Mercer

Government Human Services Consulting

Program of All-Inclusive Care for the Elderly

Capitation Rate Development and Amount that Would Otherwise be Paid Certification

State of California
Department of Health Care Services
Capitated Rates Development Division

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Contents

Section 1

Executive Summary

The State of California Department of Health Care Services (DHCS) contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to develop actuarially sound[1] capitation rate ranges for the Program of All-Inclusive Care for the Elderly (PACE) and PACE Amount that Would Otherwise be Paid (AWOP), during the calendar year 2025 (CY 2025) rating period. This letter presents an overview of the methodology and analyses used in Mercer's AWOP and experience-based rate range development that complies with the requirements set forth by the Centers for Medicare & Medicaid Services (CMS). The PACE AWOP, as defined by CMS, is "the amount that would otherwise have been paid under the State plan if the participants were not enrolled under the PACE program" and "takes into account the comparative frailty of participants." To meet CMS approval, the PACE capitation rates cannot exceed the AWOP.

[1] Actuarially sound/actuarial soundness — Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital and government-mandated assessments, fees and taxes.
Actuarial Standard of Practice 49

Section 2
PACE Program Overview

PACE Eligibility

The PACE program enrolls eligible Medi-Cal members aged 55 and older meeting nursing facility (NF) clinical criteria and living within the PACE service area. PACE AWOPs were developed to be consistent with the counties covered by each participating PACE Organization (PO). Each PO has a corresponding AWOP that was developed using data for the counties covered by that PO. PACE AWOPs were developed covering the following PACE program counties/county combinations.

Counties/County Combinations	
Alameda	Alameda, Santa Clara
Alpine, Butte, Colusa, El Dorado, Glenn, Nevada, Placer, Plumas, Sacramento, San Joaquin, Sierra, Stanislaus, Sutter, Tehama, Yuba	Contra Costa
Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo	Fresno, Madera, Kings
Fresno, Kings, Madera, Tulare	Kern, Tulare
Los Angeles	Los Angeles, Riverside, San Bernardino
Mariposa, Merced, Monterey, San Joaquin, Santa Cruz, Stanislaus	Marin, Napa, Solano, Sonoma, Yolo
Orange	Riverside, San Bernardino
Sacramento	San Diego
San Francisco	San Joaquin, Stanislaus
Santa Clara	

This certification includes rates for 13 new POs, with four expected to be operational on January 1, 2025 and another nine on July 1, 2025. AWOPs and experience-based rate ranges developed for these new POs were developed consistent with the methodology described below. Since no current experience exists, the experience-based rates were developed based on cost information submitted by other POs in the same geographic regions, accounting for differences in cost of living between the plans' county/counties and makeup of geographic region.

Covered Benefits

The PACE program encompasses a comprehensive benefit package, including NF, long-term services and supports (LTSS) including home- and community-based services (HCBS), inpatient hospital, outpatient hospital, physician services, laboratory and x-ray services, pharmacy, transportation, durable medical equipment (DME), and hospice services. A comprehensive list of covered benefits and coordinated access services can be viewed in the State of California PACE State Plan Amendment.

Section 3

Overview of Medi-Cal PACE Rate Setting

Per California Welfare & Institutions Code 14301.1, PACE capitation rate ranges are developed using an experience-based rate approach, in addition to developing the required AWOP pursuant to the CMS PACE Medicaid Capitation Rate Setting Guide and federal regulation. The PACE capitation rates paid to each PO will be determined by the State, within the experience-based rate range and less than the AWOP. The separate developments of the PACE experience-based rates and AWOPs are consistent, and not in conflict with, the Medicaid State Plan.

AWOP Methodology

The PACE AWOP for CY 2025 was developed in accordance with the CMS PACE Medicaid Capitation Rate Setting Guide. Historically, under the context of the Medi-Cal program, in a non-County Organized Health System (COHS) and non-Coordinated Care Initiative (CCI) county, institutionalized members received services almost exclusively through fee-for-service (FFS). Dual members in the community in a non-CCI, non-COHS county had the option to enroll in managed care, though most members still received services through FFS. With limited exceptions, Non-Dual members in the community now participate in mandatory managed care. In a CCI county, where the State has expanded managed care to cover a wider range of LTSS, and in a COHS county, the alternative to PACE is primarily managed care; that is, Duals and Non-Duals participate in mandatory managed care programs that include many LTSS.

With the shift of institutionalized FFS members and Dual FFS members in non-COHS and non-CCI counties mandatorily enrolling in managed care in CY 2023, an adjustment was made to shift these members in the AWOP base data to managed care for purposes of AWOP rate development.

To develop the CY 2025 AWOP, Mercer utilized state fiscal year (SFY) 2022–2023 managed care and FFS data, adjusted for the populations and services covered by the PACE program.

