Mercer

Government Human Services Consulting

Calendar Year 2022 SCAN Health Plan Mainstream Rate Development Template

Auditor's Report

California Department of Health Care Services

September 5, 2024

Contents

Section 1: Executive Summary

Pursuant to federal requirements under Title 42 of the Code of Federal Regulations 438.602(e), the State of California Department of Health Care Services (DHCS) must periodically, but no less frequently than once every three years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each managed care organization (MCO). DHCS contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to fulfill this requirement for the financial data submitted in the Medi-Cal rate development template (RDT) for calendar year (CY) 2022 by SCAN Health Plan (SCAN). Mercer designed and DHCS approved procedures to test the accuracy, truthfulness, and completeness of self-reported financial data in the RDT.

The specific financial schedules selected for testing are used by Mercer as a critical part of the base data development process for capitation rate development related to the CY 2024 rating period. The RDT tested was the final version, including any revisions stemming from resubmissions as a result of the RDT Question and Answer discussion guide process with the MCO.

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

- Schedule 1 — Utilization and Cost Experience
- Schedule 1-A — Global Subcontracted Health Plan Information
- Schedule 1-B — Incentive Payments Arrangements
- Schedule 1-C — Base Period Enrollment
- Schedule 1-O — Supplemental Financial Report for Provider Overpayments
- Schedule 1-U — UM/QA/CC
- Schedule 5 — Large Claims Report
- Schedules 6a and 6b — Financial Reports
- Schedule 7 — Lag Payment Information

The data collected in the RDT is reported on a modified accrual (incurred) basis for CY 2022 and does not follow generally accepted accounting principles with regards to retroactivity from prior year activity, including claim or capitation accruals, retroactive enrollment, or termination of enrollment of members from prior years. The data provided is designed to report only financial and enrollment activity incurred for the CY reported.

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

Section 2: Procedures and Results

Mercer has performed the procedures enumerated in Table 1 below, which were designed by Mercer and were reviewed and agreed to by DHCS, solely to test the completeness, accuracy, and truthfulness of information reported in the Medi-Cal RDT from SCAN for CY 2022. SCAN's management is responsible for the content of the RDT and has responded in a timely manner to all requests for information.

Table 1: Procedures

Fee-For-Service (FFS) Medical Expense	
Description of Procedures	**Results**
Mercer reviewed all paid claims data for each category of service (COS) to verify control totals, verify eligibility and enrollment in the Mainstream Medi-Cal program, confirm the COS grouping was correct, confirm the year reported was correct, and confirm enrollment with the MCO for date of service.	Control Totals: No variance noted. • Eligibility: 0.04% of claim submissions with no matching eligibility totaling $33,725 or 0.06% of total medical expense and is included in the variance noted below. • COS Map: Review of all COS showed an overall 93% match for all COS. The mismatches have been discussed with SCAN and they are updating their logic for future RDTs. • Service Year: No variance noted. All dates of service fall within CY 2022.
Mercer compared detailed lag tables for each major COS (Inpatient, Outpatient, Physician, Facility — Long-term Care [LTC], and All Others) created from the paid claims data files provided by the MCO and compared this support to the information reported in Schedule 7. Mercer compared the paid claims amounts from Schedule 7, line 35 and the incurred but not reported (IBNR) amount from Schedule 7, line 40 to total paid claims data as provided by the MCO.	Variance: RDT FFS Expenses are over/(understated) as compared to the support provided: • Inpatient (6.72%) • Outpatient 3.17% • LTC (1.48%) • Physician 1.18% • All Other 2.07% In Total 0.57%, or $196,041, which is 0.33% of total medical expense.

Fee-For-Service (FFS) Medical Expense	
Description of Procedures	**Results**
	The larger variances above are due primarily to over/underestimating of IBNR.
Using data files (paid claims files) provided by the MCO, Mercer sampled and tested 60 transactions and traced them through the MCO's claims processing system, the payment remittance advice, and the bank statements.	No variance noted.

Global Subcontracted Payments	
Description of Procedures	**Results**
Mercer requested global capitation supporting detail. Mercer compared the support provided to the amounts reported in Schedule 1-A.	SCAN did not have any Global Subcontractor arrangements.

Sub-Capitated Medical Expense	
Description of Procedures	**Results**
Mercer requested overall non global sub-capitation supporting detail. Mercer compared the support provided to the amounts reported in Schedule 7.	No variance noted.
Mercer reviewed a sample of the five highest provider payments and 10 random payments, reviewed the related contractual arrangements, and reviewed the total payment amounts by sub-capitated provider using roster information provided by the MCO.	Mercer reviewed the contractual arrangements and the related reporting methodology. The methodology employed to allocate the Medi-Cal portion of the sub-capitated payments is reasonable.
Mercer observed proof of payments via relevant bank statements, clearinghouse documentation, or other online financial institution support for the sampled sub-capitated provider payments in the previous step.	Overall payments to sampled providers were verified and a reasonableness test on the amount allocated to Medi-Cal members was performed. Variance: Proof of payment is understated by 0.38%, or $13,189, or

