Mercer

Government Human Services Consulting

AIDS Healthcare Foundation

Capitation Rate Development and Certification

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

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A business of Marsh McLennan

Contents

Section 1

Executive Summary

The State of California Department of Healthcare Services (DHCS) contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to develop actuarially sound internal capitation rate ranges, and to certify to final contracted capitation rates for the AIDS Healthcare Foundation (AHF) for rating period of January 1, 2022 through December 31, 2022 (CY 2022).

This report describes the rate development process and provides the certification of actuarial soundness required by 42 CFR §438.4. This report was developed to provide the requisite rate documentation to DHCS and to support the rate review process performed by the Centers for Medicare & Medicaid Services (CMS). This report follows the general outline of the CMS 2021–2022 Medicaid Managed Care Rate Development Guide dated June 2021, which is the applicable version of the guide for CY 2022. The rate development process included the historical practice of developing rate ranges. However, the actuaries are certifying to a final rate within the developed rate ranges as federally required.

Actuarially sound is being defined by Mercer as follows: Medicaid capitation rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected capitation rates, and other revenue sources provide for all reasonable, appropriate, and attainable costs. For the purpose 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, cost of capital, and government mandated assessments, fees, and taxes.

Multiple attachments are included as part of this rate certification package. These attachments include summaries of the CY 2022 capitation rates (including the final and certified capitation rates), capitation rate calculation sheet (CRCS) exhibits, and stand-alone methodology documents, which provide more detail around various rate setting components. These attachments are referenced throughout the body of this report. The final capitation rates can be found in the attached file titled *CY 2022 AIDS Healthcare Foundation Rates 2021 12.xlsm.*

Mercer has not trended forward the previous year's rates, but has done a comprehensive exercise of rebasing using more recent program experience. The rebasing means rates for various groups do not always move similarly, even with similar trend forces operating on them. The new base may emerge differently than expected in the prior year's rate development.

Beginning with the CY 2022 rating period, some significant changes within the Medi-Cal program will occur. Highlights of these changes include the implementation of multiple aspects of the California Advancing and Innovating Medi-Cal (CalAIM) proposal, which is a multi-year initiative by DHCS to improve the quality of life and health outcomes for the Medi-Cal population. Multiple components of this initiative are addressed throughout the

body of this report. Another significant change is the decision to carve retail pharmacy out of the managed care program effective January 1, 2022. Other changes are also effective during the CY 2022 rating period, all of which are described later in this report.

There will be two different sets of capitation rates applicable for CY 2022, since Proposition 56 (Prop 56) budget appropriations end for the value based purchasing program effective June 30, 2022. As a result, the value based purchasing per member per month (PMPM) add-on is applicable for the first six months of CY 2022 and not effective for the second six months of CY 2022. The certified rates differ for the two time periods due to this, with all other rating elements unchanged.

The following are the effective dates of each rate add-on:

Prop 56 Physician — January 2022 to December 2022

Prop 56 Trauma Screening — January 2022 to December 2022

Prop 56 Family Planning — January 2022 to December 2022

Prop 56 Value-Based Payment (VBP) — January 2022 to June 2022

Pass Through Hospital Quality Assurance Fee (HQAF) — January 2022 to December 2022

Martin Luther King, Jr Hospital (MLK) Pass-through Payments — January 2022 to December 2022

Major Organ Transplant (MOT) — January 2022 to December 2022

Enhanced Care Management (ECM) — January 2022 to December 2022

Throughout the full 12-month rating period, the base plan-specific capitation rates (before the application of add-ons) are the same for the entire 12-month period.

It should also be noted there may be a future amendment to this certification that will be submitted to CMS. Certain assumptions material to the rates in this certification depend on the status of the public health emergency (PHE). This rate certification assumes the PHE will conclude on December 31, 2021. A future amendment may be submitted to CMS if there are material impacts to the program due to the length of the PHE.

In addition, California provides full scope coverage to beneficiaries with unsatisfactory immigration status, referred to as the UIS population. UIS members are eligible to receive the same State Plan services as members with satisfactory immigration status (SIS). These UIS members are federally eligible to receive pregnancy and emergency related services. Capitation rates within this certification are set across the entire enrolled population, within which the UIS and SIS members are embedded together. Through communications with CMS, it has come to DHCS and Mercer's attention that these members should be separated from the population with SIS for capitation rate development purposes. If the removal of members and/or services ineligible for full scope federal funding has a material impact on these capitation rates, an amendment will be submitted accordingly.

Section 2

General Information

This section provides a brief overview of California's AHF managed care programs and an overview of the rate setting process, including the following elements:

- Program history
- Managed care organization (MCO) participation
- Covered services
- Covered populations
- Rate structure
- Federal Medical Assistance Percentage (FMAP)
- Rate methodology overview

The information provided in this section should be supplemented with the MCO contract information for additional detail.

Program History

AHF contracts with DHCS to provide covered health care services for its eligible members who are at least 21 years old and who have ever had a diagnosis of stage 3 human immunodeficiency virus (HIV) infection, also known as acquired immunodeficiency syndrome (AIDS). AHF receives a capitation payment from DHCS for the services provided.

This document describes the methodology and major steps used in the development of AHF's Medi-Cal capitation rates. Medi-Cal capitation rates for AHF's eligible members were developed in accordance with the rate-setting guidelines established by CMS.

DHCS will offer actuarially sound final payment rates to AHF. AHF has the opportunity and responsibility to independently review the rates offered by DHCS and to determine whether the rates are acceptable based on their individual financial requirements.

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

The rate development examined those enrolled AHF members without full Medicare coverage (AIDS Non-Dual) and those with full Medicare coverage (AIDS Full-Dual). The rate development process reflects the impact of State legislated policy changes implemented by DHCS and other Medi-Cal benefit changes that are not fully reflected in the base data.

Covered Services

Generally, services covered through the contract with AHF are consistent with those covered under the underlying Two-Plan model. As in the Two-Plan model, all pharmacy drugs have

been carved out to fee-for-service (FFS) including approved AIDS prescription drugs. Notable services carved out of the AHF managed care program include the following:

- Specialty mental health (MH) services (including in patient [IP] and outpatient [OP] behavioral health [BH] services, with exceptions noted below):
  - Alcohol and substance use disorder treatment services.
  - Home- and Community-Based Services (HCBS) (with the exception of community-based adult services [CBAS] in all counties).
  - Dental services (except medically necessary Federally Required Adult Dental Services and fluoride varnish dental services that may be performed by a medical professional) are carved out.
  - Administration of Coronavirus Disease 2019 (COVID-19) vaccines.
- Effective January 1, 2022, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim: covered OP drugs, including physician administered drugs, medical supplies, and enteral nutritional products.

As part of the aforementioned CalAIM initiative, there are three major benefit/service changes effective January 1, 2022. These include the following:

- MOT services
- ECM services
- 14 Community Supports services are now allowable in the managed care contracts as “in lieu of” services (ILOS) in accordance with 42 CFR §438.3(e)

Additional benefit changes effective during the CY 2022 rating period are the following:

- Doula services
- Dyadic Health Care (DHC) services
- Rapid Whole Genome Sequencing (rWGS)
- Community Health Worker (CHW)

Covered Populations

AHF contracts with DHCS to provide covered health care services for its eligible members who are at least 21 years old and who have ever had a diagnosis of stage 3 HIV infection and who voluntarily enroll in the program.

As part of the CalAIM initiative, various additional populations will become enrolled in managed care effective January 1, 2022, who were previously enrolled in FFS. These populations are listed below.

- Individuals with other health coverage
- Individuals residing in certain rural zip codes

- Trafficking and Crime Victims Assistance Program (TCVAP)
- Individuals participating in accelerated enrollment (AE)
- Child Health and Disability Prevention Infant Deeming (CHDPI)
- Pregnancy-related Medi-Cal

Also through the CalAIM initiative, beneficiaries in Coordinated Care Initiative (CCI) counties with share of cost (excluding long-term care [LTC] aid code members) will be disenrolled from managed care. These beneficiaries will receive coverage through the FFS delivery system.

Additionally, the State will enroll members age 50 and above without SIS into managed care. Additional details on the transitioning populations can be found in the “Program Changes” section of this report.

Each of these populations were analyzed to identify potentially transitioning members, and ultimately, it was found that the impact of these initiatives would be minimal. Therefore, no rate impact was applied for AHF.

Rate Structure

Because of the inherent risk for all members covered under the program, rate ranges are developed for only two categories of aid (COA) based on Medicare eligibility, AIDS Non-Dual and AIDS Full-Dual.

The capitation rates include all services covered under the managed care contract, with the exception of services specific to those covered under the supplemental payments (Hepatitis C and Maternity). Services specific to the supplemental payments are carved out of the monthly capitation rates and reimbursed to AHF only when applicable members meet the criteria in order for AHF to receive a supplemental payment. More detail on the supplemental payment is provided later in this certification letter.

Federal Medical Assistance Percentage

Depending on the Medicaid managed care program, some services or populations may be subject to a different FMAP than the regular California FMAP. Recognizing this, CMS expects the signing actuary to indicate the proportions or amounts of the costs subject to a different FMAP and show this information. If there are proposed differences among the capitation rates to covered populations, CMS requires valid rate development standards are applied and are not based on the rate of FMAP associated with the covered populations. This subsection addresses these FMAP concerns from CMS.

The rates certified in this report include coverage of several populations that receive higher FMAP than the regular FMAP received for most populations.

In particular, populations that receive a higher FMAP than the regular FMAP include the Breast and Cervical Cancer Treatment Program (BCCTP) population who meet federal standards, and the Affordable Care Act (ACA) Expansion population. For CY 2022, the

BCCTP populations receive 65% FMAP. For CY 2022, the ACA Expansion population receives 90%.

The implementation of the Families First Coronavirus Response Act (H.R. 6021) provides a temporary 6.2 percentage point increase for certain populations effective January 1, 2020, and extending through the last day of the calendar quarter in which the PHE, declared by the Secretary of Health and Human Services for COVID-19, including any extensions, terminates. The 6.2 point increased FMAP percentage applies to the standard 50% FMAP, and smaller increases apply to the BCCTP population FMAPs.

Rates are developed for each population based on expected cost and homogeneity of risk. The FMAP for each population is not taken into account and is not a consideration. Non-benefit costs are developed using a method that does not consider FMAP for different populations. This includes the provision for underwriting gain.

In addition to the populations that receive enhanced FMAP, there are services for which the State receives a different FMAP than the regular FMAP, which applies on a population basis. Those services include, but are not limited to, family planning, for which the FMAP is 90%, and adult preventive services, which earns an additional 1% pursuant to section 4106(b) of the ACA. Mercer and DHCS prepare separate memoranda that describe and document the process for estimating the proportion of the capitation rate subject to these different FMAPs.

Rate Methodology Overview

Capitation rates for the AHF managed care program were developed in accordance with rate-setting guidelines established by CMS. As noted previously, the actuary continued the historical practice of rate range development for the AHF program. However, the actuary is certifying to a rate within the developed rate range.

