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FINAL

May 28, 2013

Subject: Two-Plan Model Contract Period 2013 Rate Range Development and Certification for October 1, 2012 through September 30, 2013

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 Two-Plan model contract period 2013 (CP13). The CP13 period began October 1, 2012 and ends September 30, 2013. 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. Note that this rate range development process constituted a rebasing of the capitation rates for existing populations. Mercer previously provided certified rate ranges for San Joaquin and Stanislaus counties which are being replaced with this updated information as part of the overall Two-Plan model certification.

This certification also includes the Seniors and Persons with Disabilities (SPD) expansion. The SPD expansion is related to the new requirement of this population becoming mandatorily enrolled, instead of voluntarily enrolled, into managed care. 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 CP13 county average SPD managed care rate ranges (which are also part of this certification) 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 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 on 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,

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**TWO-PLAN MODEL RATE RANGE
DEVELOPMENT AND CERTIFICATION
(10/1/2012–9/30/2013)
STATE OF CALIFORNIA
May 28, 2013**

Government Human Services Consulting

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Rate Methodology

Overview

Capitation rate ranges for the California Department of Health Care Services' (DHCS) Two-Plan managed care program were developed in accordance with rate setting guidelines established by the Centers for Medicare & Medicaid Services (CMS). This certification also includes the process aligned with the development of rate ranges for the Seniors and Persons with Disabilities (SPD) expansion which began in May 2011. 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.

For rate range development for the Two-Plan managed care organizations (MCOs) non-SPD expansion, Mercer used calendar year 2010 (CY10) Two-Plan MCO-reported encounter data, the CY10 Rate Development Template (RDT) data and other ad hoc claims data reported by the Two-Plan MCOs. The most recently available (at the time the rate ranges were determined) Medi-Cal-specific financial reports submitted to the Department of Managed Health Care (DMHC) were also considered in the rate range development process.

Adjustments were made to the selected base data to match the covered population risk and the State Plan approved benefit package for the contract period 2013 (CP13) period. Additional adjustments were then applied to the selected base data to incorporate:

- Prospective and historic (retrospective) program changes not reflected (or not fully reflected) in the base data
- Observed changes in the population case-mix and underlying risk of the MCOs from the base data period
- Budget-neutral relational modeling for smoothing
- Trend factors to forecast the expenditures and utilization to the contract period
- Administration and underwriting profit/risk/contingency loading

Subsequent to these adjustments, DHCS takes two additional steps in the measured matching of payment to risk:

- Application of a maternity supplemental (kick) payment
- Application of risk-adjusted county average rates

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. One of the approaches ("risk adjusted managed care") utilized the existing CP13 county average SPD managed care rate ranges 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 SPD rate ranges for the CP13 period.

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 CP13 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 Two-Plan model program for the transitioning FFS members.

The above approaches have been utilized in the development of the rate ranges for the CP13 Two-Plan program. DHCS will offer final rates within the actuarially sound rate ranges of each 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.

Due to several factors that go into effect January 1, 2013, including the upcoming application of the physician fee increase related to Section 1202 of the Affordable Care Act (ACA) and a health plan transition in San Joaquin and Stanislaus counties, the CP13 period has been segmented into two periods: October 1, 2012 through December 31, 2012 (Period 1) and January 1, 2013 through September 30, 2013 (Period 2). Anthem Blue Cross is exiting both San Joaquin and Stanislaus counties. Effective January 1, 2013, in San Joaquin County, Anthem is being replaced by Health Net, while in Stanislaus County, Anthem is being replaced by Health Plan of San Joaquin. This certification covers both periods.

The various steps in the rate range development are described in the following paragraphs.