Experienced-Based Rate Ranges Methodology

Actuarially sound PACE experience-based rate ranges for CY 2025 were developed in accordance with generally accepted actuarial principles and practices, consistent with the approach utilized by DHCS in developing reasonable, appropriate, and attainable capitation rates under Medi-Cal. To develop the rate ranges, Mercer collected claims and other data using a rate development template (RDT) at the category of aid (COA) and category of service (COS) level. The final rate ranges were

developed separately for each PO and county/county combination. Adjustments and credibility blending were applied as appropriate.

Separation of Capitation Rates into Federally Eligible Unsatisfactory Immigration Status and Satisfactory Immigration Status Populations

For CY 2025, separate PACE capitation rates were developed for beneficiaries with satisfactory immigration status (referred to as the SIS population) and beneficiaries with unsatisfactory immigration status (referred to as the UIS population). Additionally, for the UIS population, the capitation payment rates have been further split into the rates applicable for services eligible for federal match (namely, pregnancy-related and emergency services) and into rates applicable for services not eligible for federal match (non-pregnancy-related and non-emergency services).

For each rate cell, UIS acuity factors compared to the SIS population and a percentage of dollars for UIS members for pregnancy-related and emergency services were developed to separate capitation rates for the UIS and SIS populations, and further break the UIS population rates into federal and state-only components. Additional information regarding the factor and percentage development is detailed in Section 5 below.

The following sections describe the program, base data, and adjustments used to develop the experience-based rate ranges and the AWOP.

Section 4
AWOP Development

Identification of PACE Eligible Population

The population meeting the PACE eligibility criteria emerged from the institutional and
non-institutional populations who are nursing facility certifiable and aged 55 and older. These two broader groups (institutional and non-institutional) were further classified into Dual and Non-Dual, based on Medicare eligibility, for a total of four groups used to develop the CY 2025 AWOPs.

For the purpose of the AWOP development, the institutional members are defined as members with a long-term care (LTC) aid code or enrolled in a CCI plan with an institutional indicator in the eligibility file during the base data period.

The non-institutional or HCBS members retained for the AWOP development met at least one of the following conditions:

- Members enrolled in CCI and considered HCBS High
- In-Home Supportive Services (IHSS) users with a severely impaired designation
- Users of Community-Based Adult Services (CBAS)
- Members enrolled in the Multipurpose Senior Services Program (MSSP) waiver
- Members enrolled in the Assisted Living Waiver
- Members enrolled in the HCBS waiver

These populations serve as the basis for the PACE AWOP development.

Category Groupings

The base data sets used to develop the PACE AWOP were divided into initial population groups, which have inherently different levels of risk. The initial population groups for the CY 2025 AWOP are as follows:

- Institutional — Dual
- HCBS — Dual
- Institutional — Non-Dual
- HCBS — Non-Dual

Non-Dual members are defined as individuals with Medicare Part A Only or Part B Only or Medi-Cal Only coverage. Dual eligible members are individuals with Medicare Part A and Part B coverage.

AWOP Methodology

County level SFY 2022–2023 (July 2022–June 2023) FFS claims and plan-reported managed care RDT data were used to develop the base data for the CY 2025 AWOP. The FFS and managed care data sets are constructed and adjusted in parallel due to the varying considerations and resulting adjustments needed for each population, as described below. The resulting AWOP rate displayed and detailed in the capitation rate calculation sheet (CRCS) is a member-weighted mix of the FFS and managed care populations; the resulting administrative and underwriting gain load assumptions shown in the CRCS exhibits are a product of this, using the non-benefit load assumptions summarized below. A sample calculation using Los Angeles County as an example can be found on the [FFS and MC GME Data – LAN] tab of the accompanying spreadsheet *"CY 2025 PACE Additional Exhibits 2024 12.xlsx"*. When necessary, adjustments were made to the base data to match the covered population risk and benefit package for the CY 2025 period. These adjustments included the following:

- Completing FFS claims to account for incurred but not reported (IBNR)
- Adjusting plan-reported managed care data to reflect a PACE-like population
- Smoothing to correct for utilization and unit cost outliers

Additionally, the following adjustments were applied to the base data to obtain the final AWOPs:

- UIS acuity factors
- Prospective program changes
- Trend factors to project the expenditures and utilization to the contract period
- Acuity adjustment to HCBS members to reflect the frailty difference between the PACE population and the PACE-like population used to develop the AWOP
- Administration and underwriting gain loads

The projected base data was summarized to obtain the CY 2025 utilization per 1,000, unit cost, and per member per month (PMPM) by initial population group and COS. Lastly, for the Dual and Non-Dual populations, the resulting PMPMs for the institutional and HCBS populations were blended at 30% and 70%, respectively, to arrive at the CY 2025 AWOP. A breakout of SFY 2022–2023 member months by county and rate cell for the population covered by managed care versus FFS in the base data period can be found on the [Enrollment] tab of the accompanying spreadsheet "*CY 2025 PACE Additional Exhibits 2024 12.xlsx*". Further, corresponding with the HCBS Acuity adjustment detailed below, Mercer's analysis has shown that not all members meeting criteria to qualify for programs used in AWOP base data, such as IHSS, MSSP and CBAS, will meet PACE level of care (LOC) criteria. There is no standard NF LOC definition that spans across the various programs; therefore, the mix within the base data used for rate setting purposes is

likely skewed towards a higher mix of community members. Mercer has leveraged this, along with available historical experience, and actuarial judgement to arrive at a 30%/70% institutional/community assumption. As in prior years, this standard statewide assumption, across all rate cells, minimizes volatility, especially in smaller counties where the mix can vary materially year-to-year. A potential variation by region/area may be considered in the future.

