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September 13, 2013

Revision to Original Certification Dated May 28, 2013

Subject: Revised Geographic Managed Care (GMC) Model Contract Year 2013 Rate Range Development and Certification for January 1, 2013 through December 31, 2013 – Assembly Bill 97, Senate Bill 78, and Affordable Care Act Physician Fee Increase Section 1202

Dear Ms. Liston:

The California Department of Health Care Services (DHCS) contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound capitation rate ranges for use during the GMC Contract Year 2013 (CY2013). The CY2013 period began January 1, 2013 and ends December 31, 2013. These original rate ranges were developed by Mercer and certified in a letter dated May 28, 2013 (please see attached document, *GMC DOC 2 - CA GMC CY2013 (01 01 2013 - 12 31 2013) with SPDs Rate Range Certification 05 28 2013.pdf*).

Actuarially sound is being defined by Mercer as follows: Medicaid benefit plan premium 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 premiums, including expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income, provide for all reasonable, appropriate and attainable costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, any government mandated assessments, fees, and taxes, and the cost of capital. (Note: Please see pages 8-9 of the August 2005, Actuarial Certification of Rates for Medicaid Managed Care Programs, from the American Academy of Actuaries, http://www.actuary.org/pdf/practnotes/health_medicaid_05.pdf.)

The following adjustments are included in the revised GMC CY2013 capitation rate ranges:

1. Primary Care Physician (PCP) fee increase outlined in the Patient Protection and Affordable Care Act (ACA), Section 1202 – Effective January 1, 2013
2. Provider payment reductions pursuant to Assembly Bill 97 (AB 97) – Effective October 1, 2013

3. Gross premium tax summarized in Senate Bill 78 (SB 78) – Effective July 1, 2013

The CY2013 capitation rate ranges were further segmented into six (January 1, 2013 through June 30, 2013 to incorporate AB 1422) and six (July 1, 2013 through December 31, 2013 to incorporate SB 78) month capitation rate ranges to account for the change in gross premium taxes.

This letter presents an overview of the analyses and methodology used in Mercer's revised managed care rate range development for the purpose of satisfying the requirements of the Centers for Medicare & Medicaid Services (CMS).

Rate Methodology

Overview

The revised capitation rate ranges for the DHCS GMC Model managed care program were developed in accordance with rate-setting guidelines established by CMS and reflect a "Model 2" approach as described in the CMS "Technical Guidance and Rate Setting Practices" checklist for Section 1202. The analyses described herein are intended to address changes necessary based on implementation of the PCP fee increase included in ACA Section 1202, effective January 1, 2013. The other updates reflected in this letter include the impact of updates associated with legislative change caused by AB 97, effective October 1, 2013, and SB 78, effective July 1, 2013.

Base Data

There have been no changes made to the base data in the development of the revised capitation rate ranges. For more detail related to the development of the base data, please refer to the May 28, 2013 certification letter and supporting documents.

Administration/Profit Loading

The administration/profit loading inherent in the original CY2013 rate development remains unchanged. With respect to the per member per month (PMPM) add-ons developed to address the PCP fee increase (described in more detail below), Mercer added an appropriate administration/profit load specific to those PMPM add-ons. (Note: Increases in non-claim expenses due to the increased payments will not be included in the 100% match calculation and will be claimed at the regular federal medical assistance percentage [FMAP] rate.) Based on an

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analysis of fixed and variable administrative costs for consideration of these additional services, Mercer utilized half of the administration/profit load applied in the original CY2013 rate development. The administration/profit load factors used in the development of the PCP PMPM add-ons were 3.8%/2.0% respectively for CY2013. For more detail related to the development of the original administration/profit load, please refer to the May 28, 2013 certification letter and supporting documents.

Rate Range Modeling

There have been no changes made to the rate range modeling approach used in the development of the originally certified capitation rate ranges. For purposes of calculating the PCP PMPM add-ons addressing ACA Section 1202, one add-on was calculated for each category of aid (COA), which is maintained throughout the rate range without variation. Combining the originally certified capitation rate ranges with the PCP add-ons by COA, and the impact of AB 97, results in the revised rate ranges discussed in this letter.

Other Elements

There have been no changes made to the COA groupings, data smoothing methods, trends, or managed care adjustments. For more detail related to these elements of the certification, please refer to the May 28, 2013 certification letter and supporting documents.