Sub-Capitated Medical Expense	
Description of Procedures	**Results**
	0.02% of total medical expense. This variance is considered reasonable.
Mercer obtained roster information for the sampled provider payments and verified eligibility of members, confirmed enrollment with the MCO and validated the amounts paid by member.	Eligibility was verified for 99.64% of members. The amount of non-global sub-capitation paid for the ineligible members is $13,557 and was considered in the reasonableness test above.
If applicable, Mercer reviewed Full Dual COA subcontracted PMPM payment rates to determine whether the amount(s) are at a reduced rate as compared to the non-Full Dual COAs.	Not applicable. SCAN members are all Full Dual.
For sub-capitated arrangements 5% or more of total medical expense, Mercer reviewed the sampled sub-capitated contracts to determine delegated administrative duties. Using this information, Mercer then reviewed the amount of administrative dollars reported in the RDT as compared to the delegated administrative functions.	SCAN had two sub-capitated arrangements that exceeded the 5% or more of total medical expense threshold. There were eleven administrative functions delegated to the sub-capitated providers and the plan did not report administrative dollars in the RDT. Therefore, this is an understatement of administrative expenses and an equal overstatement of medical expenses. See Appendix A for details.

Utilization and Cost Experience	
Description of Procedures	**Results**
Mercer compared summarized total net cost data from amounts reported in Schedule 1 to Total Incurred Claims by COS from Schedule 7.	Overall, Schedule 1 is understated by 0.39%, or $203,257, when compared to Schedule 7. This variance is 0.35% of total medical expense. However, by COS, the variances between Schedule 1 and Schedule 7 are significant. The RDT instructions provide COS mapping guidance. SCAN should ensure all schedules within the RDT utilize the COS mapping guidance and consistent data sources in order to provide accurate and reliable reporting.

Member Months	
Description of Procedures	**Results**
Mercer compared the MCO reported member months from Schedule 1-C to eligibility and enrollment information provided by the State. Mercer's procedures are to request explanations for any member months with greater than 0.5% variance in total or greater than 1.0% variance by major COA.	Variance: RDT member months understated by 0.10% in total.

Provider Incentive Arrangements	
Description of Procedures	**Results**
Mercer requested a listing of all provider incentive arrangements, by provider and by month, and compared the amounts to Schedule 6a, lines 34–36.	SCAN does not have provider incentive arrangements for CY 2022.

Reinsurance	
Description of Services	**Results**
Mercer requested reinsurance supporting detail. Mercer compared the support provided to the amount reported in the RDT.	SCAN did not have any reinsurance contracts during CY 2022.

Settlements	
Description of Procedures	**Results**
Mercer inquired of the MCO whether they incurred any settlement amounts with providers related to CY 2022 dates of service. If settlements existed, Mercer noted whether the amounts were actual or estimates based on the status of the settlements and where the amount(s) were reported in the RDT.	No Settlements were paid for CY 2022.

Third-Party Liability (TPL)	
Description of Procedures	**Results**
Mercer reviewed information submitted by the MCO as to how TPL is identified and reported. Per DHCS All Plan Letter (APL) 21-007, the MCO is not required to collect TPL; however, they are required to report to DHCS service and utilization information for covered services related to TPL.	Per review of the support provided and confirmation with DHCS, SCAN is submitting TPL information as required by APL 21-007. No further testing necessary.

Administrative Expenses	
Description of Procedures	**Results**
Mercer benchmarked administrative expenses as a percentage of net revenue across all specialty plans and compared to the amount reported in the RDT, taking into consideration the membership size of the plan when reviewing the results.	The administrative percentage reported by SCAN was within an acceptable range as compared to industry standards.
Mercer compared detailed line items from the plan's trial balance for reasonableness when mapped to line	Variance: RDT reported Administrative Expense is understated by 0.73%, or

Administrative Expenses	
Description of Procedures	**Results**
items in Schedule 6a and/or Schedule 6b. If applicable, Mercer reviewed allocation methodologies and recalculated for reasonableness.	$10,423, or 0.02% of Net Revenue. This variance is considered reasonable.

Taxes	
Description of Procedures	**Results**
Mercer reviewed to ensure proper reporting of federal, State, and local taxes on line 59 of Schedule 6a. If no taxes were reported on Schedule 6a, we confirmed the organization is not subject to taxes.	SCAN is exempt from income taxes; therefore, no taxes were reported in the RDT.

Related Party Transactions	
Description of Procedures	**Results**
Mercer obtained related party agreements for medical services and reviewed to determine whether the terms are at fair market value. Mercer compared the terms (e.g., PMPM or other payment rate amounts) to other similar non related party terms for reasonableness.	Not applicable.
If related party contracts are a material portion of the related medical COS, Mercer also reviewed any allocation methodologies for reasonableness.	Not applicable.
Mercer reviews that all services included in the related party agreements are allowable for Medicaid rate setting.	Not applicable.
When applicable, Mercer obtained related party corporate allocation methodologies for administrative services. Where significant, Mercer recalculated the amounts for reasonableness.	Mercer reviewed the related party administrative corporate allocation methodology with SCAN Group, SCAN's parent company. The allocation methodology appears reasonable.