AWOP Base Data Sources and Analysis

The SFY 2022–2023 Medi-Cal FFS and managed care claims for the four initial population groups were collected and segmented into the 20 COS shown in the table below. In addition to the Medicaid paid amount, the coinsurance amount, patient liability, and copayment amount were included in the base data such that the AWOP would include the full cost of providing State Plan services.

COS				
Inpatient Hospital	Physician Primary Care	Mental Health Outpatient	CBAS	Community Supports (CS)
Outpatient Facility	Physician Specialty	Pharmacy	Hospice	Enhanced Care Management (ECM)
Emergency Room	FQHC	Laboratory and Radiology	MSSP	HCBS Other
LTC	Other Medical Professional	Transportation	IHSS	All Other

These COS are consistent with the grouping used to develop the capitation rates for other Medi-Cal programs. Additional Medicaid covered services (such as pharmacy, MSSP, and dental) covered under FFS primarily were added to ensure the base data was complete and reflective of the services otherwise covered for a PACE member in the CY 2025 rating period.

Managed Care Claims

The SFY 2022–2023 time period was used in the development of the CY 2025 AWOP PACE base data. For the managed care population, both FFS claims and plan-reported RDT information were used to form the AWOP base. Specifically, the SPD-LTC and SPD-LTC/Full-Dual COA base from the Medi-Cal managed care program was leveraged as a starting point to form the AWOP managed care base. This was then adjusted by comparing encounters of the managed care population to encounters of the PACE-like population and applying the resulting factor to the plan-reported RDT information. Further, the managed care information was supplemented with FFS claims for services covered by FFS and not the managed

care delivery system, to make up the base for the managed care, PACE-like population.

Base Data Completion

For the FFS claims, IBNR was estimated and added to the base to reflect the fully incurred services and payments. The IBNR factors, provided on the [IBNR] tab of the accompanying spreadsheet "*CY 2025 PACE Additional Exhibits 2024 12.xlsx*", were built from the claims triangle reported by the managed care organizations (MCOs) as part of the data collected for managed care rate development. As the pure FFS data used in AWOP development is assumed to be more complete than the managed care data, it received 75% of the reported managed care adjustment.

With the approach of leveraging plan-reported RDT information, no further completion was necessary for the managed care paid portion of the base as plans were instructed to estimate IBNR to reflect fully incurred services and payments.

Non-Federal Share Costs in Designated Public Hospitals

The FFS claims for designated public hospitals (DPHs) in California are processed through a Certified Public Expenditures methodology in which the federal government covers the Federal share, and the county covers the non-federal share of costs. The FFS hospital claims in the base data contained only Federal share costs for DPHs, so adjustments to account for the non-federal share of costs for DPHs were included in the CY 2025 AWOP development. This impacts the FFS Non-Dual population only.

Data Smoothing

In certain situations, unit cost, or utilization data for certain counties and COS was deemed to be an outlier. In those situations, the unit cost or utilization was smoothed to be more reasonable. Reasonableness was based on comparison to other surrounding counties' data and actuarial judgement.

Third Party Liability

The base data was net of third party liability (TPL); therefore, TPL amounts were excluded from the base data pull.

Patient Liability/Share of Cost

The amount of patient liability was identified in the data and incorporated into the development of the AWOP base data. This was done to ensure that program changes and trend adjustments were applied to the total costs of services. The last step of the AWOP development process included removing the patient liability from the final gross AWOP.

Adjustments to Develop the AWOP

Once the base data was adjusted, the CY 2025 AWOP was obtained by applying the following components to the adjusted base data:

- Program changes (covered below with the experience-based rates methodology).
- Trend factors to project the expenditures and utilization to the contract period (covered below with the experience-based rates methodology).
- A 1.40 acuity adjustment factor was applied to the HCBS population to reflect the assumed frailty difference between the actual PACE-eligible population and the PACE-like population used to develop the AWOPs. As most HCBS programs under Medi-Cal used in the AWOP development do not require a member to meet NF LOC criteria (for example, IHSS is a personal care-like service, but is available through the State Plan), the only services whereby a member is required to be NF LOC in the same way as PACE are waiver programs. Further, not all MSSP members meet the same LOC criteria as PACE necessitating the application of the 1.40 acuity adjustment factor to bring the overall costs of the base population up to the levels of a HCBS population that better represent true NF LOC members eligible for PACE. Mercer intends to revisit this assumption, leveraging available data, and evaluate reasonableness on an ongoing basis.
- Administration and underwriting gain (not applied to FFS portion of the AWOP) loads (covered below with the experience-based rates narrative).