For rate range development for the AHF population, Mercer utilized various data elements: CY 2019 AHF-reported encounter data, CY 2019 and CY 2020 rate development template (RDT) data, and other ad hoc claims data reported by DHCS and AHF. The most recently available Medi-Cal specific financial reports submitted to the California Department of Managed Health Care at the time the rate ranges were determined were also considered in the rate range development process.

The RDT data used in the development of the rate ranges is data collected from AHF. The data requested from AHF is completed at the level of detail needed for rate setting purposes, which includes AHF membership, medical utilization, and medical cost data for the two most recent base data years (CY 2019 and CY 2020 for the CY 2022 rate ranges) by COA group and by category of service (COS).

Adjustments were made to the selected base data to match the covered population risk and the State Plan approved benefit package for CY 2022. 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.
- The addition of any FFS claims for IP, related hospital facility services that are the contractual responsibility of AHF beginning July 1, 2019.

- Trend factors to forecast the expenditures and utilization to the rating period.
- Administration and underwriting gain loading.
- Further, DHCS takes additional steps in the measured matching of payment to risk:
  - Application of a maternity supplemental payment.

The above approach has been utilized in the development of the rate range for CY 2022 AHF program to be consistent, where applicable, with rate setting under other Medi-Cal program models. DHCS will offer the final certified rate within the actuarially sound rate range as developed by the actuary. AHF has the opportunity and responsibility to independently review the rates offered by DHCS and to determine whether the rates are acceptable based on their individual financial requirements.

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

Medical Loss Ratio

Mercer confirms the capitation rate development process and resulting rates, as outlined in this certification and supporting documentation, are reasonable, appropriate, and attainable and MCOs are assumed to reasonably achieve medical loss ratio (MLR) greater than 85%.

The State has chosen to not impose remittance provisions related to this MLR for CY 2022.

Rate Ranges

To assist DHCS during its rate discussions with AHF, Mercer provides DHCS with rate ranges developed using an actuarially sound process. The COA-specific rate ranges were developed using appropriate actuarial considerations to arrive at both a lower and upper bound rate. To the extent the final contracted rates fall within the bounds of the Mercer rate ranges, the contracted rates will be determined actuarially sound and certified as such. Mercer is certifying the contracted rates and not the rate ranges.

The lower and upper bounds of the rate ranges are developed by varying certain assumptions throughout the rate development process. Once the “best estimate” assumptions are determined, the assumptions are then varied by an appropriate amount to reflect a degree of uncertainty and the potential for variability in actual results by MCO. The total variation produced by the varied assumptions is reviewed for reasonableness to ensure the final rate ranges represent reasonable, appropriate, and attainable rates for the covered populations during the rating period.

Section 3
Data

Base Data

The information used to form the base data for the AHF rate range development was 24 months of encounter and FFS data, and requested AHF RDT and Supplemental Data Request (SDR) data.

The base data elements included utilization and unit cost by the following consolidated provider types or COS, including:

- IP Hospital
- OP Facility
- Emergency Room (ER)
- LTC
- Primary Care Physician (PCP)
- Specialty Physician
- Federally Qualified Health Center (FQHC)
- Other Medical Professional
- MH–OP
- Behavioral Health Treatment Services
- Pharmacy
- Laboratory and Radiology
- Transportation
- CBAS
- Hospice
- Multipurpose Senior Services Program
- In-Home Supportive Services
- Other HCBS
- All Other

Utilization and unit cost information from the appropriate base data elements, as referenced above, was reviewed at the COS detail level for reasonability.

CY 2019 and CY 2020 served as the 24-month base data period. All selected base data was adjusted (as appropriate) to reflect the impact of historical program changes within this period. This is discussed further in the program changes section.

The data utilized was AHF data that did not include any disproportionate share hospital payments or any adjustments for FQHC or rural health clinic (RHC) reimbursements. FQHC costs considered in rate development are the costs incurred by the MCO, net of any wrap-around payment by DHCS to reimburse the FQHC at their prospective payment system rate. AHF reported this information as part of the RDT data and it was included in the aggregate base data development. Information on catastrophic claims was reported separately within the RDT submission, then it was reviewed, and discussed with the plan. No adjustments were made to the base data for catastrophic claims, as all of these amounts are already included. The RDT submission already included incurred but not reported (IBNR), adjustments that were reviewed for appropriateness. No further IBNR adjustments were applied.

A requirement of 42 CFR 438.3(c)(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 RDT and encounter data served as the starting base data for rate setting. The RDT data submissions are thoroughly reviewed, vetted, and discussed with each MCO during the rate setting process. Encounter data undergoes 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 AHF and DHCS in the development of these rate ranges. Mercer has reviewed the data and information for reasonableness and Mercer believes 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 contract. Mercer did not audit the data or information, and if the data or information is materially incomplete or inaccurate, Mercer's conclusions may require revision. However, Mercer did perform alternative procedures and analyses, which 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 CRCS for the AHF rate development. Base data are presented by COS as annual utilization per 1,000 members, average unit cost and the resulting PMPM calculations and are reflected in columns (A), (B), and (C) of the CRCS, respectively.

In Lieu of Services

As part of the CY 2019 and 2020 RDT data submissions, AHF was required to report costs for services that were not a part of the State Plan benefit package during the base data years, but were provided as an ILOS. AHF did not report amounts for ILOS in the base costs used for rate development.

Pharmacy Carve-Out

Effective January 1, 2022, retail pharmacy services will be carved out of managed care and covered by the State through the FFS delivery system. Specifically, the following pharmacy

benefits when billed by a pharmacy on a pharmacy claim will be carved out of managed care; covered OP drugs, including physician administered drugs, medical supplies, and enteral nutritional products. To remove pharmacy costs from the capitation rates, the pharmacy COS line was zeroed out within the base data, based on MCO RDT reporting. The RDT data source was reviewed and validated against encounter data for reasonableness.

For the CY 2019–CY 2020 period, approximately $23.6 million in pharmacy costs were removed from the base data.

Maternity Supplemental Payment

To further enhance the measured matching of payment to risk, DHCS utilizes a maternity supplemental payment for all health plans. Pertaining to gender, the primary issue that could result in significant variance among the AHF's enrolled population and hence their risk, is the event of maternity and its related cost. Costs for pregnant women are on average 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 within the rates, DHCS includes a maternity supplemental payment, which represents costs for the delivery event. Prenatal and postpartum care costs are not part of the supplemental payment, but remain within the capitation rates for their respective COA. AHF receives the lump sum maternity supplemental payment when one of its current members gives birth and DHCS is appropriately notified a birth event has occurred. Note that non-live birth expense data and non-live birth outcomes are excluded from the maternity supplemental payment analysis and the corresponding development of the CY 2022 maternity supplemental payments. This results in non-live birth expenses being included in the base capitation rates rather than being included in the supplemental payment.

For the CY 2019 and CY 2020 base data period, AHF did not experience any maternity events for its members and did not incur any maternity related costs. The process described below is applicable to the maternity supplemental payment development for the Two-Plan MCOs operating in Los Angeles County. The final maternity supplemental payment for AHF is based on the Los Angeles County rate, with some appropriate modifications described below.

Maternity Supplemental — Design

- Payment made on delivery event that generates a state vital record.
- One supplemental payment per delivery regardless of number of births.
- Supplemental payment reflects cost of delivery event only (mother and baby, excluding prenatal, and postpartum care).
- Supplemental payment is for the entire CY 2022.
- Same supplemental payment is utilized for AIDS Non-Dual and AIDS Full-Dual COA groups.
- If costs had existed in the base period for AHF then those costs would have been carved out of the base data. However, AHF had no such maternity experience; therefore, a carve-out was not necessary.

Maternity Supplemental — Modifications for AIDS Healthcare Foundation

As mentioned above, the maternity supplemental rate for the MCOs in Los Angeles was leveraged for AHF. Additionally, clinical guidance indicates members diagnosed with AIDS are automatically considered to have high-risk pregnancies, and therefore have a significantly higher prevalence of caesarean deliveries. A 100% caesarean delivery assumption was utilized to create the maternity supplemental payment applicable to AHF. Exhibits showing the final capitation rate and CRCS can be found in the Excel file titled *CY 2022 AIDS Healthcare Foundation Maternity Rates 2021 12.xlsm.*

Category of Aid (Aid Code) Groupings

There are significant differences between groups of individuals for whom rates must be set; therefore, capitation rates are calculated separately for each of the groups. These groups are referred to as rating groups. When an individual becomes eligible for Medi-Cal, he/she is assigned a specific aid code. AHF's rating groups, which are comprised of a number of aid codes that are similar in definition or are comprised of individual beneficiaries with similar demographic characteristics or medical conditions, are as follows:

1. AIDS Non-Dual are members who are at least 21 years old and who have ever had a diagnosis of stage 3 HIV infection, and who have no Medicare coverage or have partial Medicare coverage, such as Medicare Part A only or Part B only.
2. AIDS Full-Dual are members who are at least 21 years old and who have ever had a diagnosis of stage 3 HIV infection, with both Medicare Part A and Part B.

Section 4

Projected Benefit Costs and Trends

The adjusted base data (described in Section 3) was projected to the rating period. The adjustments used to produce the projected benefit costs and trended costs are described within this section and are listed below:

- Trend from the midpoint of the 30 month base of CY 2019 and CY 2020 (January 1, 2020) to the midpoint of CY 2022 (July 1, 2022)
- Program Changes
- Other items

The adjustments listed above are shown within the various columns of the CRCS by COS, and as capitation rate add-ons. The exact columns are noted within each subsection below. Note the maternity supplemental payment rate development process is shown in its own CRCS.

Additionally, the final subsection within this section addresses other items not listed above where no explicit adjustments to the data are applied.

Trend

Trend is an estimate of the change in the overall utilization and 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 CY 2022 rate range development for the AHF program, Mercer developed trend rates at the COA level for each provider type or COS separately by utilization and unit cost components.

Mercer reviewed and utilized multiple sources of data and information for trend development. These include recent MCO encounter and RDT data, MCO Medi-Cal-only financial statements, Medi-Cal specific hospital IP and OP payment data, consumer price index, national health expenditures updates, and multiple industry trend reports including the CMS Medicaid actuarial report[1]. 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 claim cost trend assumptions being used are consistent with the CY 2022 Two-Plan/Geographic Managed Care (GMC) assumptions.

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

The overarching trend development approach remains consistent with prior rate periods as a combination of "top down" and "bottom up" claim cost trend development. Mercer 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.

There are six COS where significant changes in annual claim cost trends took place to reflect the more recent trend experience. In these instances the annual PMPM trend factors changed more than 0.50% and at least one of the incremental changes to utilization and/or unit cost trend factors changed more than 0.25% from CY 2021 to CY 2022. These large changes from the prior year are a result of reviewing newer and emerging information (as described above) to appropriately align prospective payment levels, with additional detail regarding CBAS provided following the tables. Please see the table below for detailed changes of trend assumptions by COS for the indicated COA groups.