Revisions

Provider Payment Reductions (AB 97)

DHCS is implementing provider payment reductions (AB 97) with an effective date of October 1, 2013. The provider payment reductions pursuant to AB 97 reduce payment levels for non-facility, non-pharmacy providers and certain services. The list below outlines some highlights of providers and services, which are and are not subject to the reductions (this is not an all-inclusive list):

1. Payments made to PCPs for services rendered to recipients age 21 and older are subject to the reductions.
2. Payments made to PCPs for services rendered to recipients under age 21 are not subject to the reductions.
3. Payments made to physicians for ACA 1202 eligible services are not subject to the reductions.

4. Payments made to specialists (including OBGYN providers) and FQHCs are not subject to the reductions.

Since AB 97 is effective for the final three months of CY2013, an adjustment was made to distribute the impact across all twelve months of CY2013. The implementation of AB 97 created a decrease in the capitation rates ranges effective for CY2013 of approximately 0.2% across the entire GMC model.

Maternity Supplemental Payment

Because of the operational issues associated with making the maternity supplemental payments, these payment levels have not changed because of these latest revisions. However, the rate methodology for calculating the net capitation rates ranges is to remove the expected maternity costs after the development of the total rates. These latest program changes have been applied to the total rates, so not including these changes in the maternity rates has no impact on expected final total payments and is, therefore, budget neutral.

Gross Premium Tax (SB 78)

Effective July 1, 2013, the gross premium tax implemented by AB 1422 was amended with a new gross premium tax in SB 78. The SB 78 tax is 3.9375% (the prior tax under AB 1422 was 2.35%). Due to the effective date of SB 78, the revised CY2013 capitation rate ranges are split into two separate six month (January 1, 2013 through June 30, 2013 and July 1, 2013 through December 31, 2013, respectively) capitation rate ranges.

Physician Fee Increase for Primary Care Services under ACA Section 1202

CMS completed their review and approved California's State Plan Amendment (SPA) 13-003, submitted on March 29, 2013, which proposed to authorize increased payments to physicians in accordance with Section 1202 of the ACA. Additionally, CMS approved California's managed care methodology for implementation of the PCP fee increase. Consistent with the approved SPA and managed care methodology, the following sections describe the approach Mercer used to calculate the revision applicable to the CY2013 capitation rate ranges, including components critical to DHCS' ability to claim the portion of the capitation rates eligible for the enhanced 100% Federal Financial Participation (FFP) associated with the PCP fee increase.

Summary of Methodology

In accordance with the approved managed care methodology, DHCS has opted to utilize the prospective capitation risk model with a retrospective reconciliation (Model 2). Under this approach, the higher costs associated with complying with the PCP fee increase rule are reflected in the capitation rates via a PMPM add-on specific to the PCP fee increase. Combining the original certified rate ranges, including the impact of AB 97, with the PCP PMPM add-on results in the revised CY2013 capitation rate ranges as documented in the attached rate range summaries (*GMC DOC 10 - CA GMC CY2013 (01 01 2013 - 12 31 2013) Rate Ranges with AB 97 & ACA 1202 2013 09 13.xls*).

DHCS will pay capitation rates to the contracted Managed Care Organizations (MCOs) prospectively that are inclusive of the enhanced PCP fees and expected utilization. DHCS will reconcile with the MCOs based on actual utilization retrospectively. Thus, the capitation rates paid will be inclusive of the enhanced PCP fees and expected utilization, with actual data being used to reconcile the expected utilization with actual utilization. Based on the difference in utilization actually experienced, DHCS will reimburse/recoup from the MCOs the unit cost differential between the original CY2013 unit costs and the updated (reflective of Medicare fees) CY2013 aggregate unit costs, multiplied by the differing utilization. All calculations will be performed separately for evaluation and management codes (E&M) versus vaccine administration (VA) codes.

Data Sources

It was determined that sufficient detail did not exist in current base data sources to determine the amount of the CY2013 capitation rates associated with the qualified codes being provided by qualified PCPs under this regulation. This was remedied by an additional ad hoc data request completed by the MCOs, reporting the associated PCP payments and utilization in calendar year 2009 and calendar year 2012 that was compared to multiple data sources (including previous rate development information and encounters) for reasonableness in order to determine the portion of the CY2013 capitation rates attributed to qualifying PCP services. In addition, DHCS provided the local crosswalk to eligible E&M and VA codes, based on the SPA, and calendar year 2011 claim experience of local codes for managed care and fee-for-service (FFS) data. The managed care local code data was merged with the data provided by MCOs to establish the complete base data. The data source utilized represented the best and most reliable data available to Mercer and DHCS.

