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FINAL

February 22, 2013

Subject: Geographic Managed Care (GMC) model Seniors and Persons with Disabilities expansion – Rate range development and certification for July 1, 2011–December 31, 2012

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 the Geographic Managed Care (GMC) model Seniors and Persons with Disabilities (SPD) expansion for use during the GMC model 18 month contract period (CP12) ending December 2012.

The CP12 period began July 1, 2011 and ended December 31, 2012. The SPD expansion is related to the new requirement of this population becoming mandatorily enrolled, instead of voluntarily enrolled, into managed care. This letter presents an overview of the analyses and methodology used in Mercer's managed care rate range development for the purpose of satisfying the requirements of the Centers for Medicare & Medicaid Services.

The rate development for SPD expansion consisted of two rate-setting approaches which were blended to produce the final rate ranges for the transitioning fee-for-service (FFS) population. One of the approaches utilized the existing CP12 county average SPD managed care rate ranges (developed using the last 6 months from the calendar year 2011 rates and the full 12 months of the calendar year 2012 rates), which were risk adjusted based on the risk score relationship of managed care members to transitioning FFS members. The other approach developed rates based upon FFS data with appropriate adjustments to reflect managed care rate ranges. The rate ranges for the transitioning population were then blended with the rate ranges of the existing managed care population to produce final rate ranges.

In Mercer's opinion, the capitation rate ranges developed result from an actuarially sound process and should, along with managed care organization (MCO) investment income and any reinsurance or stop-loss cash flows, provide for all reasonable, appropriate, and attainable costs.

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If you have any questions regarding the above, please feel free to contact Mike Nordstrom at +1 602 522 6510, Jim Meulemans at +1 602 522 8597 or Branch McNeal at +1 602 522 6599.

Sincerely,

Michael E. Nordstrom, ASA, MAAA James J. Meulemans, ASA, MAAA

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GEOGRAPHIC MANAGED CARE (GMC) MODEL SENIORS AND PERSONS WITH DISABILITIES EXPANSION

18 MONTH RATE RANGE DEVELOPMENT AND CERTIFICATION (7/1/2011–12/31/2012)

STATE OF CALIFORNIA

FINAL

February 22, 2013

MARSH & McLENNAN COMPANIES

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Rate Methodology

Overview

Capitation rate ranges for the California Department of Health Care Services' (DHCS') Geographic Managed Care (GMC) model managed care program Seniors and Persons with Disabilities (SPD) expansion were developed in accordance with rate-setting guidelines established by the Centers for Medicare & Medicaid Services (CMS). The SPD expansion is related to the requirement of this population (which consists of the Aged Medi-Cal Only and Disabled Medi-Cal Only categories of aid) becoming mandatorily enrolled, instead of voluntarily enrolled, into managed care. The rate development for SPD expansion members consisted of two rate-setting approaches which were blended to produce the final rates for the transitioning fee-for-service (FFS) population. The contract period 2012 (CP12) for these rates is the 18 month period from July 1, 2011 through December 31, 2012. One of the approaches ("risk adjusted managed care") utilized the existing CP12 county average SPD managed care rate ranges (developed using the last 6 months from the calendar year 2011 (CY11) rates and the full 12 months of the calendar year 2012 (CY12) rates) risk adjusted based on the risk score relationship of managed care members to transitioning FFS members. The other approach ("managed care adjusted FFS") developed rates based upon FFS data with appropriate adjustments to reflect managed care rate ranges. The rate ranges for the transitioning population were then blended with the rate ranges for the existing managed care population to produce the final rate ranges for the CP12 18 month period.

The existing CY11 (separate certifications for Sacramento and San Diego counties) and CY12 SPD rates ranges were certified on January 31, 2013 and February 7, 2013. These rate ranges are maintained for the existing managed care population during the final blending process. For the "risk adjusted managed care" approach, this same rate range information was utilized for the transitioning population.