Annual Trend Factors — All COAs			
COS	**CY 2021**	**CY 2022**	**Change**
Laboratory and Radiology	3.26%	4.03%	0.78%
CBAS	0.85%	4.01%	3.16%
Hospice	0.25%	2.25%	2.00%
Other HCBS	2.00%	4.03%	2.03%
All Other	2.00%	4.03%	2.03%

Annual Trend Factors — SPD/Full-Dual and LTC/Full-Dual COAs			
COS	**CY 2021**	**CY 2022**	**Change**
IP Hospital	0.27%	2.98%	2.71%

The largest of the changes in trend assumptions year-over-year listed above is for the CBAS COS. Emerging experience displayed a large increase after the start of the PHE in the utilization of CBAS on a services per utilizer basis. After further review, including discussions with MCOs, Mercer concluded this increase in CBAS utilization was mostly tied to the temporary alternative services (TAS) flexibilities for delivery of CBAS services granted by DHCS in tandem with the PHE. Through the TAS, CBAS facilities (which traditionally meet in congregate settings) were granted the authority to provide services remotely in order to enhance patient safety; with this flexibility, members that utilized CBAS have been receiving

these services more frequently than in the pre-pandemic base period. The most recent information from the California Department of Aging indicates the TAS flexibility continues to remain in effect, with an end date tied to a point in time beyond the ending of the PHE (timing to be determined). As a result, Mercer increased the utilization trend assumption for CBAS from the prior rating period for consideration of the impacts from the TAS flexibility.

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, with one exception. The one exception to this is within the Two Plan and GMC CCI Institutional rates, in which a small unit cost trend assumption was applied (0.5% at the mid-point) to account for increased pricing pressures communicated to Mercer through conversations with the CCI health plans.

After the mid-point/best estimate trends were determined, a trend range was created by adding 0.25% to each of the utilization and unit cost components as the upper bound, and subtracting 0.25% as the lower bound, with the exception that no range was created for the LTC COS, where the best estimate trends were determined to be zero and handled through other rate setting components. In aggregate, the annualized lower bound claim cost trends, across all MCOs, all COA groups, and all COS, average 0.8% for utilization and 2.3% for unit cost or 3.0% PMPM. This represents an increase of 0.3% over the aggregate trend figures at the lower bound from the CY 2021 capitation rates.

The specific lower bound trend levels by utilization and unit costs for each COS are displayed in columns (D) and (E) of the CRCS, respectively, for each COA group and the maternity supplemental payment. 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 mid-point of the base period to the mid-point 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 rates were based on information provided by DHCS staff as of November 17, 2021. The program changes detailed below were viewed to have a material impact on capitation rates and were reviewed, analyzed, and evaluated by Mercer with the assistance of DHCS.

The next several subsections are the program changes adjustments explicitly accounted for within the CY 2022 capitation rates. A summary showing the managed care impact can be found within the program change charts provided within the Excel files titled *CY 2022 AIDS Healthcare Foundation Rates 2021 12.xlsx*. Additionally, the program change adjustments identified below are applied in columns (F) and (G) of the CRCS, unless otherwise indicated.

Long-Term Care Rate Changes

As noted in the Trend subsection, trend factors were not developed for the LTC COS. In lieu of a trend adjustment, rate increases for LTC services are handled through a program change adjustment and are based on legislatively mandated annual FFS rate increases. 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. Historically, rate increases for all LTC facilities typically occurred August 1 of each year. Beginning CY 2021, rate increases for Assembly Bill (AB) 1629 LTC facilities occur January 1 of each year, while rate increases for non-AB 1629 LTC facilities continue to occur on August 1 of each year. The LTC rate increase factors are developed separately for each county (or rating region). To calculate the adjustment factors for each county, costs, and rate increases by the different LTC facility types are analyzed by county/region, and the final adjustment factor is developed using this information.

Hospice Rate Increase

Similar to the LTC COS, unit cost trend factors were not developed for the Hospice COS. Instead, Hospice price increases are handled through a program change adjustment and are based on legislatively mandated annual FFS rate increases. 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 August 1 of each year, and the rate increases for Hospice room and board that occur on October 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. One adjustment factor is developed at a statewide level across all populations.

Ground Emergency Medical Transportation Fee Increase

Pursuant to approved State Plan Amendment (SPA) 18-0004, and subsequent continuances in approved SPAs 19-0020, 20-0009, and 21-0017, and anticipated future continuances, DHCS makes add-on payments to ground emergency medical transportation (GEMT) providers in the State's FFS program that meet specified requirements using proceeds from a GEMT provider quality assurance fee. Both State law (Welfare & Institutions Code § 14129.3[b]) and the approved SPAs establish that the combination of the State's FFS base and add-on payments constitutes the Rogers rates that MCOs must pay to non-contracted GEMT providers serving Medi-Cal managed care enrollees for those fiscal years in which the GEMT add-on is effective. A program change adjustment has been included in the certified capitation rates to account for this MCO obligation.

In order to develop the GEMT program change adjustment, the managed care population was first split into two subpopulations (by COA group, MCO, and county):

- Non-dual members and dual members only eligible for Medicare Part A.
- Members fully eligible for Medicare and members eligible for Part B only.

This split was done because Medicaid is the primary payer for GEMT services for non-dual/Part A only members, while Medicare is primary for Full-Dual/Part B only members (with Medi-Cal the payer of last resort).

For the non-dual/Part A subpopulation, two data sources were utilized (CY 2019 and CY 2020 dates of service were compiled for both data sources):

- SDRs sent out to the health plans to report on their transportation utilization and claims cost information, separated by mode of transportation (emergent, non-emergent medical, and non-emergent non-medical), as well as trip counts for the affected GEMT codes (A0225, A0427, A0429, A0433, and A0434).
- Health plans-submitted encounter data limited to the GEMT codes affected by the fee increase (A0225, A0427, A0429, A0433, and A0434).

Based on review and analysis of these two data sources, utilization per 1,000 statistics were developed for the non-dual/Part A subpopulation (by health plan, COA, and county). These utilization per 1,000 statistics were then applied to the GEMT unit cost add-on amount to develop the COA, county, and plan-specific GEMT PMPM amounts for non-dual/Part A only members.

For the Full-Dual/Part B subpopulation, the impact of this adjustment is much smaller since Medicare is the primary payer for GEMT services. The first step for the dual eligible members was to evaluate each GEMT code after the Medi-Cal fee increase to see if any crossover Medi-Cal liability existed by code. To do this, the Medicare ambulance fee schedule was reviewed for the applicable codes (A0225, A0427, A0429, A0433, and A0434). Based on this review, it was determined crossover Medi-Cal liability would only exist for code A0429 and only in certain counties, since 80% of the Medicare fee schedule fell below the Medi-Cal fee schedule in certain counties for this code only.

The next step in the adjustment for Full-Dual/Part B only members was to estimate the total number of GEMT trips for dual eligible members billed with code A0429. Note Medi-Cal-specific data (i.e., encounter and SDR data) for dual eligible members is likely under-reported since providers will not necessarily submit a record to Medi-Cal after being reimbursed in full by Medicare. To do this, the total GEMT trips in Medicare (across all Medicare members, regardless of Medi-Cal eligibility) were estimated using provider submitted data DHCS had collected, which included a breakout by payer. Based on this data, 1.1 million total Medicare GEMT trips were assumed (across all codes). Since this was a total Medicare trips number, regardless of dual eligibility, the next step was to estimate the number of trips for dual eligible members. Based on an eligibility and literature review, it was assumed 25% of Medicare eligible members were also dually eligible for Medi-Cal. Based on this; it was assumed 275,000 total GEMT trips would exist for dual eligible members (1.1 million times 25%). Next, using encounter data split by code across Medi-Cal, it was assumed approximately 34% of these trips were billed with code A0429. The resulting number of A0429 trips was then converted into a statewide-assumed utilization per 1,000 statistic for code A0429 for Full-Dual/Part B only members. Due to the county-specific Medicare fee schedules, the unit cost add-ons varied by county and resulted in county-specific GEMT PMPM amounts for these Full-Dual/Part B only members.

The final step in the GEMT PMPM calculation was to blend the non-dual/Part A GEMT PMPMs with the GEMT PMPMs for the Full-Dual/Part B PMPMs by COA group, since COA groups are comprised of members with differing dual statuses (in particular, seniors and persons with disabilities [SPD]). The final adjustment PMPMs were developed by MCO, county/region, and COA group and applied in the transportation COS within the CRCS.

This GEMT add-on only applies to non-contracted GEMT providers as required by State law. Within the base data in future rating periods, the current plan is for plans to report data without these add-ons included. At this time, the state and its actuary anticipate the need for this adjustment to be made in future rating periods.

Adult Optional Benefits

Effective January 1, 2020, DHCS restored coverage for optional benefits for all adults age 21 or older in all settings. The optional benefits restored include vision (optometric and optician services, except certain lens fabrication not covered under managed care), audiology, speech therapy, podiatry, and incontinence creams and washes. DHCS already provides these services under the early and periodic screening, diagnosis, and treatment benefit for individuals under 21 years of age and for pregnant women and beneficiaries receiving LTC in a NF. This benefit change is accounted for as a PMPM adjustment to the All Other COS for all applicable COAs.

To develop the PMPM adjustment for audiology, speech therapy, podiatry, and incontinence creams and washes, two data sources were utilized:

- Medi-Cal FFS data specific to each service for members age 21 or older from when the benefits were previously covered in Medi-Cal. The FFS data included dates of service from July 1, 2007 through June 30, 2009.
- Separately provided data from certain MCOs in the Medi-Cal program that already cover these benefits on their own. Note these services were not part of the State Plan benefit package and were not reported within the MCOs' RDT experience. This data included dates of service in CY 2017.

To derive the PMPM adjustments, both of these data sources were trended to CY 2022 (the period in which the benefits are effective) using trends in line with historical trend factors for the other medical professionals and All Other COS lines. Then, a blend of each data source was utilized for each service and applied consistently for each COA. The blending factors utilized were based on actuarial judgment; no specific formulas were used to develop them. The PMPMs were developed at a statewide level, with no variation across counties, since recent data was not available to make reliable PMPM assumptions by county/region.

For vision services, the PMPM adjustment was developed by estimating the price for frames and lens dispensing fees, as well as developing an assumed utilization of the benefit. To estimate the price for frames and lens dispensing fees, encounter data from CY 2017 to CY 2019 was utilized, as this benefit is already covered in Medi-Cal for children under age 21, pregnant women, and beneficiaries residing in a NF. From this data, a price per eyeglasses was developed for CY 2022, which includes frames and lens dispensing fees only, as costs for lens fabrication provided by the Prison Industry Authority are not covered in managed care. To develop the utilization assumption, historical figures budgeted by DHCS along with data estimates from the California Optometric Association estimate were reviewed. The California Optometric Association estimated approximately two million Medi-Cal beneficiaries aged 21–64 need eyeglasses.[2] Using this estimate as a benchmark,

[2] https://calmatters.org/health/2019/04/california-eyeglasses-medi-cal-restoring-benefitsr

an assumption was then made about the number of those who need eyeglasses, to determine how many would actually obtain them in CY 2022 (the period in which the benefit is effective). The ramp up assumption used was 50% and was based on actuarial judgement.

Psychiatric Collaborative Care Management Services

Effective January 1, 2021, Medi-Cal began to cover three Psychiatric Collaborative Care Management (Psych CoCM) services using current procedural terminology (CPT) codes (99492, 99493, 99494) for treatment of MH or substance use conditions billed by the treating physician or other qualified health professional. No Medi-Cal claims experience specific to the Psych CoCM codes were available at the time when a PMPM adjustment was derived. Therefore, various assumptions were used to develop a PMPM adjustment by COA for adding coverage of these new codes, detailed below.

