-through payments applied in SCAN CY 2022 capitation rates.

Section 7

Certification and Final Rates

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

In preparing the capitation rates described, Mercer has used and relied upon enrollment, eligibility, claim, reimbursement level, benefit design, and financial data and information supplied by DHCS and its vendors. DHCS and its vendors are solely responsible for the validity and completeness of this supplied data and information. 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 2022 rating period, January 1, 2022 through December 31, 2022, were developed in accordance with generally accepted actuarial practices and principles, and are appropriate for the Medi-Cal covered populations and services under the SCAN contract. Capitation rates are "actuarially sound" if, for the business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees and taxes. The undersigned actuaries are members of the

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

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

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

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 secures the advice of competent legal and taxation counsel with respect to any legal or taxation matters related to this report or otherwise.

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

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 or Jie Savage at jie.savage@mercer.com.

Sincerely,

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Michael E. Nordstrom, ASA, MAAA
Partner

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Senior Associate

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