For the "managed care adjusted FFS" approach within the rate range development for the SPD expansion, Mercer Government Human Services Consulting (Mercer) used calendar years 2009 and 2010 (CY09 and CY10) FFS data. Adjustments were made to the FFS base data to match the covered population risk and the State Plan approved benefit package for the CP12 period. Additional adjustments were then applied to the FFS data to incorporate:

- Prospective and historic (retrospective) program changes not reflected (or not fully reflected) in the base data
- Trend factors to forecast the expenditures and utilization to the contract period
- Administration and Underwriting Profit/Risk/Contingency loading

The above adjustments, prior to the Administration and Underwriting Profit/Risk/Contingency loading, produced FFS equivalent utilization per thousand, unit cost and per member per month (PMPM) amounts for each category of service (COS). These individual components were then reviewed and adjusted to reflect managed care impacts that would be expected with the expansion of the managed care GMC model program for the transitioning FFS members.

A single and consistent process of developing capitation rate ranges was used for the GMC model program expansion. DHCS will offer final rates within the actuarially sound rate ranges to each managed care organization (MCO). Each MCO 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 range development are described in the following paragraphs.

For illustrative purposes, on the rate methodology utilized and details of the exhibits presented to the plans, a separate attachment – *CP12 18 Month GMC SPD Certification Exhibits.pdf* – has been included. Exhibit A within this attachment has a high-level flow chart of the rate development process.

Base Data

"Managed Care Adjusted FFS" Approach

The information used for the base data in the "managed care adjusted FFS" approach was CY09 and CY10 FFS data. The FFS data included utilization and unit cost detail by calendar year and by 12 consolidated provider types or COS including:

- Inpatient Hospital
- Outpatient Facility
- Emergency Room Facility
- Long-Term Care(LTC) Facility
- Physician Primary Care
- Physician Specialty
- Pharmacy
- Federally Qualified Health Center (FQHC)
- Other Medical Professional
- Laboratory and Radiology
- Transportation
- All Other

CY09 and CY10 (January 2009–December 2010) make up the base data period. The data was completed to account for incurred but not reported claims based on lag triangle analysis. The CY09 and CY10 data were completed separately, then combined to form the two-year base data period. All selected base data was adjusted (as appropriate) to reflect the impact of historical program changes within this period. This is discussed further in the *Program Changes* section. The data did not include any adjustments for catastrophic claims.

A requirement of 42 CFR 438.6(c)(4)(ii) is that all payment rates under the contract are based only upon services covered under the State Plan to Medicaid-eligible individuals. As described above, FFS data served as the base data for rate setting. FFS data undergoes a substantial number of edits within DHCS to ensure quality and the appropriateness of the data for rate-setting purposes. Base period member eligibility and FFS data were pulled consistent with service code mappings from DHCS, including lists of excluded services such as abortion. Mercer has relied on data and other information provided by DHCS' Managed Care Division and Fiscal Forecasting and Data Management Branch in the development of these rate ranges. We have reviewed the data and information utilized for reasonableness and, at the time the rate ranges were developed, we believed the data and information to be free of material error and suitable for rate range development purposes for the populations and services covered under the GMC model expansion contract. Mercer did not audit the data or information and, if the data or information is materially incomplete or inaccurate, our conclusions may require revision. However, Mercer did perform alternative procedures and analysis that at the time provided a reasonable assurance as to the data's appropriateness for use in capitation rate development under the State Plan.

"Risk Adjusted Managed Care" approach

The information used for the base data in the "risk adjusted managed care" approach was the same base data from the CP12 SPD rate development certified on January 31, 2013 (revisions to November 23, 2011 original certifications) and February 7, 2013, (please see attached documents –Revised CA GMC SAC CY11 SB335 Rate Range Cert (July 2011 - December 2011) 01 31 2013.pdf; CA GMC SAC CY11 Rate Range Cert FINAL 2010 11 23.pdf; Revised CA GMC SD CY11 SB335 Rate Range Cert _July 2011 - December 2011_ 01 31 2013.pdf; CA GMC San Diego CY11 Rate Range Cert FINAL 2010 11 23.pdf; and CA GMC CY12 Rate Range w SB335 Cert (Jan - Dec 2012) 02 07 2013.pdf*)*. The base data utilized was based on the member-weighted (using CY08 member months for the CY11 data and CY09 for the CY12 data) county average of the MCOs within each GMC county. These two time periods were then further blended together (based on the actual/projected member month enrollment of existing members) to produce the final base data for the portion of rate development.