Section 5

Development of Experience-Based Rate Ranges

Base Data

The data and information used to form the base data for the PACE experience-based rate ranges was CY 2022 and CY 2023 PO-submitted RDT data and financial reporting. The CY 2022 and CY 2023 RDT data includes utilization and unit cost detail by rating group, county, and 19 consolidated provider types or COS, including:

- Inpatient Hospital
- Emergency Room
- Rehab Post-Acute Care Skilled Nursing Facility
- Outpatient Facility
- Laboratory, Radiology, and Diagnostics
- Pharmacy
- DME
- Physician Specialty Services
- Psychiatric and Behavioral Health Services
- Primary Care Services
- Other Medical Professional (Non-Physician)
- PACE Center Services
- Transportation
- Home Health
- In-Home Services
- Residential Care Services
- LTC (Custodial Skilled Nursing Facility)
- Dialysis
- All Other

Claims/expense experience for PACE Center Services was collected in the RDT separately, with additional detailed breakouts for Social Services, Routine Nursing, Recreational Therapy, Personal Care/Chore Services, Meals, Escort and Transportation, Nutritional Counseling, and Physical/Occupational/Speech Therapy. This data was reviewed for reasonableness and to provide confirmation that PACE Center Services were not included with other medical services/COS. For final base data development and all adjustments, PACE Center Services were consolidated into one COS.

The experience-based rates utilized a CY 2022 and CY 2023 base data period, applying a 50%/50% even weighting to either year. Credibility, as described below, was developed based on 24 months.

Where provided, utilization and unit cost information from the PO-specific RDT data was reviewed at the rating 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 rating group. Data reporting for utilization at the COS level continues to be challenging for the newer POs. In these cases, cost information at the total cost level was deemed more reliable than at the unit cost level.

Rate Category Groupings

The base data used to develop the PACE capitation rate ranges were divided into cohorts that represent consolidated rate groupings, which inherently represent differing levels of risk due to payment for Medicare covered services. Rate ranges are developed for two different cohorts:

- Non-Duals (includes Medicare Part A Only, Medicare Part B Only, and Medi-Cal Only members)
- Duals (members covered by Medicare Parts A and B)

Medi-Cal versus Medicare Cost Distribution

Each PO was asked to provide an actual distribution, or an allocation estimate of the percentage of costs, by COS and rating category, that were the responsibility of Medi-Cal. It was assumed that Medicare would be responsible for the remainder of the cost and the provided Medi-Cal cost distribution percentages can therefore be applied to the total reported costs for dual eligible members' experience.

The reported Medi-Cal allocations were reviewed for reasonableness and consistency across POs. Where necessary, a reasonable estimation of Medi-Cal's percentage of costs was developed based on reporting by other POs.

Credibility Blending and Regional Base Data

POs vary in size, as well as in years of operation. Due to this, a credibility blending methodology was used for those POs that were not deemed fully credible. Full credibility was defined to be 18,000 member months.

Similar to prior cycles of experience-based rate setting, POs who are not fully credible will receive a credibility-weighted base data. Historically, this comprised of a weighting on their own experience and experience from a PO in the same or neighboring county. New to CY 2025 PACE experience-based rate setting, the latter was replaced by a regional base. For each PO, a PO-specific geographic adjustment factor was also applied to recognize cost differences within a region[2].

The regions for the new regional base are as follows: Bay Area, North Non-Coastal, South Non-Coastal, and SoCal. Appendix A outlines these four regions and the counties within each. PO counties were grouped based on geographical proximity and market characteristics and then used to develop a regional rate. This change is a refinement to the process as the PACE market grows and there is now enough PACE experience to contribute to a regional base.

New PO Adjustment

To account for the assumed somewhat relatively higher acuity and operational costs in a new PACE center, Mercer applied a “New PO factor” to POs in operation for less than two years. This factor begins at 3.0% for POs starting in CY 2025 and decreases to 1.5% at the start of the second year of operation, prorated as necessary. For example, POs beginning July 1, 2024, received a 2.25% increase for CY 2025, the average of the first- and second-year factors, 3.0% and 1.5%. This adjustment factor was applied to the final rate, after credibility blending and across all COS. Mercer developed this factor by comparing available PO encounter data and PO-submitted RDT data for plans that became effective within the past three years.

Other Adjustments

A 4% increase was applied to the gross medical expense (GME), prior to the application of admin and underwriting gain loads, for the following POs to mitigate rate shock due to the updated base data methodology:

- Concerto Health (Los Angeles)
- myPlace Health (Los Angeles)
- Family Health Care Network (Kings, Tulare)
- North East Medical Services (San Francisco)
- Redwood Coast (Humboldt)

For the first four POs above, given they are newer to the PACE program, their experience was not used in the development of their base for both CY 2024 and CY 2025 rates. Any large swings in their rate would solely be due to the change in methodology to use a regional base.