Base Data

The information used to form the base data for the non-SPD expansion (including existing SPD members) Two-Plan rate range development was MCO encounter data, requested MCO RDT and ad hoc claims data, and DMHC-required Medi-Cal-specific financial reporting. The CY10

encounter and RDT claims data included utilization and unit cost detail by category of aid (COA) group, by county, by MCO, and by twelve consolidated provider types or COS, including:

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

Utilization and unit cost information from the plan-specific encounter and RDT data was reviewed at the COA group and COS detail levels for reasonableness. Ranges of reasonable and appropriate levels of utilization and unit cost were then established for each COS within each COA group. Averages of the reasonable and appropriate levels were also established for the encounter and the RDT data. This process, in essence, produced four potential data elements of utilization and unit cost for each COS within each COA group: 1) plan-specific encounter data, 2) plan-specific RDT data, 3) average encounter data, and 4) average RDT data. These four data elements were then applied credibility factors dependent upon the plan-specific data being reasonable and appropriate, and also based on the enrollment size of the population of the COA. Even with the health plan transition in San Joaquin and Stanislaus counties during Period 2, Anthem Blue Cross data (because they were the operational MCO during CY10) was utilized as the basis for the rate development for the health plan replacing them in each respective county.

CY10 served as the 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 DMHC financial reporting Revenue, Expenses, and Net Worth exhibits for each MCO that were available at the time the rate ranges were being developed were reviewed and analyzed by DHCS and Mercer for insight into changes in population case-mix and underlying risk.

The data utilized was managed care data that did not include any DSH payments or include any adjustments for FQHC or RHC reimbursements. The data did not include any adjustments for catastrophic claims. MCOs report this information as part of the base data and it is included in the aggregate rates. Information on catastrophic claims is reported separately by MCOs within the RDT submission and this is reviewed and discussed with the plans. No adjustments are made to the base as all of these amounts are already included, however, see the “Data Smoothing” section below. The RDT submissions already include incurred but not reported adjustments that are reviewed for appropriateness. No further adjustments were applied. The encounter data did receive adjustments to reflect underreporting and additional runout.

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,

MCO encounter data served as the starting base data for rate setting. Encounters undergo considerable edits within DHCS to ensure quality and appropriateness of the data for rate setting purposes. Base period MCO COA eligibility (described below) and encounter 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 the MCOs and DHCS in the development of these rate ranges. We have reviewed the data and information for reasonableness, and we believe the data and information utilized in the rate development to be free of material error and suitable for rate range development purposes for the populations and services covered under the Two-Plan contracts. 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 provide a reasonable assurance as to the data's appropriateness for use in capitation rate development under the State Plan.

The Excel rate range spreadsheets contain detailed capitation rate calculation sheets (CRCS) for the Two-Plan rate development. 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 CRCS. The various COA groupings are each represented by their own separate 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 has confirmed that there are no provisions in the Two-Plan managed care contract regarding GME. The Two-Plan MCOs do not pay specific rates that contain GME or other GME-related provisions. As Two-Plan MCO data serves as the base data, GME expenses are not part of the Two-Plan capitation rate development process.

For the SPD expansion population, the base data contained two sources as previously described:

"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.

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 upon 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 Two-Plan 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 is the same base data from the CP13 existing SPD member rate development being certified as part of the non-SPD expansion portion of this certification. The base data utilized was based on the member-weighted (using CY10 member months) county average of the MCOs within each Two-Plan county.

Exhibit D of the *CP13 Two-Plan SPD Certification Exhibits.pdf* attachment has the detailed CRCS for the FFS base (page 4) and the managed care base (page 5). 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 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 Two-Plan model managed care contract regarding GME. The Two-Plan 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 Two-Plan model expansion capitation rate development process. GME was also

not included in the “risk adjusted managed care” approach as documented above during the discussion of the non-SPD expansion base data.

Maternity Supplemental (Kick) Payment

To further enhance the measured matching of payment to risk, DHCS utilizes a maternity supplemental (kick) payment. Pertaining to gender, the primary issue that could result in significant variance among the Two-Plan 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. (Pre-natal and post-partum care costs are not part of the kick payment, but remain within the respective COA capitation rates.) A Two-Plan 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 CP13 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.