Exhibit D of the *CP12 18 Month GMC SPD Certification Exhibits.pdf* attachment has the detailed capitation rate calculation sheets (CRCS) for the FFS base (page 4) and the managed care base (pages 5, 6, and 7). Base data are presented by COS as annual utilization per 1,000 members, average unit cost and resulting PMPM calculations, and are reflected in columns (A), (B), and (C) of the respective CRCS.

Graduate Medical Education

With regards to Graduate Medical Education (GME) costs and 42 CFR 438.6(c)(5)(v) (along with item AA.3.8 of "Appendix A. PAHP, PIHP and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Ratesetting, edit date: 7/22/03"), DHCS staff have confirmed that there are no provisions in the GMC model managed care contract regarding GME. The GMC MCOs do not pay specific rates that contain GME or other GME-related provisions. As non-GME FFS data serves as the base data of the "managed care adjusted FFS" approach, GME

expenses are not part of this component of the GMC model expansion capitation rate development process. GME was also not included in the "risk adjusted managed care" approach as documented in the aforementioned certifications.

Maternity Supplemental (Kick) Payment

To further enhance the measured matching of payment to risk, DHCS utilizes a maternity supplemental (kick) payment for the SPD expansion. Pertaining to gender, typically the primary issue that could result in significant variance among the MCOs' enrolled population, and hence their risk, is the event of maternity and its related cost. Costs for pregnant women are substantially higher than the average medical cost of care for men and non-pregnant women with similar demographic characteristics. To mitigate the maternity risk issue in rates, DHCS is including a maternity supplemental payment which represents costs for the delivery event (prenatal and post-partum care costs are not part of the kick payment, but remain within the respective categories of aid [COA] capitation rates). A GMC MCO receives the lump sum maternity supplemental payment when one of its current members gives birth and DHCS is appropriately notified that a birth has occurred. Note that non-live birth expense data and non-live birth outcomes were excluded from the maternity supplemental payment analysis and the corresponding development of the CP12 maternity supplemental payments. This results in non-live birth expenses being included in the base capitation rates rather than being included in the kick payment.

Because the same maternity kick payment is utilized for the Adult/Family and SPD COA in normal rate development, maternity kick payments were not adjusted within this process to minimize DHCS' administrative burdens. Therefore, the GMC CY11 and CY12 maternity supplemental kick payment levels, which vary by county, were utilized for the SPD expansion rate development (please see the attached CA GMC SAC CY11 Rate Range Cert FINAL 2010 11 23.pdf; CA GMC San Diego CY11 Rate Range Cert FINAL 2010 11 23.pdf; and CA GMC CY12 Rate Range w SB335 Cert (Jan - Dec 2012) 02 07 2013.pdf for details on the maternity kick payment development). Use of the CY11 and CY12 maternity kick payments had no impact on final rates as this methodology is budget neutral – projecting the same total dollar outlays under a pre- and post-maternity supplemental payment approach.

Maternity Kick – Design

- Payment made on delivery event that generates a state vital record
- One kick payment per delivery regardless of number of births
- One blended kick payment combining caesarean and vaginal deliveries
- Kick payment is the same for each MCO in a specific county
- Kick payment reflects cost of delivery event only (mother and baby, excluding prenatal and post-partum care)

Maternity Kick – Rate Development Approach

- Utilize the CY 11 and CY12 maternity kick payment rate ranges by county
- Calculate delivery counts by county for the transitioning members
- Rely on Medi-Cal Deliveries Report information generated by DHCS

- Medi-Cal eligibility is the primary data source
- Calculate historical birth rates by county for the transitioning population
- Project number of delivery events in the entire county based upon birth rates and projected member months for transitioning members
- Calculate the number of delivery events happening in the "risk adjusted managed care" approach population using historical GMC managed care birth rates during the base period
- Remove dollar amount from the SPD costs by county for the "risk adjusted managed care" and "managed care adjusted FFS" approaches

The details of the maternity kick impact are displayed in Exhibit D (page 8, 9, and 10) of the *CP12 18 Month GMC SPD Certification Exhibits.pdf* attachment. Columns (B) and (H) detail the maternity kick payment by COS and columns (E) and (K) display the PMPM impact that is carved out of the pre-maternity rates. These amounts are also in Exhibit D (pages 4, 5, 6, and 7) in column (P). The impact of the maternity kick payment is fairly small within the SPD population.