[2] The geographic adjustment factors used to adjust the regional rate leveraged multiple sources, including cost-of-living, wage data from the Bureau of Labor Statistics (BLS), Medicare Hospital Wages, and CMS Medicare Physician Geographic Cost Factor (GCF).

Section 6

Components of Development that Apply to Both AWOPs and Experience-Based Rate Ranges

UIS Acuity Factor and Federal Percentage Development

As briefly described in Section 2, separate PACE capitation rates were developed for the SIS and UIS populations. To establish separate payment rates, SIS and UIS-specific experience-based rates as well as AWOPs were developed. The acuity factors and percentages of pregnancy-related and emergency services applied do not vary in the experience-based and AWOP development process.

UIS Acuity Factor Compared to the SIS Population

Analysis of RDT information specific to the SIS and UIS populations concluded the acuity of members for these two populations were not materially different therefore, the aggregate UIS rates (across federally eligible and state-only services) are equal to the SIS rates.

Percentage of Dollars for UIS Members for Pregnancy-Related and Emergency Services

As noted previously, only pregnancy-related and emergency services have been confirmed as eligible for federal match for the UIS population. As a result, it was necessary to estimate the percentage of PMPM spend for services that are pregnancy-related or emergency specific to the UIS population. Given the age demographic of the PACE population, it was assumed that little to no pregnancy-related services would be rendered in the PACE program. As such, the UIS Federal percentage applied to the UIS population only represents emergency services. Leveraging COA and COS-specific managed care emergency percentages, the resulting Federal share (3.0% for the Dual population; 11.0% for the Non-Dual population) was aggregated by PACE-specific COS mix and applied uniformly across all COS.

Trend

Trend is an estimate of the change in the overall cost of medical services over a finite period. Trend factors are necessary to estimate the expenses of providing health care services in a future period. As part of the CY 2025 AWOP and rate range development for the PACE 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 RDT data, PO financial statements, Medi-Cal MCO trend data, Medi-Cal FFS experience, Consumer Price Index, National Health Expenditures updates and multiple industry trend reports such as the CMS Medicaid actuarial report[3]. Each of these data and information sources has strengths and challenges, and those strengths and challenges may change over time. Hence, no one, or combination of data and information source(s), was utilized within a prescribed formula. Rather, each was reviewed for its potential applicability and utilized collectively with other data and information via actuarial judgement in order to inform the final trends.

The overarching trend development approach remains consistent with the Medi-Cal managed care program as well as prior rate periods as a combination of “top down” and “bottom up” claim cost trend development. Mercer, as part of the Medi-Cal managed care program’s trend development, conducted historical annual trend calculations to inform directional changes of emerging trends for consolidated service categories at the major COA level. To the extent the emerging trends, along with the host of data and information described above, indicated a material increase or decrease of service utilization or unit cost; Mercer adjusted the trends established in the prior year’s rates incrementally as the new trends for the current rates in order to reflect the directional changes. This is also referenced as a “change in the change” approach for the purpose of continuity of trend assumptions between different rating periods. In addition to “bottom up” claim cost trend analysis, a considerable amount of actuarial judgement was used in the final trend development based upon Mercer’s longstanding Medi-Cal specific program knowledge and extensive experience in working with the majority of the largest Medicaid programs in the country. These trends, developed for the Medi-Cal managed care program, are seen as appropriate for use in both PACE experience-based rate range and AWOP development. Where service categories, such as PACE Center Services and Pharmacy, are not applicable to the Medi-Cal managed care program but are pertinent to PACE rate development, the same overarching trend development approach as described was used.

Effective October 16, 2024, California Senate Bill (SB) 525 established an increased minimum wage schedule for covered healthcare employees, varying based on the employer's size and entity type. Many covered employers will be required to pay covered employees $25.00 per hour by June 2026, though the minimum wage schedule is tiered by employer entity type and increases over multiple years beyond CY 2025. An adjustment for SB 525 was incorporated into the prospective unit cost trend assumption, varying by service category to reflect the specific workforce composition.

Specific to the trends applied to the PACE experience-based rates, the Targeted Rate Increase (TRI) fee schedule, which MCOs (but not PACE organizations) must adhere to when paying their providers, was also considered in the development of trends for the experience-based rates.

[3] https://www.cms.gov/files/document/2018-report.pdf

Note that new to the CY 2025 rates, the ECM and CS COS's are only present in the AWOP development. The trends used in rate development for the ECM and CS service categories are reflective of strong expected growth in service experience and like all other service categories, are consistent with those selected in the mainstream managed care rate development.

For the experience-based rate ranges, the CY 2022 and CY 2023 base data was trended forward 30 months to the mid-point of CY 2025 with POs starting July 1, 2025 receiving an additional three months of trend. The SFY 2022–2023 AWOP base was membership-weighted and trended 30 months to the mid-point of CY 2025.

The claim cost trend range component is +/- 0.25% per year for each of the utilization and unit cost components. The upper bound trend was applied in the development of the AWOPs.