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 varies by county, but not by MCO within a county
- Kick payment reflects cost of delivery event only (mother and baby, excluding pre-natal and post-partum care)
- Kick payment is for the entire 12 month CP13 period (utilizing 33 months of trend from the base period to the CP13 period) except in San Joaquin and Stanislaus counties where separate 3 month and 9 month kick payment levels have been established based on adjustments to the number of trend months applied for Period 1 (28.5 months) and Period 2 (34.5 months)
- Same kick payment is utilized for non-SPD expansion and SPD expansion rate ranges
- Combine prior Adult and Family COA groups
 - Without maternity event, risk of Adult group is similar to Family group
- Carve-out maternity costs from Adult & Family and Aged/Disabled/Medi-Cal Only COA groups (99.9% of all deliveries)

Maternity Kick – Rate Development Approach

- Calculate delivery costs by county
- Calculate delivery costs from CY10 MCO RDT data
 - Same general data selection process used as in regular rate range development
 - Developed smoothed data points to replace missing or unreasonable data and blend with plan-specific data

- Blend reported and smoothed costs from the MCOs to generate county-specific amounts
- Trend base costs forward to the midpoint of the contract period
- Adjust for applicable program changes
- Add load for administration and underwriting profit/risk/contingency
- Calculate delivery counts by MCO
 - Rely on Medi-Cal Deliveries Report information generated by DHCS
 - Medi-Cal eligibility is the primary data source
- Calculate historical birth rates by MCO (prior years reviewed for consistency)
- Project number of delivery events based upon birth rates and Period 1 and Period 2 projected member months for applicable COA groups (same method for non-SPD expansion and SPD expansion populations)
- Remove dollar amount from Adult & Family and Aged/Disabled/Medi-Cal Only costs by MCO

Across the Two-Plan MCOs non-SPD expansion population, the equivalent PMPM adjustment for the maternity supplemental payment is \$13.35 for Adult & Family and \$4.18 for the combined Aged/Disabled/Medi-Cal Only COAs at the lower bound of the rate range in Period 1. In Period 2, the equivalent PMPM adjustment is \$13.38 for Adult & Family and \$4.16 for Aged/Disabled/Medi-Cal Only at the lower bound of the rate range.

The details of the maternity kick impact for the SPD expansion population are displayed in Exhibit D (page 6) of the *CP13 Two-Plan 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 and 5) in column (P). The impact of the maternity kick payment is fairly small within the SPD expansion population.

This methodology is budget-neutral, projecting the same total dollar outlays under a pre- and post-maternity supplemental payment approach.

Category of Aid (Aid Code) Groupings

The base data sets used to develop the Two-Plan CP13 non-SPD expansion population capitation rate ranges were divided into cohorts that represent consolidated COA (or Aid Code) groupings which inherently represent differing levels of risk. These eight COA cohorts are (alphabetically):

- Adult & Family
- Aged/Disabled Med-Cal Only
- Aged/Dual Eligible
- AIDS/Dual Eligible
- AIDS/Medi-Cal Only
- BCCTP
- Disabled/Dual Eligible
- Maternity
-

For the dual eligible COA groups, Medi-Cal managed care only covers Non QMB and Non SLMB qualified duals. The same aid codes for the non-dual population are utilized for the dual

population. The QMB Plus and SLMB Plus qualified duals are not part of the non-dual managed care population and are in FFS.

Share of cost members (recipients who establish eligibility for Medicaid by deducting incurred medical expenses) are not part of the managed care population; therefore, none of these costs are included in the development of the rate ranges.

With the use of the maternity supplemental (kick) payment, as well as risk-adjusted county average rates (each described in more detail elsewhere within this certification), DHCS and Mercer were able to combine prior COAs with similar remaining underlying risk. The separate Adult and Family COAs from prior contract periods were combined into Adult & Family, and the separate Aged/Medi-Cal Only and Disabled/Medi-Cal Only were combined into Aged/Disabled Medi-Cal Only. This same process has been used in the Two-Plan model since the implementation of the maternity supplemental payment and risk-adjusted county average rates in October 2009.