Trend

Trend is an estimate of the change in the overall cost of medical services over a finite period of time. Trend factors are necessary to estimate the expenses of providing health care services in a future period. As part of the CP12 contract period rate range development for the GMC SPD expansion, Mercer developed trend rates for each provider type or COS separately by utilization and unit cost components.

Trend information and data were gathered from multiple sources, including Medi-Cal FFS experience, MCO encounter and RDT data, MCO financial statements, historical California Medical Assistance Commission (CMAC) adjustments, Consumer Price Index (CPI) and National Health Expenditures (NHE) updates and multiple industry reports. Mercer also relied on professional judgment based upon our experience in working with the majority of the largest Medicaid programs in the country. The CY09 and CY10 FFS base data was trended forward 27 months to the midpoint of the rating period for the "managed care adjusted FFS" approach. The CY08 and CY09 managed care base data were trended forward 39 and 36 months respectively to the midpoint of the appropriate rating periods for the "risk adjusted managed care" approach.

The specific lower bound trend levels by utilization and unit costs for the 12 COS are displayed in columns (D) and (E) of Exhibit D (pages 4 and 5). Note trends for the LTC provider type are 0.0% for both utilization and unit cost. Due to the high level of legislatively-mandated changes surrounding LTC, Mercer has handled LTC trends through the program changes portion of the methodology. The range for the claim cost trend component is +/- 0.25% per year for each of the utilization and unit cost components or roughly +/- 0.5% PMPM per year. For the "managed care adjusted FFS" approach, over the 2.25-year period from the midpoint of the CY09 and CY10 base period to the midpoint of the CP12 contract period, this contributes approximately +/- 1.1% to the upper and lower bounds. For the "risk adjusted managed care" approach, over the 3.25 and 3-year period from the midpoint of the CY08 and CY09 base periods to the midpoint of the

respective 6 and 12 month periods contributes approximately +/- 1.6% to the upper and lower bounds.

Program Changes/Other Adjustments

Program change adjustments recognize the impact of benefit or eligibility changes that took place during or after the base data period.

"Managed Care Adjusted FFS" Approach

The program changes incorporated in the development of the "managed care adjusted FFS" approach rate ranges were based on information provided by DHCS staff as of November 30, 2012. Following are the most material program changes (with effective dates) that were viewed to have an impact on capitation rates and which were analyzed and evaluated by Mercer with the assistance of DHCS' Managed Care Division and Fiscal Forecasting and Data Management Branch staff.

- LTC rate adjustments – Multiple dates
- Provider payment reduction – July 2008 (reflects all refinements [i.e., injunctions] through November 2012)
- Discontinue Adult Optional Benefits – July 2009
- Hospice rate increases – Multiple dates
- Reinstatement of Optometry services – July 2010
- SB 335 – July 2011
- SB 208 – July 2011
- CBAS Program (assessments and ECM costs) – October 2011

Any program changes with an effective date prior to January 1, 2011 were treated as retrospective changes. Retrospective program changes were applied during the development of the base data and are already reflected in the amounts in columns (A), (B) and (C) of Exhibit D of the *CY 2012 GMC SPD Certification Exhibits.pdf* attachment.

"Risk Adjusted Managed Care" Approach

The information used for the program changes in the "risk adjusted managed care" approach was the same program change information from the CY11 and CY12 SPD rate development (please see attached certifications for more detail).

Program change adjustments are developed based on a "utilization per 1,000" or a "unit cost" basis. These adjustments are reflected in columns (F) and (G) of the CRCS information and Exhibit D (pages 5 and 6). The various program changes are calculated at the COA (only changes impacting the SPD population are included) and COS level. Multiple program changes may be reflected within a final percentage represented in a given COS field.