- The proportion of the population with BH conditions, which was estimated based on pharmacy records submitted for the Medicaid Rx risk adjustment analysis.
- The proportion of the eligible population that would utilize the Psych CoCM services during CY 2022, which was based primarily on review of another State's Medicaid experience, consultation with clinical resources, and actuarial judgement.
- FFS reimbursement rate for each CPT code provided by DHCS.

Coronavirus Disease Adjustment

Significant national uncertainty exists regarding the impact of COVID-19 during CY 2022 due to the ever-changing situation with regionalized infection rates, responses driven by local governments, and new treatment protocols, to name a few factors. Utilization and cost assumptions considered many elements, including infection rate and severity mix of cases, the impact of social distancing, the Federal Government’s involvement in COVID-19-related funding (e.g., HHS and FEMA), and the availability and take-up rate of a vaccine. Given the limited experience resulting from the COVID-19 pandemic, Mercer used several data sources to develop the COVID-19 impacts to CY 2022 capitation rates, including Mercer and Oliver Wyman internal modeling, and national and state data sources.

Mercer separated assumptions into the following categories.

Testing

Testing costs were developed using a “bottom up” approach. An assumed testing rate was developed through a combination of statewide-expected testing outcomes and rate cell demographic information. The analysis includes testing for current infection and antibody testing. Costs were included for the test, as well as associated administrative costs, and any corresponding services (e.g., emergency department or office setting).

Treatment

Treatment costs considered the estimated cost of treatment based on case severity. Scenarios were considered that ranged from in-home care for mild cases to hospitalization, including the intensive care unit, for more severe cases. Average treatment costs were developed based on projected treatment protocols, including average days in the hospital.

The treatment costs were then weighted based on an assumed distribution of incidence rate and severity of cases, which varied by rate cell. For example, older members are assumed to be at higher risk for more severe infection, requiring more costly treatment than younger members. Results were calibrated based on rate cell demographic information, and adjusted to be county specific based on county specific IP hospital unit costs.

Deferred Care

No explicit adjustment for net deferred care is included in the CY 2022 capitation rates. This decision was driven by the arrival of available vaccines in CY 2021 as well as uncertainties around the timing of any potential deferred care. At the time this adjustment was considered within the rate development process, no conclusive evidence was available to indicate the level at which services would rebound in late CY 2021 or into CY 2022. As a result, no explicit adjustment was made.

Mental Health Outpatient Services Acuity

Acuity changes may occur as new needs develop and treatment becomes warranted. Based on national evidence that the pandemic is having a material impact on MH needs, Mercer is forecasting an uptick in BH-related services relative to the CY 2019 base data time period, including services to treat the mild to moderate MH conditions covered by managed care. CY 2022 capitation rates include additional costs for this increase, modeled as a 5% increase in the projected MH–OP services.

Considered but Not Adjusted

The following impacts were not explicitly adjusted in the COVID-19 program change:

- Coverage of Vaccines — the vaccine, including the cost to administer the vaccine, are not covered through managed care and any costs are paid for by the State via FFS. Consequently, no adjustment was made for these costs.
- Long-Term Impact of COVID-19 — given uncertainty around long-term implications of COVID-19, Mercer did not make an explicit assumption specific to this potential impact for CY 2022.

CalAIM Community Supports

Under the CalAIM initiative, a Community Supports program will be implemented effective January 1, 2022. Within the Community Supports program, select services, many of which were previously provided under the Whole Person Care (WPC) program, will be available under managed care. The following 14 pre-approved Community Supports services will be available under Medi-Cal managed care through the CalAIM proposal:

1. Housing Transition/Navigation Services
2. Housing Deposits
3. Housing Tenancy and Sustaining Services
4. Short-Term Post-Hospitalization Housing

5. Recuperative Care (Medical Respite)
6. Respite Services
7. Day Habilitation Program
8. Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities
9. Community Transition Services/Nursing Facility Transition to a Home
10. Personal Care and Homemaker Services
11. Environmental Accessibility Adaptations
12. Meals/Medically Tailored Meals
13. Sobering Centers
14. Asthma Remediation Services

Whole Person Care Adjustment

This adjustment specifically adjusts for expenses for services that were provided under the WPC entities that align with one of the newly available Community Supports services. Because these services were provided within the WPC program, anticipated managed care experience was not appropriately reflected in the base data. This adjustment corrects for this understatement. To develop the WPC adjustment, two data sources were utilized:

- Costs reported by the WPC entities, reported at the county level for CY 2019.
- List of WPC utilizers for CY 2020, provided by DHCS.

Costs for any WPC services deemed to align with any of the 14 Community Supports services were assigned to MCOs according to each MCO's share of the WPC membership within a given county/region. Similarly, each MCO's costs were assigned to COAs based on the COAs of the MCO's WPC members. These costs were further assigned to COS based on a Community Support/COS allocation developed by DHCS and Mercer.

Remote Patient Monitoring

Remote patient monitoring (RPM) services became a managed care covered benefit effective July 1, 2021. RPM will be included as an allowable telehealth modality in managed care delivery systems. RPM treatment management services are provided when clinical staff use the results of remote physiological monitoring devices to manage a patient under specific treatment plans.

To develop a rate adjustment for this program change, an assumption driven methodology was used, with actuarial judgement as well as clinical input. First, total monthly eligibles were identified for all managed care programs, and the percentage of potential users was estimated (using disease prevalence statistics from risk-adjustment analysis by COA group). Of the members assumed to be eligible for RPM in this process, a penetration rate was assumed for members who would ultimately utilize the benefit. Mercer then estimated the

average duration (the months of use per year) per user for each RPM service. The specific services covered under this program change are the following, listed by procedure code:

- 99453: Initial set-up and patient education of equipment: One unit per user month.
- 99454: Remote monitoring: One unit per user month.
- 99457: Remote monitoring treatment **or** 99091: Collection and interpretation of data: One unit per user month.
- 99458: Remote monitoring treatment, additional 20 minutes.

The assumptions noted above in conjunction with the unit cost assumptions provided by DHCS (based on Medi-Cal fee schedule information by code) produced the total projected dollars for RPM. However, it is not expected that all of the estimated RPM utilization will occur in CY 2022 as the service began July 1, 2021, and it is likely the ramp up of the service will be gradual. A ramp up assumption of 24% was used for the CY 2022 capitation rates. The final RPM dollars were distributed to the SP and PCP COS. This service will be monitored in future years for potential capitation rate adjustments in subsequent rating years.

Program Changes Applied as Add-ons to the Rate

All program changes described up until this section of the certification were applied in columns (F) and (G) of the CRCS. The following program changes were applied as PMPM add-ons to the capitation rates. The PMPM add-ons are added to the capitation rates after the blended “plan-specific” and risk-adjusted county average rate process described later in this report.

Major Organ Transplants

CY 2022 capitation rates include PMPM add-ons to reflect the impact of MOT becoming a managed care covered benefit effective January 1, 2022. Add-on rates were developed for the following transplant types: Bone Marrow, Liver, Heart, Lung, Intestine, and Pancreas. Kidney and cornea transplants are already covered in all managed care models.

For the PMPM add-on development, Mercer reviewed historical CY 2018 and CY 2019 FFS data and identified individuals who received a MOT by each transplant type listed above through All Patients Refined Diagnosis Related Groups and/or surgical codes. Mercer then reviewed eligibility to establish, by individual, the pre- and post-transplant periods. The pre-transplant period was identified when an individual disenrolled from an MCO to FFS prior to a MOT surgery event. The post-transplant period was identified as the period where, after a MOT surgery, the average number of months before an individual re-enrolled into an MCO. Costs for the transplant event itself were reviewed and defined as costs incurred during the IP stay of the transplant surgery. Average costs for these transplant periods (pre, event, and post) were then converted to per utilizer per month figures.

Mercer reviewed and identified outliers in the FFS data and made adjustments to unit cost pricing to account for outliers. Mercer also applied unit cost pricing adjustments to account for the shift in coverage from the FFS delivery system to managed care in Two-Plan, GMC, and Regional model counties.

As the data collection method described above did not capture individuals who become deceased waiting for a transplant, Mercer included cost estimates based on industry reports for the incurred pre-transplant costs. Individuals who become deceased during the operation or in the post-transplant period were captured in the FFS data and did not require an adjustment.

DHCS is implementing a State directed payment under 42 CFR §438.6(c) to providers for transplant surgeries transitioning from FFS to managed care in Two-Plan, GMC, and Regional counties. The directed payment directs MCOs to pay hospitals at levels consistent with those paid in the Medi-Cal FFS delivery system. As FFS data was utilized in the development of this adjustment, no additional adjustment for the State directed payment was required.

Adjusted base period unit costs and utilization per 1,000 statistics were trended from the midpoint of the base period (January 1, 2019) to the midpoint of the contract period (July 1, 2022) for a total duration of 42 months. Further, county-specific historical prevalence of transplant events were reviewed to develop PMPM add-ons that vary by county. Annual trends by service category are consistent with lower bound trends used for the broader mainstream rates. Add-on rates reflect a full administration load consistent with lower bound assumptions used for the broader capitation rates. The fully loaded rates have an impact of approximately $3.8 million for the CY 2022 rating period.

Enhanced Care Management

The ECM program, effective January 1, 2022 is part of the CalAIM initiative developed by DHCS. The ECM benefit will replace elements of the care management services provided by the WPC pilots, and ensure the state's most vulnerable, high needs Medi-Cal beneficiaries can receive WPC that addresses both clinical and non-clinical needs through intensive and comprehensive care management support.

The impact of the program to the CY 2022 capitation rates was developed at a statewide level, with Los Angeles county-specific adjustments, for an AHF-specific PMPM add-on to the capitation rates. Without any prior claims experience, the development of this adjustment focuses on the needs of the ECM-eligible population — specifically who meets the criteria and the assumed amount of care management utilized.

Statewide Build-up of Enhanced Case Management Per Enrollee Per Month Rate Development

The following flow charts detail the caseload and provider hour breakdown for varying severity levels of ECM members. These charts, built at a statewide level, detail the hours spent by care managers (CM) and CHWs at varying severity levels, the distribution of these severity levels over the course of the rating period, as well as the distinction between "new" ECM enrollees and "grandfathered" ECM enrollees (individuals transitioning from WPC and/or Health Homes Program (HHP — not applicable for AHF), labeled "WPC/HHP ECM Members").