The specific lower bound trend levels by utilization and unit cost for the 19 COS are displayed in columns (G) and (H) of the experience-based CRCS, respectively. These annual trend figures are applied for the number of months represented in the time periods section in the upper right corner of the CRCS. The number of trend months is determined by comparing the mid-point of the modeled CY 2022 to CY 2023 base period to the mid-point of the rating period, CY 2025.

Annual lower bound claim cost trends, across all COS range (varying by PO) from 3.0% to 4.2% for Duals and 4.0% to 4.6% for Non-Duals on a PMPM basis. For the AWOPs, upper bound claim cost trends were used and across all COS range (varying by AWOP) from 1.0% to 1.7% for Duals and 2.9% to 3.6% for Non-Duals on a PMPM basis (Institutional and HCBS combined). Note the trend figures exclude unit cost changes associated with the program changes listed below.

Program Changes

Program change adjustments recognize the impact of benefit, eligibility, and/or reimbursement changes that have become effective since the beginning of the base period or will become effective by the end of the contract period. The program changes incorporated in the development of the rates were based on information provided by DHCS staff. The following program changes were accounted for in the development of the CY 2025 AWOP and capitation rates:

- **LTC Rate Increase —** This increase to LTC and NF unit costs accounts for rate increases to assembly bill (AB) 1629 facilities and other LTC facilities. LTC program changes are based on the historical increases of LTC daily rates and the projected increase for CY 2025. The county-specific percentage program change is calculated by comparing the average cost level in the respective experience-based (CY 2022 and CY 2023) and AWOP (SFY 2022–2023) base data periods to the contract period (CY 2025).
- **IHSS Wage Increase —** The IHSS wage increase is an increase to unit costs for the Personal Care COS from the base period to CY 2025 wage levels. The

county-specific program change was developed by comparing the average IHSS hourly rate in the respective base data periods to the projected average hourly rate in the contract period. As Medicare does not cover IHSS services, the change in hourly rate affects both the Non-Dual and Full-Dual populations.

- **Hospice Rate Increase —** The hospice adjustment considers annual rate increases to hospice services and room and board. An adjustment was applied to all populations, consistent with the managed care rates. In general, managed care payment levels have aligned closely with FFS payment levels for these services and it was deemed reasonable and appropriate to use the FFS rate increases in the managed care rate setting process. There are two components to the Hospice rate increase; the rate increases for Hospice services that occur on October 1 of each year, and the rate increases for Hospice room and board that occur on August 1 of each year. To calculate the adjustment factor applied in the capitation rates, the rate increases for Hospice services are weighted with the rate increases for Hospice room and board. In addition, SB 525 was considered in the development of the adjustment. Two adjustment factors are developed at a statewide level across Non-Dual and Dual populations.
- **Part A Buy-in —** Effective January 1, 2025, DHCS will pay the Medicare Part A premium for eligible Medicaid beneficiaries. Upon this change, the eligibility information for the qualified members within the non-Dual rate cell will become reflective of the Full-Dual rate cell characteristics. This adjustment is to account for the movement of members from Non-Dual to Full-Dual, as well as the reduction in costs associated with these members that will now be covered by Medicare Part A. Eligibility data from the SFY 2023-2024 time period was used to develop member month impacts for members switching out of Non-Dual to Full-Dual rate cells. Cost relativities (based on SFY 2023-2024 encounter data for AWOPs and CY 2022-2023 RDT data for experience-based rates) were used to calculate the PMPM impacts of removing these members from the Non-Dual rate cell. Further, these membership impacts and cost relativities were then used to calculate the PMPM impacts of adding these members to the Full-Dual rate cell, while applying reductions to Medicare Part A covered services consistent with the new benefit coverage these members will have.

While POs are not required to pay at FFS levels for LTC, hospice, or personal care, Mercer believes the program change adjustments developed for the AWOP are reasonable approximations of upward cost pressures for similar services provided by the POs.

The program changes outlined below apply to one or both the Medi-Cal managed care and FFS programs and therefore were included in the development of the AWOPs:

- **SB 523 and AB 1705 Ground Emergency Medical Transportation (GEMT) —** SB 523 established the GEMT Quality Assurance Fee (QAF) program, which provides for an annual GEMT QAF rate that will be imposed on each emergency medical transport provided by each non-public GEMT provider subject

to the QAF. The QAF collected will be used to provide increased reimbursement in the form of an add-on to the FFS fee schedule rate for the appropriate billing codes. AB 1705 established the Public Provider GEMT (PP-GEMT) program resulting in a per trip rate increase for public GEMT providers. Both State law (Welfare & Institutions Code 14129.3[b]) and approved SPAs establish the combination of the State's FFS fee schedule rates and the add-on payments constitute the Rogers rates MCOs must pay to non-contracted GEMT providers serving Medi-Cal managed care enrollees for those years in which the GEMT add-on is effective. The amount included in the AWOP was consistent with rate setting for other Medi-Cal programs.