SB 335 requires further description with consideration of similar prior adjustments. SB 335 is a legislated policy change implemented by DHCS with effective dates of July 1, 2011 through December 31, 2013. This policy is being treated the same way as the previous AB 1653 and SB 90 policy changes, which impacted the rate range time periods prior to July 1, 2011. This SB 335 change is increasing the Medi-Cal FFS inpatient payment levels in total approximately 29.5% and the Medi-Cal FFS outpatient hospital and emergency room payment levels in total approximately 88.5%. The associated managed care service category increases, being implemented at approximately 77.5% of the FFS increase levels, are applied to the managed care inpatient, outpatient hospital, and emergency room unit costs. The specific program change for inpatient unit costs is 22.9% and the program change for outpatient hospital and emergency room unit costs is 68.5%. Because of the large nature of this program change, the administrative costs and underwriting profit/risk/contingency PMPM amounts were maintained at the levels established after the implementation of the other program changes noted above prior to applying the SB 335 adjustment.

Another legislative adjustment similar to SB 335 is SB 208 which deals with State and Designated Public Hospitals (DPHs). The transition of non-dually eligible Seniors and Persons with Disabilities (SPDs) to a mandatory managed care enrollment status in the Two-Plan and GMC counties created a financial impact for the DPHs and their affiliated governmental entities. The application of the SB 208 adjustment is discussed in the attached document related to the SB 208 methodology (*SB 208 DPH Payment Methodology Year 1.PDF*). County specific SB 208 adjustment factors are included in the attached program change chart noted below. Also included in the program change charts are the updated SB 335 factors which have been adjusted downward so that no adjustments for SB 335 were applied to costs associated with SB 208. This was done on a county by county basis.

The SB 335 and SB 208 adjustments were applied to the data after blending the managed care and FFS components.

Section 2702 of the Affordable Care Act of 2010 (ACA) required the Centers for Medicare & Medicaid Services (CMS) to establish regulations prohibiting federal Medicaid payments to states for amounts expended for health care-acquired conditions. On June 30, 2011, CMS published the final rule implementing the requirements set forth in Section 2702 of the ACA, but delayed compliance action until July 1, 2012.

This Medicaid regulation builds upon the Medicare program experience with payment adjustments for hospital-acquired conditions (HACs) and “never events.” The regulation applies to Medicaid non-payment for most Medicare HACs and “never events” as a baseline, but also expands the settings in Medicaid and provides States with additional flexibility to define and implement the rules. For example, Medicare’s rules exclude critical access and children’s hospitals; however, under the Medicaid rule no inpatient hospital facility is excluded, including out-of-state facilities.

As such, Mercer initially reviewed potential encounter data information for making an appropriate adjustment. Unfortunately, the required information (a present on admission indicator, for example) is not currently part of the encounter data. Additional data requests were then sent to the MCOs to have them assist in the identification of these potential payments. This is an ongoing process without any current information available for a program change adjustment. Other studies and other state experience has shown limited needed adjustments related to these types of conditions. This issue will continue to be reviewed. No adjustment has been included within these rates for the six month time period beyond July 1, 2012.

Effective January 1, 2009, DHCS implemented a legislative policy change. The change, referred to as "AB 1422 Tax," categorizes Medi-Cal managed care plans under California Revenue and Taxation Code 12201, and at a tax rate under Code 12202, as administered by the California Department of Insurance. The AB 1422 Tax rate is 2.35%.

An additional attachment (*CP12 18 Month GMC SPD MC & FFS Program Change Charts [July 2011 – Dec 2012].pdf)* has been included to provide further detail related to the program changes for the "managed care adjusted FFS" approach and the "risk adjusted managed care" approach. The attachment provides information on each of the program changes for the two approaches including a description, effective date (including whether the impact was retrospective or prospective), COAs, COSs and geographic areas impacted, and also the level of the impact.

Is should be noted that the provider payment reduction (PPR) program changes were applied slightly differently within the two approaches because of the different base data being utilized.