Data Smoothing

The Two-Plan non-SPD expansion program is very large, covering over 2.8 million lives. In aggregate, each MCO has a fully credible population base for rate setting purposes. However, there are a number of MCO COA groups for which there is concern over specific COA group credibility. In those instances, Mercer analyzed data and information on a more aggregate level across the entire Two-Plan model counties and, from this, developed factors or relativities to overcome any excessive variation brought on by small membership or extraordinary (high or low) utilization or unit costs. Adjustments were made via a budget-neutral relational modeling process. No dollars were gained or lost in this process.

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 CP13 rate range development for the Two-Plan program, 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 MCO encounter and RDT data, MCO financial statements, Medi-Cal FFS experience, 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 CY10 base data used for the non-SPD expansion population was trended forward 28.5 months to the mid-point of the rating period for Period 1 and 34.5 months to the mid-point of the rating period for Period 2. The CY09 and CY10 FFS base data used for the SPD expansion population was trended forward 34.5 and 40.5 months to the midpoints of the Period 1 and Period 2 rating periods respectively.

Note that trends for the LTC provider type are displayed as 0.0% for both utilization and unit cost. Due to the relatively high level of legislatively-mandated changes surrounding LTC, Mercer has handled LTC trends through the “Program Changes” section of the methodology.

Given the recent financial information available at the time the rate ranges were developed, 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. (The +/- 0.25% does not apply to a 0 value such as those for LTC.) For the non-SPD expansion population, over the 2.375 and 2.875 year periods from the midpoint of the CY10 base period to the midpoint of respective CP13 rating periods, this contributes approximately +/- 1.19% and +/- 1.45% to the upper and lower bounds of the rate ranges for Period 1 and Period 2. For the SPD expansion population, over the 2.875 and 3.375 year periods from the midpoint of the CY09 and CY10 FFS base period to the midpoint of respective CP13 rating periods, this contributes approximately +/- 1.45% and +/- 1.70% to the upper and lower bounds of the rate ranges for Period 1 and Period 2.

The specific lower bound trend levels by utilization and unit costs for the 12 COS are displayed in columns (D) and (E) of the CRCS. These annual trend figures are applied for the number of months represented in the “Time Periods” section in the upper right hand corner of the CRCS. The number of trend months is determined by comparing the midpoint of the base period to the midpoint of the rating period.

Program Changes

Program change adjustments recognize the impact of benefit or eligibility changes that took place during or after the base data period. The program changes incorporated in the development of the rate ranges were based on information provided by DHCS staff as of November 30, 2012. Following are the program changes (with effective dates) that were viewed to have a material impact on capitation rates and were reviewed, analyzed, and evaluated by Mercer with the assistance of DHCS’ Managed Care Division and Fiscal Forecasting and Data Management Branch staff:

- Community-Based Adult Services (CBAS)/Enhanced Case Management (ECM) member transition from FFS (risk differential and ECM costs) – April 2012
- 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
- Inclusion of GHPP services in Two-Plan managed care program – July 2011
- SB 335 – July 2011
- SB 208 – July 2011

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 84.3% 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 24.9% and the program change for outpatient hospital and emergency room unit costs is 74.6%. 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, but only applicable to the SPD expansion population is SB 208 which deals with State and Designated Public Hospitals (DPHs). The transition of non-dually eligible 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 charts 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 SPD expansion population data after blending the managed care and FFS components.

An additional component related to the SB 335 and SB 208 program changes is the timing of the implementation of the adjustments within the rates. Because of the statutory timing of these rates that include these adjustments having a potential 90 day delay following all necessary federal approvals, (*Section 14169.5 (f) (1) of California Welfare and Institution Code: The increased capitation payments to managed health care plans under this section shall be made to support the availability of hospital services and ensure access to hospital services for Medi-Cal beneficiaries. The increased capitation payments to managed health care plans shall commence no later than the later of December 31, 2011, or within 90 days of the date on which all necessary federal approvals have been received, and shall include, but not be limited to, the sum of the increased payments for all prior months for which payments are due.*) this certification covers two sets of rate ranges: rate ranges that include the SB 335 and SB 208 adjustments and rate ranges that exclude the SB 335 and SB 208 adjustments.