The data request, along with local code data, was utilized to determine how much PCPs are currently being paid (as well as current and anticipated utilization for 2012, which was used in the analysis of the 2013 levels) for the prescribed codes and appropriate providers. The data request required the plans to conduct the additional analysis of determining the costs within the structure of sub-capitated arrangements. Mercer also compared the MCO-submitted reports with other available rate-setting data, including plan-submitted financial reports and encounters, for reasonableness. The data sources provided by the MCOs and DHCS were reviewed, but not audited.

For Medicaid beneficiaries dually eligible for Medicare, the 100% FFP match will only be claimed where it exceeds the amount that would have been payable under the SPA in effect on July 1, 2009. Utilization of E&M codes for Dual COA was adjusted to reflect the zero paid claims and under-reported claims since Medicare rates are higher than Medicaid rates before ACA 1202 and often not reported. The projected unit cost for dual eligibles was compared to the cost-sharing portion of the Medicare rates and the differential becomes the Medicaid MCO's responsibility, as Medicaid rates are equal to 100% of Medicare rates due to ACA 1202. As for VA codes, the utilization is low for dual eligible as few vaccines are not covered by Medicare, but are covered by Medicaid. In cases where MCOs are responsible for payments and the VA met the requirements of ACA 1202, the additional payment up to 100% of Medicare rates were modeled.

Please note that the increased payment is not applicable to services provided by a physician delivering services under any other benefit under Section 1905(a) of the Social Security Act, such as, but not limited to, the Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) benefits because, in those instances, payment is made on a facility basis and is not specific to the physician's services. This information was not included in the data used to quantify the PCP fee increase. Utilization of eligible E&M and VA codes provided by MCOs was compared to different FQHC utilization levels for reasonableness and possible further adjustments.

Calculation of the Calendar Year 2013 Capitation Rate Unit Costs

To calculate the portion of the capitation rate attributed to qualifying PCP services in calendar year 2013, Mercer used the MCO data requests and the local code data to establish the base data, and trended the base data forward to calendar year 2013. The trended data including utilization, unit cost, and PMPM were compared to acceptable ranges, varying by different FQHC utilization levels. If falling within the range, the plan-specific data gets blended with average utilization and PMPM for the FQHC utilization level in which the plan falls. Once the appropriate projected

utilization and PMPM are determined, the unit costs are determined by calculating unit costs based on the projected utilization and PMPM. These calculations were completed by COA, and separately for E&M codes, versus VA codes. MCO vaccine utilization was considered in a manner consistent with the crosswalk included in the approved SPA 13-003. The resulting calendar year 2013 unit costs are displayed in Attachments 1A and 1B, identified with the label {A}.

2013 Medicare Fee Schedule Rates

The 2013 Medicare fee schedule rates are based on the 2009 conversion factor and 2013 relative value units (RVUs), consistent with the geographic practice cost index schedule published by CMS in January 2013. The 2013 Medicare rates utilized conform to the approach used in California's FFS program for each of the specified E&M and vaccine billing codes.

For service codes without corresponding Medicare RVU components and therefore not listed on the SPA as eligible for fee increases, these service codes were not included in the analyses and are not subject to the PCP payment increase. Similar to the calculation for unit costs inherent in the rates, Mercer calculated aggregate weighted average 2013 Medicare unit costs using 2012 utilization from the MCO data requests, separately for the E&M codes and VA codes. The aggregated 2013 Medicare fee schedule rates serves as a benchmark for comparison to the unit costs inherent in the CY2013 capitation rate ranges. The 2013 100% of Medicare benchmark unit costs are displayed in Attachments 1A and 1B, identified with the label {B}.

Calculation of the 2013 Medicare Fee Schedule Rates Adjusted for Payments Above 100% of Medicare

To account for utilization for payment levels above 100% of Medicare that are reflected in the capitation rate unit costs, an appropriate adjustment was needed. Mercer paid particular attention to unit cost levels relative to the Medicare fee schedule. The methodology used to calculate the adjusted 2013 Medicare benchmark was consistent with the process used to develop the unadjusted 2013 Medicare benchmark (component {B}) described in the previous section. The adjusted 2013 100% of Medicare benchmark unit costs are displayed in Attachments 1A and 1B, identified with the label {C}. This adjustment was not applied to dual COAs or VA codes as it is determined to be immaterial.