Medi-Cal Enhanced Care Management
ECM Monthly Service Hours Per Enrollee Development

"New" ECM Members	Months 1-6 for Enrolled Members				Months 7-12 for Enrolled Members			
Severity Level	Percent Distribution	Hours per ECM Enrollee per Month			Percent Distribution	Hours per ECM Enrollee per Month		
		CM	CHW	Combined		CM	CHW	Combined
Level 1	35%	3.0	7.4	10.5	20%	3.0	7.4	10.5
Level 2	30%	2.3	4.6	6.9	35%	2.3	4.6	6.9
Level 3	20%	1.2	2.2	3.5	35%	1.2	2.2	3.5
Level 4	15%	0.9	1.2	2.1	10%	0.9	1.2	2.1
	100%	2.1	4.6	6.7	100%	1.9	4.0	5.9
	% of "New" ECM Member Enrollment			27%	% of "New" ECM Member Enrollment			73%

6.1

CY22 Average Monthly Service Hours Per "New" ECM Enrollee

WPC/HHP ECM Members	Months 1-6 for Enrolled Members				Months 7-12 for Enrolled Members			
Severity Level	Percent Distribution	Hours per ECM Enrollee per Month			Percent Distribution	Hours per ECM Enrollee per Month		
		CM	CHW	Combined		CM	CHW	Combined
Level 1	15%	3.0	7.4	10.5	20%	3.0	7.4	10.5
Level 2	30%	2.3	4.6	6.9	30%	2.3	4.6	6.9
Level 3	30%	1.2	2.2	3.5	30%	1.2	2.2	3.5
Level 4	25%	0.9	1.2	2.1	20%	0.9	1.2	2.1
	100%	1.7	3.5	5.2	100%	1.8	3.8	5.6
	% of WPC/HHP ECM Member Enrollment			64%	% of WPC/HHP ECM Member Enrollment			36%

5.3

CY22 Average Monthly Service Hours Per WPC/HHP ECM Enrollee

Layering onto the caseload assumptions related to the CM and CHW positions, fully-loaded employee cost assumptions that include salary and bonus pay, benefits, and Federal/State employer taxes were taken into account. The rate impact calculation then incorporates a provider overhead assumption of 20% that includes provider costs in addition to ECM staff members such as facility costs, hardware/software, transportation costs associated with care management services, management staff, general administration, information technology,

and human resource function costs. The rate development includes costs associated with ECM provider outreach efforts to ECM-eligible individuals prior to enrollment in the program.

County-specific Adjustments for Per Enrollee Per Month and Outreach

On top of the county-specific methodology of identifying ECM-eligible enrollees, several county-specific adjustments were made:

- Provider Cost Trend (applied to unit cost) — since the base per enrollee per month (PEPM) was developed using CY 2020 salary information, 24 months of 5.0% annual trend is applied to project costs to the CY 2022 contract period.
- County Wage Adjustment (applied to unit cost) — an adjustment is applied to factor in wage differences for ECM providers for Los Angeles County relative to the statewide average.
- Medicare Part B Chronic Care Management (CCM)/BH Integration Services Adjustment (applied to utilization) — this adjustment accounts for Part B eligible ECM enrollees who are eligible for CMS' CCM or BH Integration programs. ECM providers are expected to collaborate with the member's physician in order to pursue the appropriate CCM and BH Integration payments from CMS for their ECM enrollees with Part B coverage. As CMS will be covering ECM-like services through the CCM and BH Integration programs, a portion of the CMs service hours (utilization) were reduced. The result is a downward rate adjustment to the AIDS/Full-Dual COA to account for the overlap in services rendered.
- County-run targeted case management (TCM) services adjustment (applied to utilization) — this adjustment accounts for the overlap between TCM and ECM services for ECM enrollees enrolled in both programs. For the first year of ECM, no adjustment will be applied as the state and health plans are navigating through systematic and operational data complications in properly identifying TCM enrollees. This adjustment will be reassessed for year two (CY 2023) of the ECM program.
- County Rural Adjustment (applied to utilization) — a 25% upward adjustment factor is applied to account for the additional service hours required to serve ECM enrollees residing in a rural setting.

Converting from a Per Enrollee Per Month to Per Member Per Month Add-on

The entirety of the ECM rate development is done at a PEPM-level. To convert this to a PMPM, projected targeted individuals and ECM enrollees are used to convert the PEPM and monthly outreach costs to a PMPM.

Identifying Enhanced Care Management "Eligible" Members for Outreach and Enrollment

The count of ECM-eligible members was informed by an in-depth analysis of flags, where the flags represent condition groups or qualifying utilization statistics that would likely identify a member as potentially ECM-eligible. These flags were then assigned a "flag weight" depending on how closely they aligned with the populations of focus at the time of rate development and the underlying prevalence of the condition/category.

For members transitioning from other sun setting care management programs such as WPC, the State and Mercer worked closely with WPC Lead Entities to better understand Los Angeles County's WPC program and determine WPC enrollees who would transition to ECM in January 2022. Specifically, the count of WPC enrollees is based on the most recent member list from the program available at the time of rate development (4Q 2020) along with appropriate growth assumptions. It is assumed the entire group (after an initial adjustment) will transition into ECM in January 2022. Given this identification criteria for the WPC program and the approach in identifying those who are ECM-eligible, 95% of transitioning WPC members are assumed to remain in ECM after six months.

As for the "new" ECM enrollees (counts and member months [MMs]), ECM-eligible individual counts (excluding WPC transitioning individuals) by health plan and COA were projected based on guidance provided by the ECM policies from DHCS regarding identifying ECM-eligible "populations of focus" as well as discussions with AHF regarding their analysis to identify ECM-eligible members within their populations. In the development of these projections, it was assumed health plans will outreach to approximately 75% of the ECM-eligible population during the first 12 months and given the existing relationship between AHF and its members, approximately 80% of those targeted will enroll in ECM. These ramp up assumptions are the basis for "new" ECM enrollee counts and MM projections.

Consistent with CY 2022 AHF rate setting, full lower bound administrative (13.0%) and underwriting gain (2.0%) loads were used for ECM. This differs from other add-ons, which typically use 50% of the lower bound mainstream administrative load, but is deemed appropriate given the additional burden AHF will experience as they ramp up their ECM program.

AHF currently provides some care management services for its members, which necessitates the development of a PMPM carve-out to avoid funding the MCO for existing care management services currently accounted for in the AHF capitation rate. As such, for ECM-eligible and enrolled members only, half of the utilization management/quality assurance/Children's Choice costs built into the CY 2022 capitation rates was carved out. These costs can be thought of to be on a PEPM basis and similar to the ECM add-on, are then converted to a PMPM basis and removed from the capitation rate. The following table displays how this PMPM carve-out adjustment is netted from the ECM add-on to give the health plan a holistic view of the additional PMPM funding as a result of the ECM program in CY 2022; this should be thought of as a carve-out amount independent of ECM and not part of any ECM risk corridor calculations.

COA	ECM Final Add-on	Existing Care Management Carved From ECM Rate Add-On	ECM Net Add-on
AIDS	$54.69	$12.58	$42.11
AIDS/Full-Dual	$25.70	$0.75	$24.95

Program Changes Considered, but Not Adjusted For

In addition to the program changes mentioned in the sections above, Mercer analyzed several program and policy changes for inclusion in CY 2022 capitation rates, but ultimately found these to have zero rate impact.

Populations Transitioning from Managed Care to Fee-for-Service

Certain Medi-Cal populations designated by CalAIM within managed care will transition to FFS effective January 1, 2022. These populations are:

- Share of Cost

For the Share of Cost population, there was no AHF membership found in the encounters data during the base period, and therefore no explicit adjustment was made.

Asset Thresholds

Asset limit qualifications will be raised for non-modified adjusted gross income, LTC, and Medicare Shared Savings Program Medi-Cal applicants effective July 1, 2022.

From discussions with DHCS surrounding the incoming population, the projected incoming membership is minimal, and there is no reasonable indication these incoming members would have a different cost profile than the members currently in managed care. Therefore, an explicit adjustment was not made for this program change.

Populations Transitioning into Managed Care or Extending Managed Care Coverage

The following populations have been analyzed and ultimately found to have low membership volume and/or similar cost profiles to the total population. Therefore, no explicit adjustment was made for the following populations:

1. Undocumented Young Adults Full-Scope Expansion — full-scope Medi-Cal coverage of adults 19–25 regardless of immigration status was expanded effective January 1, 2020. Note this population will be included in the capitation rates for the UIS population, when the amendment is made.
2. Postpartum Expansion — identified beneficiaries who receive pregnancy-related services would be eligible for Medi-Cal postpartum care for up to 12 months after the last day of the pregnancy effective January 1, 2022.
3. Health Insurance Premium Payout Transition — the Health Insurance Premium Payout program will be discontinued effective January 1, 2022, and these members will be transitioned to managed care.

Telehealth — Post Public Health Emergency

Pursuant to the Welfare and Institutional Code 14124.12(f), telehealth modality flexibilities present during the PHE will be extended through December 31, 2022 regardless of the PHE end date. These flexibilities require payment levels made for telehealth services to be in line

with similar services provided at an in-person setting. Therefore, no explicit adjustment was made in the CY 2022 rates.

Substance Use Disorder in the Emergency Department

Starting January 1, 2021, the initiation of medication for substance use disorders in the ER system (billed under health care common procedure coding system code G2213) was added as a reimbursable service in the Medi-Cal fee schedule with a reimbursement rate of $58.05. Mercer identified the potential utilization of this benefit using 2019 managed care encounter data and ultimately found this benefit would have no rate impact due to low utilization in conjunction with relatively low reimbursement costs. Therefore, no explicit rate adjustment was applied.

Doula Benefit

Doula services will become a Medi-Cal covered benefit effective July 1, 2022. Doula services include personal support to women and families throughout a woman's pregnancy, childbirth, and postpartum experience. Medi-Cal's standard doula benefit will include maternity and labor support visits, which can be at the member’s home, or part of a member's office visit, and during delivery.

No explicit adjustment was made for this program change as AHF assumed there were not any births for the CY 2023 rating period.

Continuous Glucose Monitoring Durable Medical Equipment Carve-Out

The continuous glucose monitoring benefit has been covered in managed care only in certain situations where the benefit was deemed medically necessary. Effective January 1, 2022, this benefit will be carved out of managed care as it is considered part of the pharmacy carve-out.

No explicit adjustment was made to carve-out durable medical equipment expenses related to continuous glucose monitoring within the base period as no applicable experience was found in AHF encounters.

Community Health Worker

Effective July 1, 2022, CHW will be seen as an addition to the group of skilled and trained individuals who are currently able to provide clinically appropriate Medi-Cal covered benefits and services to Medi-Cal beneficiaries. While this benefit is also available through ECM, this program change is separate from the ECM add-on detailed later in this certification letter.

Through discussions with AHF, it was found that due to high acuity and attributes of this population, the services for CHW would be included in the ECM capitation add on to the rates.

Rapid Whole Genome Sequencing

Rapid whole genome sequencing will become a managed care covered benefit effective January 1, 2022. This benefit is available to infants’ age’s one year old and younger receiving IP hospital services in an intensive care unit and covers individual sequencing, trio

sequencing for parent(s) and their child, and ultra-rapid sequencing. This benefit will be covered as a California Children's Services covered service when case review confirms the study is warranted and when the test relates to a California Children's Services eligible condition. As a result, this program change will not apply to AHF members.

Dyadic Health Care Services

Effective July 1, 2022, the DHC program change considers an integrated BH care model that provides health care for the child delivered in the context of the caregiver and family (i.e., "DHC services"). Families are screened for various BH problems, including interpersonal safety, tobacco and substance misuse, and social determinants of health such as food insecurity and housing instability. Families who are given referrals receive follow-up to ensure they received the services. DHC services are available for Medi-Cal beneficiaries ages 0–20, and any services rendered during the DHC visit or child's medical visit are billable to the child's Medi-Cal ID. As AHF beneficiaries are aged 21 and older, this program change will not apply to AHF members.