Section 2702 of the ACA of 2010 required the 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 adjustments have been included within these rates. It should be noted that reductions related to potentially preventable inpatient admissions have been included as part of our efficiency adjustments related to the base managed care data. Please see the section below related to this topic for further detail.

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

For the “managed care adjusted FFS” approach, the PPR impacts were applied in three steps. The 2009 FFS base data was adjusted upward because the base data reflected PPR impacts and needed to be brought back to standard payments rates. The 2010 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 (and also the non-SPD expansion calculations), 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.

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. The various program changes are calculated at the COA and COS level. Multiple program changes may be reflected within a final percentage represented in a given COA and COS field.

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%. Two sets of rate ranges were provided: one that includes this tax and one that excludes the tax. Continuation of this tax is currently under review.

Any program changes with an effective date prior to January 1, 2011 were treated as retrospective changes (outside of the aforementioned PPR issues). Please see the following attachments (“CP 12-13 TP (3 month Oct - Dec 2012) Program Change Charts.pdf”, “CP 12-13 TP SPD (3 month Oct - Dec 2012) Program Change Charts.pdf”, “CP 12-13 TP (9 month Jan - Sept 2013) Program Change Charts.pdf” and “CP 12-13 TP SPD (9 month Jan - Sept 2013) Program Change Charts.pdf”) for further details.

Managed Care Adjustments (SPD Expansion only) **“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 Two-Plan 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 CY10 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 9% reduction to the FFS data excluding pharmacy costs. Factors producing the 9% adjustment included reducing Inpatient Hospital and Outpatient Facility utilization. As an example, Inpatient Hospital utilization was reduced by 25% and Outpatient Facility was reduced 12.5% 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.

Risk Adjustment of the County Average (SPD Expansion only)

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, CY09 and CY10 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 CY09 and CY10 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 0.9552 and the managed care factor was 1.0576. By calculating the differential in these risk scores, the existing FFS members costs (based on health acuity) are expected to be approximately 90.3% ($0.9552/1.0576$) 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 CY09 and CY10 were based on pharmacy encounters and claims incurred January 1, 2009–December 31, 2010, 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 period. Individual acuity factors are developed for each recipient. The individual acuity factors are subsequently aggregated to either the FFS or managed care population.

Blending (SPD Expansion only)

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.

Pharmacy Adjustments

The pharmacy components of the managed care data also received two adjustments. One of the adjustments was to account for the loss of pharmacy rebates due to the passage of the ACA and the other adjustment was related to an efficiency analysis.

Adjustment for Lost Rebates Due to ACA

An adjustment has been made to the CP13 managed care base data to account for the current loss of pharmacy rebates being experienced by the MCOs due to the passage of the ACA on March 23, 2010. This regulation extends to the states the ability to collect federal rebates on outpatient drugs delivered within Medicaid managed care contracts, which has had demonstrated implications for the MCO pharmacy contracts and net pharmacy expense levels. To help establish the impact of the ACA on the MCOs rebate levels, a data request was submitted to the MCOs in 2011 to gather information related to prior and projected rebate experience. The rebate levels utilized for the CP13 rates were based on a thorough review of this MCO submitted information and current RDT submissions, by Mercer's Pharmacy and actuarial staff.

Efficiency Adjustment – Maximum Allowable Cost

For the CP13 rating period, DHCS is utilizing an adjustment to the managed care base data that analyzes the effectiveness of each Two-Plan model MCO's pharmacy cost management through a Maximum Allowable Cost (MAC) avoidable cost analysis.

