MERCER

AUDITORS REPORT

CALENDAR YEAR 2017 SCAN HEALTH PLAN RATE DEVELOPMENT TEMPLATE

November 12, 2020

Contents

1 Executive Summary

Pursuant to federal requirements under Title 42 of the Code of Federal Regulations 438.602(e), the 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) [1]. DHCS contracted with Mercer Government Human Services Consulting (Mercer) to fulfill this requirement for the financial data submitted in the Medi-Cal Rate Development Template (RDT) for calendar year (CY) 2017 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 DHCS as a critical part of the base data development process for capitation rate development related to the calendar year 2019 rating period. The RDT tested was the final version, including any revisions stemming from resubmissions.

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

- Schedule 1 Utilization and Cost Experience
- Schedule 1A – Global Subcontracted Health Plan Information
- Schedule 1C – Base Period Enrollment by Month
- 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 2017 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 calendar year reported.

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

[1] 42 CFR 438.602(e)

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Procedures and Results

We have 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 the CY 2017. SCAN's management is responsible for the content of the RDT and responded timely to all requests for information.

Table 1: Procedures

Category	Description	Results
Utilization and Cost Experience	We compared summarized total net cost data from amounts reported in Schedule 1 to category of service (COS) totals from Schedule 6a and to total incurred claims by COS for Schedule 7 for consistency. Due to different mapping between sources for Schedule 1 and Schedule 7, variances exist at the COS level, but in total they agree. The variances were known at the time of submission and SCAN understood Schedule 1 to be the source for rate setting and Schedule 7 primarily for IBNR. Therefore, for Schedule 1 they utilized a COS mapping obtained from Milliman (Health Cost Guidelines grouper) and for Schedule 7 they utilized their internal IBNR database. Also to note, a large portion of the variances for Inpatient and LTC are a result of $610,191 of inpatient claims that are categorized as LTC under the Milliman grouper. This change alone would reduce the reported variances for inpatient to 13.62% and (5.21)% for LTC.	No variance noted in the total net cost data across all schedules. Schedule 1 and Schedule 6a showed no variance at the COS level. Schedule 7 was over/(understated) as compared to Schedule 1 as follows: Inpatient 36.73%; Outpatient (15.42)%; LTC (10.99)%; Physician 2.04%; Pharmacy 0.00%; All Other 3.31%; In Total 0.00% RDT instructions provide COS mapping guidance. SCAN should ensure all schedules within the RDT utilize the same COS mapping in order to provide accurate and consistent reporting.
Member Months	We compared MCO reported member months from Schedule 1C to eligibility and enrollment information provided by the State. Our procedures are to request explanations for any member months with greater than 1% variance in total or greater than 2% variance by major category of aid.	Variance: RDT overstated by 0.65% in total.

Category	Description	Results
Capitation Revenue	We discussed how capitation was recorded. SCAN provided support for their reported capitation revenue. We compared the support to capitation paid to SCAN as reported by DHCS.	RDT overstated by 7.50%, or $4,368,065. Per SCAN, the variance is primarily due to capitation revenue adjustments of $4.8 million that relates to CY 2016. Per RDT instructions, prior year adjustments are not to be included. SCAN should not include prior year adjustments in future reporting.
Interest and Investment Income	We requested interest and investment income for the MCO entity as a whole and information regarding how the income reported in Schedule 6a was allocated to the Medi-Cal line of business. SCAN did not report any interest or investment income on Schedule 6a. Variance was determined based on the proportion of the Medi-Cal line of business revenue to the total revenue as reported in SCAN's audited financial statements.	Variance: RDT is understated by 100.00%, or $166,304.
Fee For Service Medical Expense	Using data files (paid claims files) provided by SCAN, we sampled and tested transactions for each major category of service (COS) (Inpatient, Outpatient, Physician, Pharmacy, Facility-Long Term Care (LTC), and All Others) and traced sample transactions through SCAN's claims processing system, the payment remittance advice, and the bank statements.	No variance observed.
	We compared detailed lag tables for each major COS (Inpatient, Outpatient, Physician, Pharmacy, Facility- (LTC), and All Others) created from the data files provided by SCAN and compared the information reported in Schedule 7. We compared the paid claims amounts from Schedule 7, line 35 to total paid claims prior to the additional runout detail included in the data files, expecting no changes.	Variance: RDT understated in total by 1.94% of total FFS claims payments reported on Schedule 7, or $513,810.