- **Community Health Worker (CHW) —** Effective July 1, 2022, CHWs were an addition to the group of skilled and trained individuals who are able to provide clinically appropriate Medi-Cal covered benefits and services to Medi-Cal beneficiaries. Further, effective January 1, 2023, CHWs were also allowed to be reimbursed for asthma remediation services and violence prevention services. This benefit is available in the managed care delivery system and the impact of this program change is quantified by identifying potential CHW utilizers and leveraging research on CHW staffing. The expected program change adjustment for CHW was reduced from the adjustment applied in prior years as initial CHW experience was reviewed and the ramp up of this benefit is lower than was originally anticipated. As such, the expected ramp up of this benefit was revised downwards.
- **Recent Experience Review —** This adjustment accounts for anticipated changes in existing utilization and costs due to contracting changes related to the CY 2024 procurement. This was built into the Medi-Cal managed care portion of the AWOPs consistent with its development and application within the CY 2025 Medi-Cal managed care capitation rates.
- **Targeted Rate Increase —** This was built into the Medi-Cal managed care portion of the AWOPs consistent with its development and application within the CY 2025 Medi-Cal managed care capitation rates.

  Pursuant to the 2023 Budget Act and AB 118, the State established a minimum fee schedule directed payment for select primary care services, obstetrics services, and non-specialty mental health (MH) services. The State aims to create a new fee schedule that will supersede the current FFS rates for select procedure codes and that will be "87.5% of the lowest maximum allowance established by the federal Medicare Program for the same or similar services or the level of reimbursement, as specified".

  For the select primary care services, the increase will only be applicable to the following providers:

  A. Physicians

  B. Physician Assistants

C. Nurse Practitioners

D. Podiatrists

E. Certified Nurse Midwife

F. Licensed Midwives

G. Doula Providers

H. Psychologists

I. Licensed Professional Clinical Counselor

J. Licensed Clinical Social Worker

K. Marriage and Family Therapist

For select obstetric and non-specialty MH services, the increase is applicable to all providers. The Proposition 56 physician supplemental payment previously developed as a PMPM add-on is now included within this adjustment.

The development of the rate impact of this policy change leveraged SFY 2021–2022 encounter data at the detailed claim line level with the applicable procedure codes. The data was then limited to the applicable providers subject to the directed payment, as noted above.

For Non-Dual or Part A only non-capitated claims, the targeted rate increase for each claim detail line was assumed to be the difference between the targeted rate and the current managed care payment level per each detailed claim line. For capitated claims, sub-capitation information for these encounters was collected from the managed care plans by rating region and sub-capitated contractor. Plans then benchmarked their contract costs against the applicable Medi-Cal fee schedule during the base period. These assumptions were then audited, and the targeted rate increase for each claim detail line was then assumed to be the difference between the targeted rate and the projected sub-capitated paid amount per each detailed claim line.

For Full-Dual or Part B only claims, the targeted rate increase per procedure code was assumed to be the unit cost increase above 80% of the corresponding Medicare fee schedule amount. This methodology reflects the current payment arrangement where MCOs are responsible for paying the difference between the State Plan fee schedule and the Medicare reimbursement amount, which itself is usually 80% of the Medicare fee schedule.

Disproportionate Share Hospital, Graduate Medical Education, and Indirect Medical Education Payments

The expenditure and utilization data did not include Disproportionate Share Hospital (DSH), Graduate Medical Education (GME) or Indirect Medical Education (IME) payments. The State processes DSH, GME, and IME payments outside the PACE

contract. Therefore, these payments are not part of the AWOP or capitation rate development process.

Administration

The administration loads for the POs were developed in aggregate across all rate groupings. This factor is expressed as a percentage of the capitation rate (i.e., percent of premium). For the experience-based rate ranges, this mid-point percentage was developed from a review of the POs' historical reported administrative expenses, which are submitted as part of their attested RDTs on an annual basis. The administrative costs are reviewed to ensure they are appropriate and reasonable for the Medicaid eligible PACE members. Mercer also utilized its experience and professional judgment in determining the mid-point and lower/upper bound percentages to be reasonable. Similar to CY 2024, the mid-point administration load was established at 12% across all POs. The range for the administrative component is +/- 3% at the lower/upper bounds from the mid-point value. This PACE wider range reflects the unique nature of POs in terms of member size and operating model, as well as a wide range of actual PO results.

The AWOPs were developed to include a provision for the State's administrative costs for the FFS portion of the base data. Similarly, an appropriate managed care factor was included for the managed care portion of the base. FFS also includes a 2.0% load factor (as a percent of the total AWOP) to reflect the State's administrative costs. Managed care administrative costs across all counties were assumed to be between 4.1% and 5.9%, consistent with other capitated rate setting assumptions for similar populations under Medi-Cal at the upper bound.

The application of the administrative PMPM and percentages can be found in the bottom right corner of the CRCS.