Populations Transitioning from Fee-for-Service to Managed Care

Certain Medi-Cal populations within the FFS deliver system, including some designated by the CalAIM initiative, will transition to managed care effective January 1, 2022.

The populations identified to transition from FFS to managed care are as follows:

- TCVAP, excluding the share of cost population
- AE
- CHDPI
- Pregnancy-related Medi-Cal
- BCCTP
- Beneficiaries with Other Healthcare Coverage (OHC)
- Beneficiaries in rural zip codes (Rural)

As outlined in the CalAIM initiative, the TCVAP, AE, pregnancy-related Medi-Cal, OHC, and Rural populations will mandatorily transition and/or enroll into managed care starting January 1, 2022. For pregnancy-related Medi-Cal members, only newly enrolled members will enroll in managed care in CY 2022, and members who are already in FFS prior to 2022 will not be transitioned.

Although not specifically indicated by CalAIM, DHCS has identified the CHDPI and BCCTP populations as additional FFS populations transitioning to managed care.

Within these populations, certain populations were excluded from transitioning:

- LTC aid code members
- LTC Utilizers in non-LTC aid codes

- Mandatory FFS populations as outlined in the CalAIM initiative
- Members with waiver exclusions (Intermediate Care Facilities for the Developmentally Disabled, HCBS Waiver, and Veteran's Home of California)
- Dual members (partial or full Medicare eligibility) identified within the BCCTP, OHC, and Rural populations

Membership experience and claims were analyzed to see if there were any applicable members within the encounters experience within the base data and ultimately found no applicable members from these populations who could be enrolled in AHF on January 1, 2022.

Undocumented Population Aged 50 and Older

Effective May 1, 2022, the State will transition Medi-Cal members aged 50 and older to full-scope Medi-Cal and move them into managed care, regardless of the member's immigration status. This population was identified to be in the Adult, ACA Expansion, and SPD COAs.

Membership experience and claims were analyzed to see if there were any applicable members within the encounters experience within the base data and ultimately found no applicable members from these populations who could be enrolled in AHF on May 1, 2022.

Other Items

Health Care-Acquired Conditions

Section 2702 of the ACA of 2010 required CMS to establish regulations prohibiting federal Medicaid payments to states for amounts expended for health care-acquired conditions (HACs). 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 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 IP hospital facility is excluded, including out-of-state facilities.

As such, Mercer initially reviewed potential encounter data information for making an appropriate adjustment (though because AHF went full risk on July 1, 2019, encounter data is very limited). Unfortunately, the required information (a present on admission indicator, for example) is not currently part of the encounter data. This is an ongoing process without any current information available for a rate adjustment. Other studies and other state experience have 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 IP admissions have been included as part of Mercer's efficiency adjustments related to the base managed care data, as noted previously.

Graduate Medical Education

With regard to graduate medical education costs and along with item AA.3.9 of "Documentation Requirements for Actuarially Sound Capitation Rates, Effective Date: November 15, 2014", DHCS staff has confirmed there are no provisions in the AHF managed care contracts regarding graduate medical education. AHF does not pay specific rates that contain graduate medical education or other graduate medical education-related provisions. As MCO data serves as the base data for the rate ranges, graduate medical education expenses are not part of the capitation rate development process.

Third-Party Liability

The MCO experience used to develop the base data was reported net of any third-party liability; therefore, no adjustment was necessary in the capitation rate development process.

Member Cost Sharing

The Medi-Cal program requires no member copayments or other cost sharing; therefore, cost-sharing considerations do not impact rate development.

Retrospective Eligibility Periods

The AHF program is not required to cover retrospective eligibility periods for their enrollees. These periods are covered in the Medi-Cal FFS program. Since MCO data serves as the base data for the rate ranges, retrospective eligibility periods are not part of the capitation rate development process. No adjustments are necessary.

Mental Health Parity and Addiction Equity Act

With regard to the MH Parity and Addiction Equity Act, DHCS staff has confirmed there are no provisions in the AHF managed care contracts in violation of MH Parity and Addiction Equity Act.

Institutions for Mental Disease

Covered benefits associated with these capitation rates do not include services associated with an Institution for Mental Disease (IMD). In addition, if a managed care member is in an IMD in a given month, the state does not pursue federal match for that individual for that month. Therefore, the only potential rate impact from a federal perspective for members utilizing an IMD for more than 15 days in a given month would be associated with the potential impact of those members experiencing significantly higher costs than other non-IMD utilizing members. The consideration of this potential limited impact was viewed as immaterial and no adjustments were made to the base data. This element of the rate setting process will continue to be monitored in future rate setting periods.

Provider Overpayments

The RDT and encounter data used for rate setting are net of provider overpayments. AHF was instructed to report medical expenditures net of provider overpayments within the RDT

submissions, and have policies and procedures for these types of payments per 42 CFR § 438.608(d).

Section 5

Projected Non-Benefit Costs

The projected costs as described in Section 4 represent the benefit costs. This section describes the components of the rate that are not directly related to benefit costs, which include the following:

- Administration
- Underwriting gain
- MCO tax

Capitation rates appropriately include provision for the administrative expenses that MCOs incur as they operate under the risk contract requirements, as well as the MCOs' risk and cost of capital.

Administration

The administration loading for AHF was developed from a review of AHF's 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 for the approved State Plan services and Medicaid eligible members. Mercer utilized its experience and professional judgement in determining the mid-point and lower/upper bound percentages for the AHF population that are reasonable and appropriate within the context of this certification, taking into account the size and specialized nature of the AHF population. The administration load for the lower bound, mid-point, and upper bound are all 13.0%.

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

Underwriting Gain

The underwriting gain component at the lower bound, mid-point, and upper bound are all established at 2.0%. Mercer has implicitly and broadly considered the cost of capital within Mercer's rating assumptions. Mercer's conclusion is that Mercer's assumptions surrounding underwriting gain, as well as the income an MCO generates from investments, are sufficient to cover at least the minimum cost of capital needs for the typical MCO.

Managed Care Organization Tax

The MCO tax does not apply to AHF.

Section 6

Special Contract Provisions Related to Payment

This section describes the following contract provisions that impact the rates and the final net payments to the MCOs for reasons other than risk adjustment under the MCO contract:

- Incentive arrangements
- Withhold arrangements
- Risk-sharing mechanisms
- State directed payments
- Pass-through payments

None of these items explicitly appear within the CRCS, but were considered within the rate development process.

Incentive Arrangements

The total incentive payments under each contract and certification will not exceed 5% of the applicable capitation payments in accordance with 42 CFR §438.6(b)(2).

COVID-19 Vaccination Incentive Program

COVID-19 vaccination incentive payments are being utilized to encourage vaccinations among Medi-Cal's beneficiaries. The new program to boost COVID-19 vaccination rates will allow Medi-Cal MCOs to earn incentive payments for activities that are designed to close vaccination gaps with their enrolled members, based upon lessons learned so far in the pandemic. MCOs provide case and care management services for Medi-Cal members and are well positioned to provide enhanced coordination services, partner with primary care providers, and conduct outreach for vaccine distribution to their members. The vaccination incentive program will also encourage significantly expanded outreach in underserved communities.

Funding will incentivize outreach programs and activities by MCOs and their providers, particularly primary care providers and pharmacies, as well as engagement with trusted community organizations, such as food banks, advocacy groups, and faith-based organizations.

The vaccination incentive program runs from September 2021 through February 2022. The funding for these incentives that will be paid in accordance with 42 CFR §438.6(b) will not exceed $250 million across all applicable managed care contracts and certifications. The vaccination incentive program has no effect on the development of capitation rates.

Additional detail regarding the vaccination incentive program is available through the managed care contract, All Plan Letter 21-010 and any subsequent revisions, and similar instruction issued to MCOs.

CalAIM Incentive Program

CalAIM is a multi-year DHCS initiative to improve the quality of life and health outcomes of the Medi-Cal managed care population through the implementation of broad delivery system, program, and payment reform across the Medi-Cal program. CalAIM's ECM and Community Supports programs will launch January 1, 2022, requiring significant investments in care management capabilities, ECM, and Community Supports infrastructure, information technology, and data exchange, and workforce capacity across MCOs, city, and county agencies, providers and other community-based organizations.

The state will implement the CalAIM Incentive Payment Program (IPP) during CY 2022, which provides incentive payments to MCOs for the achievement of specified metrics and milestones. The total maximum incentive funding that may be earned across all participating MCOs over the full duration of the program is $1.5 billion. The IPP has no effect on the development of capitation rates.

The purpose of IPP is to build appropriate and sustainable capacity, drive MCO investment in delivery system infrastructure, bridge current silos across physical and BH care service delivery, reduce health disparities and promote equity, achieve improvements in quality performance, and incentivize MCO take up of Community Supports.

The IPP will be for a fixed period of three program years (PYs):

- PY 1 will be January 1, 2022 through December 31, 2022, which aligns with California's CY 2022 rating period.
- PY 2 will be January 1, 2023 through December 31, 2023, which will align with California's CY 2023 rating period.
- PY 3 will be January 1, 2024 through June 30, 2024, which will align with the first half of California's CY 2024 rating period.

MCOs will receive incentive payments for achievement of pre-determined milestones and metrics in domains such as:

- Delivery System Infrastructure
- ECM Capacity Building
- Community Supports Capacity Building and Take-Up
- Quality

The enrollees covered by the IPP are Medi-Cal populations that may benefit from enhancements in care management capacity and infrastructure, alternative care delivery, and improvements in quality. The providers covered by the IPP include, but are not limited to, counties, hospitals, professional providers, community-based organizations, and ECM and Community Supports providers.

Additional detail regarding the IPP is available through the managed care contract, APL 21-016 and any subsequent revisions, and similar instructions issued to MCOs.[3]

Housing and Homeless Incentive Program

As part of the state's overarching HCBS spending plan, the state will implement the Housing and Homeless Incentive Program (HHIP) during CY 2022 which provides incentive payments to MCOs for the achievement of specified metrics and milestones. The total maximum incentive funding that may be earned across all participating MCOs over the full duration of the program is $1.3 billion. The HHIP has no effect on the development of capitation rates.

The purpose of HHIP is to address homelessness. MCOs would be able to earn incentive payments for making investments and progress in addressing homelessness and keeping people housed. MCOs would have to meet specified metrics in order to receive available incentive payments. As a condition of participations, MCOs would be expected to develop, in partnership with local public health jurisdictions, county BH, public hospitals, county social services, and local housing departments, and submit a Local Homelessness Plan to DHCS. The Local Homelessness Plan must include, among other elements:

- A housing and services gaps/needs assessment;
- Mapping the continuum of services with focus on homelessness prevention, interim housing (particularly for the aging and/or disabled population), rapid re-housing (families and youth), and permanent supportive housing;
- Available services, how referrals will be made, how other local, state, and federal funding streams will be leveraged, and how progress will be tracked towards goals; and
- How CalAIM services are integrated into homeless system of care.