For the "managed care adjusted FFS" approach, the PPR impacts were applied in three steps. The 2008 FFS base data was adjusted upward because the base data reflected PPR impacts and needed to be brought back to standard payments rates. The 2009 FFS base data was also adjusted upward in a similar fashion. Both of these steps were performed retrospectively The third step was to prospectively apply the needed PPR reduction factors. These factors are applied as a negative adjustment.

For the "risk adjusted managed care" approach, the PPR impacts were applied in one single step with the needed base year upward adjustments combined with the prospective downward adjustments to produce a single factor for each COS.

Managed Care Adjustments

"Managed Care Adjusted FFS" Approach

Because the underlying base data was FFS for this approach, Mercer also applied managed care adjustments. The application of trend and program changes to the base FFS data produced FFS equivalent utilization per thousand, unit cost and PMPM amounts for each COS. These individual components were then reviewed and adjusted to reflect managed care impacts that would be expected with the expansion of the managed care GMC program to include FFS members. County-specific adjustments were utilized for the unit cost adjustment component to

take into consideration the existing unit cost levels in the CY09 managed care base data. These adjustments applied to the facility and professional COS (pharmacy, lab, transportation and "other" COS were not adjusted at the county level). Similar to the trend development, multiple sources were utilized in this managed care savings review.

Overall, the impact of the managed care adjustments was a 3% reduction to the FFS data excluding pharmacy costs. Factors producing the 3% adjustment included reducing Inpatient Hospital and Outpatient Facility utilization. As an example, Inpatient Hospital utilization was reduced by 10% and Outpatient Facility was reduced 5% at the midpoint. Other adjustments included increasing Physician Primary Care utilization to account for a higher level of care management. As an example, the Physician Primary Care utilization was increased 30% at the midpoint. Unit cost changes also occurred due to assumed provider contracting negotiations and also because of service mix change assumptions.

The range of managed care savings is +/- 2.5% (applied multiplicatively with factors of 0.975 and 1.025) for each of the utilization and unit cost components or approximately +/- 5.0% PMPM at the lower and upper bounds.

The lower bound managed care adjustments are displayed in columns (K) and (L) of Exhibit D (page 4) of the "managed care adjusted FFS" approach CRCS. Column (K) represents the utilization impacts and column (L) represents the unit cost impacts.

Administration and Underwriting Profit/Risk/Contingency Loading

"Managed Care Adjusted FFS" Approach

The Administration load factor is expressed as a percentage of the capitation rate (i.e., percent of premium). The percentage was developed from a review of the established GMC MCOs' historical reported administrative expenses as well as new contract requirements. Mercer utilized its experience and professional judgment in determining the selected percentage to be reasonable. The Administration load for the SPD expansion within the "managed care adjusted FFS" approach is 6.0%. The range for the Administration component is +/- 1.0% at the lower/upper bound from the midpoint value (7.0% at the lower bound and 5.0% at the upper bound). These administrative loading factors correlate to the greater/lesser range of managed care savings described above.

"Risk Adjusted Managed Care" Approach

The Administrative load factor used in the "risk adjusted managed care" approach was the same Administrative load factor that was used in the CY11 and CY12 SPD rate development (please see attached certifications for more information).

The Underwriting Profit/Risk/Contingency load is 3.0% at the midpoint, 2.0% at the lower bound and 4.0% at the upper bound. Mercer has implicitly and broadly considered the cost of capital within our rating assumptions. Our conclusion is that our assumptions surrounding the Underwriting Profit/Risk/Contingency load, as well as income an MCO generates from

investments, are sufficient to cover at least minimum cost of capital needs for the typical health plan.