Category	Description	Results
	We compared total final incurred amounts including incurred but not reported (IBNR) estimates from Schedule 7 to total paid amounts from all months reported in the data files to verify the accuracy/reasonableness of IBNR for each COS. Allowable absolute value variances were deemed to be not greater than 2% for inpatient claims and 1% for all other COS. As previously mentioned, for audit purposes, SCAN provided FFS claims data using their internal IBNR database methodology vs. utilizing the Milliman grouper mapping as explained in the Utilization and Cost Experience section above.	Variance: RDT over/(understated): Inpatient 18.71%; Outpatient 16.88%; LTC 12.81%; Physician 7.84%; Pharmacy 2.13%; All Other (4.81)%; In Total 0.52%, or $141,921. RDT instructions provide COS mapping guidance. SCAN should ensure all schedules within the RDT utilize the same COS mapping in order to provide accurate and consistent reporting.
	We reviewed a sample of claims from each COS to verify control totals, verify eligibility, confirm the COS grouping was correct, and confirm the year reported was correct.	Control totals: No variance noted. Eligibility: No variance noted. COS Map: 199 claims totaling $610,191 classified as Inpatient that should have been reported as LTC claims. See explanation in Utilization and Cost Experience section above. Service Year: No variance noted.
Sub-capitated Medical Expense	We requested overall sub-capitation supporting detail. We compared the support provided to the amounts reported in Schedule 7. The total of the detail provided was less than the amounts reported in the RDT.	Variance: RDT reported sub-capitation amounts are overstated by 0.26%, or $46,288.
	We sampled membership from 15 rosters across nine subcontractors, verified eligibility of members and analyzed claims to verify none of the FFS claims paid should have been paid by the sub-capitated provider.	Eligibility: No variance. FFS claims: No variance.
	We reviewed a sample of the contractual arrangements with SCAN's sub-capitated providers and recalculated the total payment amounts by sub-capitated provider using roster information provided by SCAN. The recalculated amounts were greater than the sub-capitation amount reported in the supporting detail provided.	Variance: RDT is understated by 0.13%, or $3,996.

Category	Description	Results
	We observed proof of payments for the sampled sub-capitated providers in the previous step.	No variance noted.
Administrative Expenses	We reviewed administrative expenses as a percentage of capitation and on a PMPM basis, taking into consideration the dynamics of the plan and the membership size when reviewing the results.	SCAN reported $19.46 PMPM and 5.78% of revenue. We reviewed the administrative costs in conjunction with the UM/QA/CC costs. The combined results on a PMPM and percentage basis are in line with expected results.
	We compared detailed line items from the plan's trial balance mapped to line items in Schedule 6a for reasonableness. We reviewed allocation methodologies and recalculated for reasonableness.	No variance noted.
Utilization Management, Quality Assurance, Care Coordination (UM/QA/CC)	We reviewed UM/QA/CC expenses reported on Schedule 6a on a PMPM basis and as a percentage of revenue for reasonableness as compared to similar type programs, taking into consideration the plan dynamics and membership size when reviewing the results. Per SCAN, three operational cost centers, quality improvement, care coordination, and disease management, provide UM/QA/CC services. In consultation with the cost center owners, SCAN Financial Planning & Analysis (FP&A) develops allocation percentages by cost center. The allocation percentages are derived by the cost center owner as a result of assessing their staff's activity in support of Medicaid and other business lines. The allocation percentages are applied to the salaries, other labor, and non-labor expenses incurred in the cost center to determine the cost allocation to UM/QA/CC for Medi-Cal.	SCAN reported $42.00 PMPM and 12.47% of revenue. We reviewed the UM/QA/CC costs in conjunction with the administration costs. The combined results on a PMPM and percentage basis are in line with expected results.
	We compared detailed line items from the plan mapped to line items in Schedule 1-U for reasonableness. We reviewed allocation methodologies and recalculated for reasonableness.	No variance noted.
	We interviewed SCAN's financial management to determine how health care quality improvement activities such as care coordination are isolated from general administrative expenses in the general ledger. Confirmed with SCAN management via interview that UM/QA/CC costs were not also included in general administrative expenses.	Confirmed.

Category	Description	Results
Pharmacy	We confirmed and observed if pharmacy benefit manager (PBM) fees were recorded as administrative expenses and not included in pharmacy claims expenses in the RDT.	No variance noted.
Other Information	We reviewed the audited financial statements for the plan for the CY 2017 for a clean audit opinion or identification of significant deficiencies or material weaknesses.	No variance noted.
	Audited financial statements were not segregated by line of business, therefore no ability to segregate and compare Medi-Cal to the RDT. However, internal financial statements and financial statements filed with DHCS were provided by line of business and reasonably compared to the amounts reported in Schedule 6a and to the audited financial statements in total.	No material variances noted.
	We inquired how hospital-acquired conditions (HACs) were treated in the RDT and policies for payment.	SCAN does not screen for HACs and does not track them separately. SCAN uses a third-party tool from Optum to obtain the DRGs and prices based on DRGs. The software applies any HAC reduction to total payments based on CMS released information at the provider level.

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Summary of Findings

Based on the procedures performed, the total amount of gross medical expenditures in the CY 2017 RDT were overstated by $188,208 or 0.36% of total medical expenditures in the CY 2017 RDT.

Based on the procedures performed, the total amount of gross administrative expenditures in the CY 2017 RDT showed no variance.

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

It should be noted, however, that SCAN should align the COS mapping methodologies utilized in the creation of Schedule 1, Schedule 6a, and Schedule 7 with RDT instructions in order to provide more accurate and consistent information across all RDT schedules.

SCAN has reviewed this report and had no comment.

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