The HHIP will be for a fixed period of two PYs:

- PY 1 will be January 1, 2022 through December 31, 2022, which aligns with California's CY 2022 rating period.
- PY 2 will be January 1, 2023 through December 31, 2023, which will align with California's CY 2023 rating period.

The enrollees covered by the HHIP include, but are not limited, to; aging adults, individuals with disabilities, individuals with serious mental illness and/or substance use disorder needs at risk for, or transitioning from incarceration, hospitalization, or institutionalization, families, individuals reentering from incarceration, homeless adults, chronically homeless individuals, persons who have/had been deemed (felony) incompetent to stand trial, Lanterman-Petris Short Act designated individuals, and veterans.

The providers covered by HHIP include but are not limited to public health departments, county BH, public hospitals, and others.

[3] All Plan Letter 21-016 is available at https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-016.pdf.

Additional detail regarding the HHIP is available through the managed care contract, associated All Plan Letters, and similar instructions issued to MCOs.

Withhold Arrangements

There are no withhold arrangements between DHCS and the MCOs. This subsection is not applicable to this rate certification.

Risk Sharing Mechanisms

Proposition 56

The state is continuing two-sided risk corridors associated with the four Prop 56 directed payment initiatives applicable to this certification that had such mechanisms in the prior rating period (CY 2021). This risk mitigation mechanism will be applicable to all MCOs receiving Prop 56 add-ons (including AHF).

Rationale for the Use of the Risk-Sharing Arrangement

Risk corridors are necessary for these programs for several reasons. Firstly, there was limited credible and complete claims experience data available in the base period with which to develop capitation rates. Secondly, DHCS is still in the process of completing the first two years of the risk corridors (SFY 2018-19 and Bridge Period
[July 1, 2019–December 31, 2020]). When the risk corridor results are available from those earlier rate periods, DHCS will be in a better position to assess the prior rate setting assumptions. Lastly, the risk corridors support DHCS' policy interest in mitigating potential perverse financial incentives to avoid appropriate utilization of services subject to these Prop 56 directed payments by limiting gains and losses associated with these initiatives to a reasonable threshold.

Description of How the Risk-Sharing Arrangement is Implemented

A two-sided risk corridor shall be in effect for Prop 56 Directed Payments capitation payments to MCOs. Prop 56 Physician's Services, Prop 56 Family Planning Services, and Prop 56 Value Based Payments, will each have separate and distinct risk corridors. The Prop 56 Physician's Services risk corridor will also include the Prop 56 Developmental Screening (not applicable to this certification) and Prop 56 Trauma Screening directed payments. The risk corridors shall be based on the medical expenditure percentage (MEP) achieved by each MCP, as calculated by DHCS. The MEP shall be calculated in aggregate across all applicable categories of aid and rating regions where the MCP operates for dates of service within the PY. DHCS will perform the risk corridor calculation no sooner than 12 months after the end of the PY.

For each risk corridor, DHCS will calculate the numerator of the MEP using an MCP's submitted encounters that have been accepted by DHCS, in accordance with its policies, for services eligible to receive a Prop 56 Directed Payment add-on amount, multiplied by the applicable directed payment add-on amount for each encounter. The resulting amount will be considered the "actual amount" of Prop 56 Directed Payments expenditures issued by the MCP to its eligible network providers in accordance with this preprint for dates of service within the PY. For each risk corridor, the denominator of the MEP shall be equal to the total

of the medical (i.e., non-administrative and non-underwriting gain) portion of the MCP's applicable Prop 56 Directed Payments capitation payment revenues for the PY, as calculated by DHCS.

The risk corridor will consist of the following bands:

- If the aggregate MEP is less than or equal to 98 percent, the MCP will remit to DHCS within 90 days of notice the difference between 98 percent of the medical portion of the MCP's Prop 56 Directed Payments capitation payment revenues and the aggregate amount of the MCP's MEP numerator, plus a proportional amount for the non-medical portion of the capitation payments aligned with the Prop 56 Directed Payments.
- If the aggregate MEP is greater than 98 percent but less than 102 percent, the MCP will retain all gains or losses, with no reconciliation payments from DHCS to the MCP, or vice versa.
- If the aggregate MEP is greater than or equal to 102 percent, DHCS will remit to the MCP the difference between 102 percent of the medical portion of the MCP's Prop 56 Directed Payments capitation payment revenues and the aggregate amount of the MCP's MEP numerator, plus a proportional amount for the non-medical portion of the capitation payments aligned with the Prop 56 Directed Payments.

Description of Any Effect that the Risk-Sharing Arrangements Have on the Development of the Capitation Rates

There is no impact on the CY 2022 capitation rates for the provision of a risk corridor. The CY 2022 capitation rates, outlined in this rate certification, reflects Mercer's best estimate of the anticipated costs associated with Prop 56.

Documentation Demonstrating the Risk-Sharing Mechanism has been Developed in Accordance with Generally Accepted Actuarial Principles and Practices

Mercer confirms the CY 2022 Prop 56 add-on risk sharing mechanism was 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.

Enhanced Care Management

Effective for CY 2022, DHCS will use a symmetrical, two-sided risk corridor as part of the ECM program. This risk mitigation mechanism will be applicable to all MCOs receiving the ECM add-on (including AHF).

Rationale for the Use of the Risk-Sharing Arrangement

The potential variability associated with the implementation and ramp up of ECM supports the benefits of utilizing two-sided risk corridors. While there is expected to be a level of consistency with unit costs, utilization of ECM services could vary significantly by health plan and county depending on the effectiveness of their roll out of the ECM program. MCO-submitted encounters and plan reported supplemental data submitted in a DHCS created template will be utilized in the risk corridor calculations. The use of a risk corridor

helps promote accurate encounter submissions from providers and MCOs. Therefore, the use of this risk corridor is an excellent approach to better match the payments to the overall risk and will help ensure complete and accurate data.

Description of How the Risk-Sharing Arrangement is Implemented

The risk-sharing arrangement will be a two-sided risk corridor that utilizes actual ECM expenditures experienced by the MCOs relative to ECM costs funded within the capitation rates. The risk corridor shall be based on a calculated MEP achieved by each MCO. The MEP shall be calculated in aggregate across all applicable COA and rating regions where the MCO operates for dates of service within the rating period. The risk corridor calculations shall be performed no sooner than 12 months after the end of the rating period.

The numerator of the MEP will be calculated utilizing a MCO's-submitted encounters that have been accepted by the state in accordance with its policies and plan reported supplemental data reported in a DHCS created template, for either of the following allowable medical expenses:

- Approved ECM services for individuals enrolled in ECM
- Outreach efforts performed by an ECM provider on individuals targeted for ECM enrollment

The denominator of the MEP shall be equal to the total of the medical (i.e., non-administrative and non-underwriting gain) portion of the MCO's applicable ECM add-on capitation payment revenues for the rating period.

The risk corridor will consist of the following bands:

- If the aggregate MEP is less than 95%, the MCO will remit to the state within 90 days of notice the difference between 95% of the medical portion of the MCO's applicable ECM add-on capitation payment revenues and the aggregate amount of the MCO's MEP numerator.
- If the aggregate MEP is greater than or equal to 95%, but less than or equal to 105%, the MCO will retain all gains or losses, with no reconciliation payments from the state to the MCO, or vice versa.
- If the aggregate MEP is greater than 105%, the state will remit to the MCO the difference between 105% of the medical portion of the MCO's applicable ECM add-on capitation payment revenues and the aggregate amount of the MCO's MEP numerator.

Once a MEP is calculated, the percentage may be increased by an appropriate credibility adjustment for MCOs with low MMs. The State anticipates leveraging the methodology described at 42 CFR § 438.8(h) for federally required MLR calculations but reserves the right to use an alternative methodology if the State, in consultation with Mercer, deems the alternative to be reasonable and appropriate for this purpose.

DHCS will make appropriate adjustments to allowable medical expenses, as defined above, to exclude items such as:

- Non-medical expenses, e.g., non-service investments for infrastructure and capacity.

- IBNR expenses that cannot be adequately supported.
- Medical expenses for non-ECM services and populations, e.g., expenses for Community Supports services, expenses for members who do not meet ECM population, or phase-in criteria.
- Unreasonable outlier medical expense levels for which the MCO does not provide satisfactory justification based on member mix, utilizer acuity, unique network considerations, and/or other factors. As experience may be inherently more volatile in the first year of the ECM benefit, DHCS will ensure the review process includes discussion with MCOs in advance of any adjustments to provide an opportunity to support outlier cost levels.
- Related party expense levels in excess of unrelated party expense levels.
- Separate and distinct payments that are exclusively for administrative costs as defined in Title 28, California Code of Regulations, § 1300.78, such as but not limited to network development and claims processing.

The State reserves the right to make other appropriate adjustments to other MCO-reported expense items that are identified during the State's review of each MCO's data.

Allowable medical expenses will include appropriate expenses for ECM services delivered by the MCO, subject to DHCS having previously authorized the MCO's use of their own staff to deliver ECM services as required in the ECM contract and model of care requirements.

Description of Any Effect that the Risk-Sharing Arrangements Have on the Development of the Capitation Rates

There is no impact on the CY 2022 capitation rates for the provision of a risk corridor. The CY 2022 capitation rates, outlined in this rate certification, reflects Mercer's best estimate of the anticipated costs associated with ECM.

Documentation Demonstrating the Risk-Sharing Mechanism has been Developed in Accordance with Generally Accepted Actuarial Principles and Practices

Mercer confirms the CY 2022 ECM add-on risk sharing mechanism was 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.

Major Organ Transplant

Effective for CY 2022, DHCS will implement a risk corridor for the portion of the MOT PMPM add-on associated with the directed payment that directs MCOs to pay for the transplant event itself at established Medi-Cal FFS rates.

Rationale for the Use of the Risk-Sharing Arrangement

Due to the initial roll-out of the MOT benefit in Two-Plan, GMC, and Regional counties effective January 1, 2022 and potential differences in observed MCO costs versus the capitation rates, DHCS is implementing a two-sided risk corridor for the MOT benefit. Since

MOT is a low volume event with large associated costs, there is potential for variation in rate setting assumptions for MOT compared to capitation rates developed for these events. As a result, DHCS is imposing a risk corridor.

Description of How the Risk-Sharing Arrangement is Implemented

The risk-sharing arrangement will be a two-sided risk corridor that utilizes actual MOT expenditures experienced by the MCOs relative to MOT services subject to the directed payment requirements funded within the capitation rates. The risk corridor shall be based on a calculated MEP achieved by each MCO. The MEP shall be calculated in aggregate across all applicable COAs and rating regions where the MCO operates for dates of service within the rating period. The risk corridor calculations shall be performed no sooner than 12 months after the end of the rating period.

The numerator of the MEP will be calculated utilizing a MCO's submitted encounters that have been accepted by the state in accordance with its policies and plan reported supplemental data reported in a DHCS created template.

The denominator of the MEP shall be equal to the subtotal of the medical (i.e., non-administrative and non-underwriting gain) portion of the MCO's applicable MOT add-on capitation payment revenues, for the subset of MOT services subject to the directed payment requirements, for the rating period.