To identify potentially avoidable costs due to reimbursement inefficiencies, Mercer utilized the Two-Plan MCOs' CY10 pharmacy data and reviewed the reimbursement contracting for generic products. Each pharmacy claim was compared against a benchmark Medicaid MAC list for the same timeframe to create a cost savings amount for each claim. To calculate the cost savings amount, a derived paid amount which utilized the unit price from the benchmark MAC list was calculated for each claim and subtracted from the actual paid amount on each claim. The total cost savings for each claim was then combined and aggregated for each MCO to calculate the total cost savings for each MCO. In instances where the actual paid amount was less than the derived paid amount (negative cost savings), the negative amount was counted against the cost savings amount.

Inpatient Adjustment

The inpatient component of the managed care base data also received an adjustment related to an efficiency analysis.

Efficiency Adjustment – Potentially Preventable Admissions

For the CP13 rating period, DHCS is utilizing an adjustment to the managed care inpatient base data that analyzes levels of inefficiency and/or potentially avoidable expenses present in the health plan encounter data.

Potentially preventable hospital admissions were identified through the CY10 Medi-Cal health plan encounter data using criteria from the Agency for Healthcare Research and Quality (AHRQ) Guide to Prevention Quality Indicators (PQI) and Pediatric Quality Indicators (PDI). Additional exclusions for enrollment duration and risk were made as part of the analysis.

This analysis represents a conservative approach to identifying and quantifying potentially unnecessary expenditures utilizing the AHRQ definitions for each PQI and PDI and their specific exclusions (i.e., deaths, transfers to other facilities, etc.). Additionally, only individuals meeting specific Medicaid Rx risk score criteria and enrollment durations by PQI/PDI in the same Medi-Cal health are considered for the analysis. A benchmark methodology was utilized in order to apply an adjustment factor based on a PPA level that has been achieved by some of the health plans.

Risk Adjustment

Capitation rates for DHCS' Two-Plan model are risk-adjusted using the Medicaid Rx Version 5.2 health-based payment model developed by UCSD. The risk adjustment applies to the Adult & Family and Aged/Disabled/Medi-Cal Only COA (including the blended SPD expansion population) groups only. Capitation rates for the Aged and Disabled dual eligible, BCCTP, and

AIDS COA groups are not risk adjusted. Also, since a separate maternity supplemental payment rate has been developed, maternity costs were excluded from the risk-adjustment process.

Capitation rates for the Aged and Disabled dual eligible, BCCTP, and AIDS COA groups are not risk-adjusted. The application of risk adjustment to the capitation rates is to better match the payment to the risk. For the Aged and Disabled duals, there are two main reasons that these populations will not be risk-adjusted. First, the Medicaid Rx model utilizes pharmacy data within the process of producing risk scores. The dual populations have very limited pharmacy experience within the Medi-Cal program, as the vast majority of their pharmacy claims are covered by Medicare Part D. Further, even when using a non-pharmacy- (i.e., diagnosis-) based risk-adjustment model, much of the claims history is captured through Medicare, further complicating the use of risk adjustment for dual members. Second, for the Aged and Disabled dual COAs, the majority of the dollars paid for all medical claims are covered by the Medicare benefit. The capitation rates only represent the costs of the services not already covered through Medicare. The current cost weights developed for the Medi-Cal program assume that all managed care covered services are paid by the Medi-Cal MCOs. Creating a risk-adjustment system for the dual populations would require a unique set of cost weights that account for services paid through Medicare and a methodology to overcome the data issues mentioned above. This additional level of resources with potentially limited benefit of better matching payment to the limited remaining risk for these dual eligible members was not performed. For BCCTP and AIDS, separate capitation payments are already developed for these members with narrowly-defined disease conditions (e.g., breast and cervical cancer) that allow entrance into these COAs. These separate capitation payments developed for the BCCTP and AIDS populations are not risk-adjusted since they already appropriately match the payments to the risk.