UM/QA/CC	
Description of Procedures	**Results**
Mercer benchmarked UM/QA/CC expenses as a percentage of total medical expense across all specialty plans and compared to the amount reported on Schedule 1-U, taking into consideration the membership size of the plan when reviewing the results.	The UM/QA/CC percentage reported by SCAN was within an acceptable range as compared to industry standards.
Mercer interviewed financial management to determine how healthcare quality improvement activities such as care coordination are isolated from general administrative expenses in the general ledger. Mercer confirmed with MCO that UM/QA/CC costs were not also included in general administrative expenses.	Confirmed.

Capitation Revenue	
Description of Procedures	**Results**
Mercer compared capitation amounts reported in Schedule 6a for CY 2022 with the Capitation Management System (CAPMAN) file received from DHCS for the same period. The CAPMAN file contains all amounts paid to the health plan by DHCS.	Variance: RDT is overstated by 0.49%, or $325,068.

Interest and Investment Income	
Description of Procedures	**Results**
Mercer requested interest and investment income for the MCO entity as a whole and information regarding how the income provided in Schedule 6a was allocated to the Medi Cal line of business.	SCAN did not report any interest or investment income in the RDT. Per SCAN, interest and investment income was not allocated at the county level and therefore it was not disclosed in Schedule 6a. For reference, SCAN's Audited Financial Statements reported $17.1 million as investment income for all lines of business.

Other Information	
Description of Procedures	**Results**
Mercer reviewed the plan's audited financial statements for CY 2022 for a clean audit opinion or identification of significant deficiencies or material weaknesses.	Mercer confirmed a clean audit opinion.
Mercer compared reported expenses, including IBNR and administrative expenses, to audited financial statements for consistency.	No material variances noted.
Mercer requested information on the efforts to identify and recover provider overpayments and on how the recoveries are recorded in the RDT.	SCAN provided the written policy for the identification and recovery of overpayments. Based on a review of that policy, SCAN is appropriately excluding provider overpayments in the RDT medical expenses.

Section 3: Summary of Findings

Based on the procedures performed, the total amount of capitation revenue for the CY 2022 RDT was understated by $325,068 or 0.49%.

Based on the procedures performed, the total amount of gross medical expenditures in the RDT was understated by $7,282 or 0.01% of total medical expenditures in the CY 2022 RDT. In addition, the plan should prepare for properly recording a portion of their provider sub-capitation expense as administrative, thus reducing their medical expense.

While the overall medical expense variance was immaterial, the results by COS showed large variances. The RDT instructions provide COS mapping guidance. SCAN should ensure all schedules within the RDT utilize consistent COS mapping guidance and data sources in order to provide accurate and reliable reporting. These findings are consistent with the 2017 RDT Audit. It is expected that SCAN will make the appropriate updates to their COS reporting methods for future RDT submissions.

Based on the procedures performed, administrative expenditures in the CY 2022 RDT were understated by $10,423 or 0.73%.

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

SCAN reviewed this report and had the following comments:

The plan is working to have the category of service (COS) mapping methodology updated for future rate development tool (RDT) submissions. Regarding the Schedule 1 & 7 variances, SCAN chose to continue to use different data sources because the Schedule 1 data source has claim line level detail, so it is better suited to populate Schedule 1, but the Schedule 7 data source provides completed data through a later date. If the Schedule 1 data was used, then we would have had data completed to 3/2024 versus the 5/2024 completion provided on Schedule 7. SCAN saw the later completion date as a greater benefit.

In addition, the Non-Medical or Admin Component of Non-Global Sub-capitation Payment requirement is not applicable to SCAN. SCAN does not delegate risk or admin functions to subcontractors for Medi-Cal covered services. SCAN's contracts with its delegated providers are based exclusively on Medicare covered services. Therefore, the

amount to be reported as Non-Medical or Admin Component of Non-Global Sub-capitation Payment will be zero.

SCAN allocates a portion of the paid capitation dollars (which are exclusively based on Medicare) to the Medi-Cal line of business based on a set of Actuarial Equivalent (""AE"") values. The AE values for Hospital & Physician are calculated to estimate the member cost sharing, therefore they represent the financial impact of providing care to SCAN members that receive their Medi-Cal benefits through SCAN.

Appendix A: Administrative Duties in Subcontracted Arrangements

Administrative Task	Heritage Provider Network	Optum
Quality Management	X	X
Quality Measure Tracking	X	X
Member Grievance		
Encounter Submission	X	X
Claims Adjudication and Payment	X	X
Member Services		
Provider Services	X	X
Case Management	X	X
Claims Processing	X	X
Utilization Management	X	X
Provider Relations and Education	X	X
Provider Contracting	X	X
Credentialing and Recredentialing	X	X

Mercer Health & Benefits LLC
2325 East Camelback Road, Suite 600
Phoenix, AZ 85016
www.mercer-government.mercer.com