Calculation of the Calendar Year 2013 Capitation Rate Unit Costs Attributed to Qualifying PCP Services

The unit cost levels inherent in the CY2013 capitation rate ranges (component {A}), were compared to the adjusted 2013 Medicare fee schedule rates (component {C}). The differential between the 2013 Medicare fee schedule rates and the CY2013 unit costs determines the unit cost rate adjustment needed to bring the overall capitation rate to a level that compensates the MCOs with an appropriate amount to be able to pay the qualifying providers at least the 2013 Medicare fee schedule benchmark (i.e., the amount attributed to qualifying PCP services in the updated rates). By utilizing the adjusted 2013 Medicare benchmarks for this calculation, Mercer has accounted for payment levels made above 100% of Medicare to ensure those costs do not artificially reduce the amount needed to bring payment levels up to 100% of Medicare. The CY2013 unit cost differentials were calculated by COA, for the E&M codes separately from the VA codes, and are displayed in Attachments 1A and 1B, identified with the label {D}. This amount will also be used in the calculation of the rate differential eligible for enhanced 100% federal match as described in the “Rate-setting Documentation for Federal Claiming” section of this letter.

CY2013 PCP Utilization

As the unit costs and differentials described above were evaluated at an aggregate level, for the E&M codes separately from VA codes, expected utilization was also calculated at an aggregate level (i.e., the aggregate unit cost differential for E&M codes will be paid for all applicable E&M code utilization). Mercer utilized the MCO data requests and local code utilization for the applicable codes reported in 2012. The blended utilization data was trended forward to 2013 using trend assumptions consistent with historical medical professional services trends. Additionally, the results were also compared with available historical rates for reasonableness and blended, where practical, to smooth out data anomalies. Mercer calculated the anticipated utilization levels by COA. Mercer considered that the possibility of induced utilization may occur for the PCP fee change and determined that it is premature to project any utilization increase due to results from similar program changes, and will continue to monitor the PCP utilization throughout calendar year 2013 and will take action in the following rate setting cycle if the utilization pattern has materially changed due to ACA 1202. The assumed utilization for the CY2013 contract period is displayed in Attachments 1A and 1B, identified with the label {E}.

CY2013 PCP Fee Differential PMPM

For purposes of prospective capitation payments under the “Model 2” methodology, Mercer calculated the PMPM add-ons associated with the increased costs of implementing the

ACA Section 1202 PCP fee increase, separately for E&M codes and VA codes. The CY2013 fee differential PMPMs, excluding administration/profit loading and the gross premium tax, are displayed in Attachments 1A and 1B, identified with the label {F}. Combining the E&M and VA components, as well as adding appropriate amounts for administration/profit loading and gross premium tax, the final PCP PMPM add-ons and revised CY2013 capitation rate ranges are documented in the attached rate range summaries (Attachment 2).

Reconciliation Process

In accordance with the approved managed care methodology, DHCS will reconcile payments made to the MCOs through the prospective capitation rates with actual utilization reported by the MCOs. DHCS is requiring each MCO to submit detailed, annual files with claims data on each applicable code for eligible providers documenting the paid amount made to the providers.

Once DHCS receives the annual files documenting the appropriate payments by code to the eligible PCPs, DHCS will reconcile with the MCOs and CMS, any overpayment or underpayment. The MCO will be reimbursed (or funds recouped) through the reconciliation process for the amount of unit cost rate differential (the aggregate unit cost differential established in the process of the capitation rate adjustment defined above, and not based on the individual current payment amounts) based on actual utilization relative to the utilization level utilized in the capitation rate development (amount previously described and labeled as component {E}). This step will include detailed instructions to the MCOs on how to document to DHCS the utilization and unit cost rate paid for PCPs. (Note: This reconciliation will be performed separately for E&M codes, versus VA codes.)

Rate Range Certification

In preparing the rate ranges 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 responsible for the validity and completeness of this supplied data and information. Mercer has reviewed the data and information for internal consistency and reasonableness, but we did not audit it. In our opinion the data used for the rate development process is appropriate for the intended purposes. If the data and information are incomplete or inaccurate, the values shown in this report and associated exhibits may need to be revised accordingly.

Mercer certifies that the revised rate ranges for January 1, 2013 through June 30, 2013 (including AB 1422) and July 1, 2013 through December 31, 2013 (including SB 78) 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. The undersigned actuaries are members of the American Academy of Actuaries and meet its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

Rate ranges developed by Mercer are actuarial projections of future contingent events. Actual MCO costs will differ from these projections. Mercer has developed these rate ranges on behalf of DHCS to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and accordance with applicable law and regulations. There are no stop loss, reinsurance, risk-sharing or incentive arrangements in these rates. Use of these rate ranges for any purpose beyond that stated may not be appropriate.