The individual acuity factors and final plan factors that are in effect for CP13 were based on pharmacy encounters and claims incurred December 1, 2010 through November 30, 2011 (referred to as the study period), with process dates through the end of March 2012. Four months of data lag was used to help complete the pharmacy claims and encounters. After individual acuity factors were calculated using the above study period, these acuity factors were aggregated by MCO and COA group using each plan's enrollment snapshot as of April 2012 to calculate the unadjusted risk factors for each Two-Plan MCO. To ensure that the risk-adjustment process does not increase or decrease the total amount of capitation payments, the MCOs' risk factors are adjusted for budget neutrality. The intent of this adjustment is to recalibrate all the MCO risk-adjustment factors to yield a county average of 1.0000. Each MCO's own risk-adjustment factors are then applied to the county average base capitation rates to arrive at each MCO's risk-adjusted rate. The risk-adjusted county average rates for each MCO are then blended at 35% weight, with the historical MCO "plan-specific" rate approach blended at 65%. Mercer believes this blending approach is appropriate and is consistent with the risk-adjustment process utilized in previous rate development processes.

Because there will be new health plans taking over Anthem Blue Cross' book of business in San Joaquin and Stanislaus counties in Period 2, the Period 2 risk-adjustment for the new health

plans is based on the Anthem data within the study period, as well as the Anthem member assignment as of April 2012.

DHCS continues to validate encounter data and is working with the MCOs to support and monitor their efforts to continually improve the collection and reporting of encounter data. For example, prior to running the pharmacy encounter data through the Medicaid Rx classification system, the reasonableness of the pharmacy claims and encounter data volume were reviewed by calculating the monthly average number of claims per recipient across the MCOs. Additionally, analyses and reviews were performed on the pharmacy claims and encounters to measure claims without National Drug Code (NDC) information and to evaluate the validity of reported NDCs.

DHCS and Mercer used the prospective Medicaid Rx model to evaluate risk differences between the participating Two-Plan model MCOs. The risk-adjustment process only includes experience data for individuals who have at least six months of total Medi-Cal eligibility within the twelve-month study period. Individuals who do not meet the six-month eligibility criterion are assigned the respective MCO's average risk factor associated with that individual's COA group.

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 Two-Plan 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 Two-Plan program, UCSD staff and Mercer modified the cost weights to reflect California Medi-Cal-specific data and services covered under the Two-Plan managed care program. For additional details of the risk-adjustment methodology, please see the separate document "*CP13 CA RAR Methodology Letter 082812.pdf*."

Administration and Underwriting Profit/Risk/Contingency Loading

The administration loading for the Two-Plan model MCOs non-SPD expansion population was developed in aggregate. The administration load factor is expressed as a percentage of the capitation rate (i.e., percent of premium). This mid-point percentage was developed from a review of the MCOs' historical reported administrative expenses, which are submitted as part of their attested rate development templates on an annual basis. The administrative costs are reviewed to ensure that they are appropriate for the approved state plan services and Medicaid eligible members. Mercer also utilized its experience and professional judgment in determining the mid-point and lower and upper bound percentages to be reasonable. The mid-point Administration load is 8.5% across all Two-Plan model MCOs. The range for the Administration component is +/- 0.9% upper/lower bound from the mid-point value.

While the above is the overall targeted aggregate administrative percentage, the administrative expense associated with each COA group varies from the overall percentage. The Administrative component can be viewed in two pieces: a fixed cost component and a variable cost component. The fixed cost component represents items such as accounting salaries, rent, and information systems, while the variable cost component represents items such as claims processing and

medical management per eligible. Allocating the administrative costs as a uniform percentage of each of the COAs is an appropriate method; however, it does not take into account the differences in fixed versus variable administrative costs for each.

Certain COA groups have capitation rates ten (or more) times larger than other COAs. In these instances, the uniform allocation methodology will produce an administrative component for the more expensive COA ten (or more) times larger than the administrative component for the less expensive COA groups. While a more expensive eligible is probably more administratively intensive, this ten (or more) to one relationship in administrative costs is most likely exaggerated.