Underwriting Gain

For experienced-based rate setting, the underwriting gain range was established across all POs at 2.0% (lower bound), 2.5% (mid-point), and 3.0% (upper bound). For AWOP rate setting, consistent with assumptions implemented in managed care rates, the underwriting gain range is 2.0% (lower bound), 3.0% (mid-point), and 4.0% (upper bound), with the development of the AWOP load using the upper bound. Mercer has implicitly and broadly considered the cost of capital within the rating assumptions. Mercer's conclusion is that assumptions surrounding underwriting gain, as well as the income a PO generates from investments, are sufficient to cover at least minimum cost of capital needs for the typical PO.

A managed care underwriting gain is applied to the AWOP only for the portion of base data derived from managed care data. That is, no underwriting gain was applied to FFS.

Incentive Arrangements

There are no PO incentive arrangements in place.

Rate Ranges

To assist DHCS during its rate discussions with each PO, Mercer provides DHCS rate ranges for the experience-based rates developed using an actuarially sound process. The 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 gain loading percentage to arrive at both a lower/upper bound capitation rate. The final contracted rates selected by DHCS and paid to each PO fall within the rate ranges provided by Mercer and below the AWOP.

Section 7

Rate and Rate Range Certification

In preparing the AWOPs and rate ranges described, Mercer has used and relied upon enrollment, eligibility, claim, reimbursement level benefit design, financial data and information supplied by DHCS, its POs and its vendors. DHCS, its POs and its vendors are solely responsible for the validity and completeness of this supplied data and information. Mercer has reviewed the summarized data and information for internal consistency and reasonableness, but we did not audit it. In Mercer's opinion, it is appropriate for the intended rate-setting purposes. However, if the data and information are incomplete or inaccurate, the values shown in this report and associated exhibits may differ significantly from values that would be obtained with accurate and complete information; this may require a later revision to this report.

Because modeling all aspects of a situation or scenario is not possible or practical, Mercer may use summary information, estimates, or simplifications of calculations to facilitate the modeling of future events in an efficient and cost-effective manner. Mercer may also exclude factors or data that are immaterial in our judgment. Use of such simplifying techniques does not in our judgment, affect the reasonableness, appropriateness, or attainability of the results for the Medicaid program. Actuarial assumptions may also be changed from one certification period to the next because of changes in mandated requirements, program experience, changes in expectations about the future and other factors. A change in assumptions is not an indication that prior assumptions were unreasonable, inappropriate, or unattainable when they were made.

Mercer certifies that the PACE model rate ranges for the CY 2025 time period, January 1, 2025 through December 31, 2025, 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.

AWOPs and rate ranges developed by Mercer are actuarial projections of future contingent events. All estimates are based upon the information and data available at a point in time and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely, and potentially wide, range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use. Actual PO costs will differ from these projections. Mercer has developed these rates and rate ranges on behalf of DHCS to demonstrate compliance with the CMS requirements identified in the CMS PACE Medicaid Capitation Rate Setting Guide and are appropriate for the populations and services covered under the PACE

program. Use of these rates and rate ranges for any purpose beyond that stated may not be appropriate.

POs are advised that the use of these rates and rate ranges may not be appropriate for their particular circumstance, and Mercer disclaims any responsibility for the use of these rate ranges by POs for any purpose. Mercer recommends that any PO 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.

DHCS understands that Mercer is not engaged in the practice of law, or in providing advice on taxation matters. This certification letter, which may include commenting on legal or taxation issues or regulations, does not constitute and is not a substitute for legal or taxation advice. Accordingly, Mercer recommends that DHCS secures the advice of competent legal and taxation counsel with respect to any legal or taxation matters related to this report or otherwise.

This certification letter assumes the reader is familiar with PACE and the Medi-Cal program, PACE and Medi-Cal eligibility rules and actuarial rating techniques. It has been prepared exclusively 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. Mercer is not responsible for, and expressly disclaims liability for, any reliance on this report by third parties.

DHCS agrees to notify Mercer within 30 days of receipt of this report if it disagrees with anything contained in this report or is aware of any information or data that would affect the results of this report that has not been communicated or provided to Mercer or incorporated herein. The report will be deemed final and acceptable to DHCS if nothing is received by Mercer within such 30-day period. If there are any question regarding this report, please contact Ethel Tan at [redacted].

Sincerely,

[redacted]

Ethel Tan, ASA, MAAA
Senior Associate

Copy:

David Bishop, DHCS
Daniel Thorne, DHCS
Brandon Lee, DHCS
Sadikshya Pandey, DHCS
Jon Jolley, Mercer
Branch McNeal, Mercer
Stacey Luong, Mercer
James Moore, Mercer

Lisa Volek, Mercer

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

Mercer

Geographic Region Groupings

Region	County
Bay Area	Alameda Contra Costa Marin Napa San Francisco Santa Clara Solano Sonoma
N. Non-Coastal	El Dorado Humboldt Merced Placer Sacramento San Joaquin Stanislaus Sutter Yuba
S. Non-Coastal	Fresno Imperial Kern Kings Madera Riverside San Bernardino Tulare
SoCal	Los Angeles Orange San Diego