Risk Adjustment of the County Average Managed Care Rates

The last step involved in the “risk adjusted managed care” approach was to account for any health acuity differential between the existing managed care members and the transitioning FFS members within each county. To evaluate the differences in health acuity between these two populations, Mercer produced risk factors using the Medicaid Rx Version 5.2 health-based payment model developed by the University of California at San Diego (UCSD). Within the risk adjustment process, 12 months of base data (i.e., "study period") are used to produce risk scores. To coincide with the base period used for the capitation rate development, CY08 and CY09 data were used for the risk analysis. The risk scores for each respective time period were blended using a weighting based on the membership from CY08 and CY09 respectively. The blended result produced a single risk factor for the two evaluated populations by each county. The upper half of Exhibit C displays the steps involved in this process. As shown in Exhibit C, the FFS risk factor was 1.1039 and the managed care factor was .9988. By calculating the differential in these risk scores, the existing FFS members costs (based on health acuity) are expected to be approximately 110.52% (1.1039/0.9988) of the cost for that of managed care members. Since a separate maternity supplemental payment rate has been developed, maternity costs were excluded from the risk-adjustment process.

The individual acuity factors for CY08 and CY09 were based on pharmacy encounters and claims incurred January 1, 2008– December 31, 2009, with six plus months of data claims and processing lag to ensure that the data were adequately complete. Similar to the approach used to adjust Medi-Cal capitation rates, the prospective Medicaid Rx Version 5.2 model was used for this acuity study. The risk-adjustment process only includes experience data for individuals who have at least six months of total Medi-Cal eligibility within each 12-month study periods. Individual acuity factors are developed for each recipient. The individual acuity factors are subsequently aggregated to either the FFS or managed care population.

The Medicaid Rx Version 5.2 model was recently updated by UCSD in 2010 and has been further adjusted to more closely align with the risk associated with the GMC model covered benefits. For example, the cost weights reflected in the national Medicaid Rx Version 5.2 model were developed assuming a comprehensive acute care and behavioral health benefit package and utilized over 30 states’ data. Since the model is applied to the GMC program, UCSD staff and Mercer modified the cost weights to reflect California Medi-Cal-specific data and services covered under the GMC managed care program. Please see the separate document, *CY 2012 CA RAR GMC Methodology Letter 07182011.pdf* for more detail.

Final Blending

One of the last steps involved to produce rate ranges for the SPD FFS population transitioning into managed care is the blending of the two approaches. As displayed in Exhibit C, the risk adjusted managed care values are blended with the managed care adjusted FFS rate ranges, with risk adjusted managed care values receiving a 25% weighting and the managed care

adjusted FFS receiving a 75% weighting. The final step in producing the rate ranges for the transitioning FFS members is to introduce the plan-specific budget-neutral (by county) risk adjustment factors for the transitioning SPD populations. This factor is based on the April 2012 plan assignment of the transitioning members. Please see the separate document, *CP13 CA RAR Methodology Letter 082812.pdf* for more detail. This factor is applied to the county average to produce a risk adjusted rate. This rate is included as 25% of the final with the other 75% being the non-risk adjusted county average. Please see exhibits A and B with reference to the identifiers {E}, {F}, and {G} depicting this calculation.

The final step in producing rate ranges for the entire SPD population, including both the transitioning FFS members and the existing managed care members, involves a straightforward member-weighted blending of the two sets of rate ranges. As shown in Exhibit A, the 75/25 blended SPD transitioning FFS member rate range (item {G}) is blended with the existing risk adjusted, plan-specific managed care rate ranges (item {H}). The existing managed care, plan-specific rate ranges are those CY11 and CY12 GMC Aged/Disabled Medical Only rates, which were certified on January 31, 2013 and February 7, 2013 respectively. This final step produces the rate ranges which will be utilized in determining the final payments to the plans.

Rate Ranges

To assist DHCS during its rate discussions with the MCOs, Mercer provides DHCS rate ranges which were developed using an actuarially sound process. The SPD rate ranges were developed using a combination of a modeling process, which varied the medical expense (i.e., risk) trend, assumed managed care savings, the administration loading percentage and the Underwriting/Profit/Risk/Contingency loading percentage to arrive at both an upper and lower bound capitation rate. The final contracted rates agreed to between DHCS and the MCOs will fall within the rate ranges provided by Mercer.

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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. We have 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 CP12 18 month GMC SPD rate ranges effective July 1, 2011 through December 31, 2012 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 in 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.

Michael E. Nordstrom, ASA, MAAA	James J. Meulemans, ASA, MAAA

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