MCOs are advised that the use of these rate ranges may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these rate ranges 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 rate ranges before deciding whether to contract with DHCS.

This certification letter assumes the reader is familiar with the Medi-Cal program, Medi-Cal eligibility rules, and actuarial rating techniques. It is intended 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.

Rate-setting Documentation for Federal Claiming

In addition to DHCS' approved managed care methodology and the revised CY2013 actuarially sound capitation rates described in this letter, the following section provides the additional rate-setting documentation required in Section 7 of the CMS "Technical Guidance and Rate Setting Practices" checklist for Section 1202. For DHCS' use in claiming the portion of the capitation rates eligible for enhanced 100% FFP associated with the PCP increase, Mercer calculated the 2009 base rate and the differential between the CY2013 capitation rate and the 2009 base rate to determine the amount eligible for 100% federal match. The following sections describe each component and other federal claiming considerations.

Calculation of the 2009 Base Rate Unit Costs

To calculate the 2009 base rate unit costs (for federal claiming purposes) in accordance with the CMS-approved managed care methodology, Mercer reviewed the July 1, 2009 unit costs reported by the MCOs on the data requests and developed factors to adjust the smoothed 2013 unit costs due to the wide variations observed in the MCO-reported 2009 unit costs. The factors are derived from historical PCP unit cost trends, rate changes for professional services, and rate changes for all categories of service based on actual 2009 capitation rates. The 2009 unit cost baseline is established by using the projected calendar year 2013 unit cost divided by the developed factors. This put the 2009 unit costs on a comparable basis with the calendar year 2013 unit costs and utilization mix. The calculated 2009 base rate unit costs are displayed in Attachments 1A and 1B, identified with the label {G}.

Calculation of the PMPM Differential That Qualifies for 100% FFP

As DHCS is using the “Model 2” approach, the portion of the CY2013 capitation payment that is eligible for 100% FFP is determined by calculating the difference between the base 2009 aggregate weighted average unit cost calculation (within Attachments 1A and 1B – component {G}) and the aggregate weighted average unit costs inherent in the CY2013 capitation rate ranges (component {A}). Using the projected utilization assumed in the CY2013 capitation rate ranges (component {E}), the differential was put on a PMPM basis. This calculation was performed separately for E&M codes, versus VA codes, and results in positive PMPMs. The calculated PMPM differentials (excluding administration/profit loading and gross premium tax) are displayed in Attachments 1A and 1B, identified with the label {H}, and will be eligible for 100% FFP. The costs associated with these services are currently part of the existing capitation rates and underlying federal match.

Additional Federal Claiming Considerations

In addition to the PMPM differential between the 2009 base rate unit costs and the unit costs inherent in the CY2013 capitation rate ranges described above (component {H}), the fee differential PMPMs (component {F}) are also eligible for 100% FFP. The fee differential PMPMs were calculated using the assumed utilization within the CY2013 capitation rate ranges and represent the amount of funding necessary to raise payment levels to qualifying providers, for qualifying services, up to 100% of Medicare. These calculations were also performed separately for E&M codes, versus VA codes, to facilitate proper claiming on the separate lines on the

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CMS 64 for E&M and VA codes. (Note: Increases in non-claim expenses due to the increased payments will not be included and will be claimed at the regular FMAP rate.)

Through DHCS' reconciliation process, MCOs are required to submit detailed, annual files with claims data on each applicable code for eligible providers. The MCO will be reimbursed (or funds recouped) through the reconciliation process for the amount of unit cost rate differential (component {D}), based on actual utilization relative to the utilization level in the capitation rate development (component {E}). This reconciliation will be performed separately for E&M codes, versus VA codes, and any additional payments (or recoupments) will be eligible for 100% FFP.

Please note that if actual unit cost varies, there will be no re-pricing of unit costs. The reconciliation will be based on the unit costs built into the CY2013 capitation rate. Additionally the State will not be collecting or paying the base calendar year 2013 unit cost (component {A}) if utilization is lower or higher than what is projected in the capitation.

If you have any questions on any of the above, please feel free to contact Mike Nordstrom at +1 602 522 6510, Jim Meulemans at +1 602 522 8597, or Dazhi Fan at +1 602 522 6442.

Sincerely,

Michael E. Nordstrom, ASA, MAAA

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