If the fixed component of administrative costs is broken down and viewed on a PMPM basis, then this fixed dollar amount is a larger percentage of the capitation rate of the less expensive COA groups, and a smaller percentage of the capitation rate for the more expensive COA groups. This concept has been applied in a budget-neutral fashion (no administrative dollars have been gained or lost) to the capitation rates, whereby the administrative percentage will be greater for less expensive COA groups than the aggregate administrative percentage over the entire population. Similarly, the administrative percentage for the more expensive COA groups will be less than the aggregate administrative percentage over the entire population.

**For the SPD expansion population administration calculation:
“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 Two-Plan MCOs’ historical reported administrative expenses, as well as new contract requirements. The administrative costs are reviewed to ensure that they are appropriate for the approved state plan services and Medicaid eligible members. 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 6.5%. The range for the Administration component is +/- 1.0% at the lower/upper bound from the midpoint value (7.5% at the lower bound and 5.5% 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 CP13 SPD rate development described above for the existing SPD population.

The underwriting profit/risk/contingency load is 3.0% at the mid-point, 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 the income an MCO generates from investments, are sufficient to cover at least minimum cost of capital needs for the typical health plan.

Blended "Plan-specific" and Risk-adjusted County Average Rates

In an effort to encourage and reward cost efficiencies and effectiveness, DHCS is using a blended "plan-specific" and risk-adjusted county average rates approach for CP13, consistent with the approach that has been used for prior rate development periods. As mentioned in the "Risk Adjustment" section, the CP13 blend is 35% of the risk-adjusted county average approach and 65% of the MCO "plan-specific" approach. Each of these approaches produces actuarially sound rates or rate ranges, and blending the approaches does not impact actuarial soundness, but enhances DHCS program goals.

"Plan-specific": The same general methodology employed for the 75% blend in the CP12 rate development has been utilized for the 65% blend portion for CP13. While a large number of rate-setting factors/components/loads are not MCO-specific (items such as utilization trend, unit cost trend, program changes, administration, and underwriting profit/risk/contingency are Two-Plan model specific), at the mid-point the medical expense base data has a strong relationship to recent MCO claims experience. For this reason, this approach has often been referred to as "plan-specific" rate setting. In spite of the stated caveats, we retain that terminology.

Risk-adjusted county average rates: County-specific rates are developed on a weighted average (using projected CP13 member months) basis to maintain budget neutrality. All health plan data/experience in a county considered in the "plan-specific" approach are considered here. The county-specific approach is obviously already done for the DHCS County Organized Health Systems (COHS) model. In Mercer's opinion, with two or more MCOs in a county, a best practice is to also incorporate the use of risk adjustment, where an MCO's plan-specific budget-neutral risk scores are applied to the applicable county-specific rates.

For CP13, this blending applies to the Adult & Family and Aged/Disabled/Medi-Cal Only COAs. The Maternity Supplemental Payment COA was developed on a county-specific basis. All other COA groups, other than the above three, remain "plan-specific."

Rate Ranges

To assist DHCS during its rate discussions with each MCO, Mercer provides DHCS rate ranges that were developed using an actuarially sound process. The COA group-specific rate ranges were developed using a combination of a modeling process which varied the medical expense (i.e., risk) trend, 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 each MCO fall within the rate ranges provided by Mercer.

The final step in producing the 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 base transitioning FFS member (75% managed care adjusted FFS rate/25% risk adjusted managed care rate) is 65/35 risk adjusted to produce a SPD transitioning FFS member rate range (item {G}) which is blended with the existing 65/35 risk adjusted, plan-specific managed care rate ranges

(item {H}) which are part of non-SPD expansion population component of this certification. This final step produces the rate ranges which will be utilized in determining the final payments to the plans.

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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 Two-Plan model rate ranges (both, including and excluding the SB 335 and SB 208 adjustments) for the CP13 time period, October 1, 2012 through September 30, 2013 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.