The risk corridor will consist of the following bands:

- If the aggregate MEP is less than 95%, the MCO will remit to the state within 90 days of notice the difference between 95% of the medical portion of the MCO's applicable MOT add-on capitation payment revenues and the aggregate amount of the MCO's MEP numerator.
- If the aggregate MEP is greater than or equal to 95%, but less than or equal to 105%, the MCO will retain all gains or losses, with no reconciliation payments from the state to the MCO, or vice versa.
- If the aggregate MEP is greater than 105%, the state will remit to the MCO the difference between 105% of the medical portion of the MCO's applicable MOT add-on capitation payment revenues and the aggregate amount of the MCO's MEP numerator.

Once a MEP is calculated, the percentage may be increased by an appropriate credibility adjustment for MCOs with low MMs. The State anticipates leveraging the methodology described at 42 CFR § 438.8(h) for federally required MLR calculations but reserves the right to use an alternative methodology if the State, in consultation with Mercer, deems the alternative to be reasonable and appropriate for this purpose.

DHCS will make appropriate adjustments to allowable medical expenses to exclude items such as:

- Non-medical expenses.
- IBNR expenses that cannot be adequately supported.

- Medical expenses for non-MOT services or MOT services not subject to the directed payment requirements, e.g., costs for kidney and cornea transplants.
- For services subject to the directed payment requirements, costs in excess of the directed payment levels.

The State reserves the right to make other appropriate adjustments to other MCO-reported expense items that are identified during the State's review of each MCO's data.

Description of Any Effect the Risk-Sharing Arrangements Have on the Development of the Capitation Rates

There is no impact on the CY 2022 capitation rates for the provision of this risk corridor. The CY 2022 capitation rates, outlined in this rate certification, reflects Mercer's best estimate of the anticipated costs associated with MOT.

Documentation Demonstrating the Risk-Sharing Mechanism has been Developed in Accordance with Generally Accepted Actuarial Principles and Practices

Mercer confirms the CY 2022 MOT directed payment risk sharing mechanism was 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.

State Directed Payments

There are several State directed payments applicable to the CY 2022 AHF capitation rates. All applicable directed payments are summarized in the table below. The following subsections provide more detail around each initiative.

Control Name of the State Directed Payment	Type of Payment	Brief Description	Is the Payment Included as a Rate Adjustment or Separate Payment Term?
Control Name TBD–Prop 56 Family Planning	Uniform dollar increase	Uniform dollar increases for specific Family Planning services	Rate adjustment
Control Name TBD–Prop 56 Physician Services	Uniform dollar increase	Uniform dollar increases for specific Physician and other professional services	Rate adjustment
Prop 56 Trauma Screening	Minimum fee schedule using State Plan approved rates	Minimum fee schedule for specific ACEs Screening services	Rate adjustment

Control Name of the State Directed Payment	Type of Payment	Brief Description	Is the Payment Included as a Rate Adjustment or Separate Payment Term?
CA 438.6(c) Proposal J–2019–Prop 56 VBP	VBP	Value-based enhanced payments to providers for specific events tied to performance on 17 core measures across four domains.	Rate adjustment
Control Name TBD – MOT	Delivery system reform	FFS-equivalent payment requirement for network and non-network providers for newly transitioning transplant surgeries	Rate adjustment
Control Name TBD–Private Hospital Directed Payment (PHDP)	Uniform dollar increase	Uniform dollar increases for services limited to predetermined pool amounts for IP and OP/ER	Separate payment term
Control Name TBD–Enhanced Payment Program (EPP)	Uniform dollar or percentage increases	Uniform percentage increase to capitation payments and uniform dollar increase for FFS services limited to predetermined pool amounts by Division of Public Health (DPH) class and IP/non-IP service sub-pools	Separate payment term
CA 438.6(c) Proposal J–2021–DPH QIP	Quality/performance payments	Payments based on performance on designated measures with specified maximum allowable payments for each DPH	Separate payment term
CA 438.6(c) Proposal	Quality/performance payments	Payments based on performance on	Separate payment term

Control Name of the State Directed Payment	Type of Payment	Brief Description	Is the Payment Included as a Rate Adjustment or Separate Payment Term?
I–2021–District and Municipal Public Hospitals (DMPH) QIP		designated measures with specified maximum allowable payments for each DMPH	

There are no additional directed payments in the program for CY 2022 that are not addressed in this rate certification. There are no requirements regarding the reimbursement rates the health plans must pay to any providers unless specified in the certification as a directed payment or pass-through payment or authorized under applicable law, regulation, or waiver.

Proposition 56 Directed Payments

Consistent with 42 CFR §438.6(c), DHCS is utilizing the following four provider directed payment initiatives applicable to this certification. All of them share the same designation of "Proposition 56" as all four payment initiatives are funded for their State shares through a ballot proposition to increase the excise tax rate on cigarettes and other tobacco products under the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Prop 56) and are listed as follows:

- Physician Prop 56
- Trauma Screening (Adverse Childhood Experiences Screening as named in the preprint) Prop 56
- Family Planning Prop 56
- VBP Prop 56

Prop 56 add-ons are contingent on appropriations of funds being approved by the California Legislature. Currently, all components are effective for the entire CY 2022 period (January 1, 2022 through December 31, 2022), except for VBP, which is effective 1H 2022 (January 1, 2022 through June 30, 2022). To the extent the California Legislatures does not appropriate Prop 56 funds for the State share for one or more of these payment initiatives for any portion of the CY 2022 period, the State will either discontinue the program(s) as of that date (and submit a rate certification amendment) or continue the program(s) using State General Fund for the State share.

To facilitate CMS rate review for each of the Prop 56 payment initiatives, the table below summarizes the Prop 56 payments incorporated into the capitation rates as a rate adjustment. The rest of this section is structured to provide documentation individually for each directed payment.

Control Name of the Directed Payment	Rate Cells Affected	Impact	Description of the Adjustment	Confirmation the Rates are Consistent with the Preprint	For Maximum Fee Schedules, Provide the Information Requested
Control Name TBD – Prop 56 Family Planning	AIDS Non-Dual	See exhibit referenced above	See prior description	Confirmed. The preprint is anticipated to be submitted to CMS in December 2021.	Not applicable
Control Name TBD – Prop 56 Physician Services	AIDS Non-Dual	See exhibit referenced above	See prior description	Confirmed. The preprint is anticipated to be submitted to CMS in December 2021.	Not applicable
Control Name TBD – Prop 56 Trauma Screening	AIDS Non-Dual	See exhibit referenced above	See prior description	No preprint required (minimum fee schedule).	Not applicable
CA 438.6(c) Proposal J–2019–Prop 56 VBP	AIDS Non-Dual	See exhibit referenced above	See prior description	Confirmed	Not applicable

Physician Proposition 56 Add-On Per Member Per Month

The Physician Prop 56 add-on PMPM provides a uniform dollar adjustment across 12-specific evaluation and management (E&M) CPT codes and 10 specific preventive visit CPT codes utilized by providers (listed in the following table).

Preprints for this payment initiative have been approved for prior rating periods and the renewal version applicable to the current rating period is anticipated to be submitted to CMS for approval no later than December 31, 2021, with no changes to major terms and conditions with the lone exception of the American Medical Association deactivating the 99201 E&M code. The anticipation is providers who previously billed to the 99201 CPT code will transition to using the 99202 CPT code. To account for this anticipated shift in utilization, the historical 99201 CPT code office visits were priced at the 99202 CPT code add-on amount for purposes of rate development.

The dollar adjustments vary by E&M and preventive visit CPT code as displayed in the following table.

Procedure Code	Description	Uniform Dollar Amount
99201	Office/OP Visit New	$18.00
99202	Office/OP Visit New	$35.00
99203	Office/OP Visit New	$43.00
99204	Office/OP Visit New	$83.00
99205	Office/OP Visit New	$107.00
99211	Office/OP Visit Est	$10.00
99212	Office/OP Visit Est	$23.00
99213	Office/OP Visit Est	$44.00
99214	Office/OP Visit Est	$62.00
99215	Office/OP Visit Est	$76.00
90791	Psychiatric Diagnostic Evaluation	$35.00
90792	Psychiatric Diagnostic Evaluation With Medical Services	$35.00
99381	Preventive Visit New	$77.00
99382	Preventive Visit New	$80.00
99383	Preventive Visit New	$77.00
99384	Preventive Visit New	$83.00
99385	Preventive Visit New	$30.00
99391	Preventive Visit Est	$75.00
99392	Preventive Visit Est	$79.00
99393	Preventive Visit Est	$72.00
99394	Preventive Visit Est	$72.00
99395	Preventive Visit Est	$27.00

The application of these adjustments across all managed care models and all impacted COA groups is shown in the table below. The table highlights the components of the total amounts including the projected MMs (based upon the baseline enrollment projection that utilized actual experience through July 2021), projected impacted E&M and preventive visits, the resulting PMPMs, and the total dollars. The payment adjustments for the given E&M and

preventive codes are being made to all eligible contracted providers who perform these services for managed care enrollees. Services where Medicare would be the primary payer (Full-Dual and Part B partial dual members) are excluded from the add-on payments. Services provided within FQHC/RHC facilities are also excluded from the add-on payments due to the wrap-around payment structure associated with these types of facilities. Services provided by American Indian Health and Services (AIHS) providers and Cost-Based Reimbursement Clinics (CBRCs) are also excluded.

Physician (January 2022–December 2022)				
COA	Projected MMs	Prop 56 Add-on Projected Units	Total PMPM	Total Dollars
Child	53,881,813	7,843,477	$8.36	$450,454,863
Adult	20,737,252	3,732,236	$9.50	$197,010,825
ACA Expansion	43,823,834	7,321,700	$8.98	$393,515,517
SPD	9,107,940	2,422,713	$15.08	$137,371,497
LTC	107,498	19,319	$10.31	$1,108,041
WCM	338,871	135,998	$24.21	$8,202,529
AIDS Non-Duals	4,980	1,375	$15.25	$75,945
All COAs	**128,002,188**	**21,476,820**	**$9.28**	**$1,187,739,217**

The PMPM adjustments were developed based upon MCOs' encounter data as well as MCO information submitted through the RDT. These two data sources, the encounters, and RDT data, were then utilized in developing a distribution and projected utilization of the impacted codes. Through a blended approach of the two data sources, similar in structure to the base data development that reviews the reasonableness of each data element, a final PMPM was developed based upon the projected utilization by code and the resulting needed add-on amount associated with each code. As described previously, certain provider types (FQHC/RHCs, AIHS providers, and CBRCs) were excluded from the analysis, as well as the exclusion of services provided where Medicaid was not the primary payer. This PMPM amount was then further adjusted to include an administrative load (representing the variable administrative costs of the program, fixed administrative costs are covered in the base capitation rates), and an underwriting gain of 2.0%. These load factors are consistent with the values utilized for the other supplemental payments as described further above. Further detail of these components, including MCO-specific amounts are included within the accompanying rate development detail provided in an Excel format.

The final add-on PMPM amounts are included in the applicable final rate ranges after the application of risk adjustment. There is no variation of the add-on PMPMs across the rate ranges.

Per the preprint, the add-on rate payment for this payment initiative will be subject to a two-sided risk corridor together with the Trauma Screening Prop 56 add-on rate payment. As outlined in the preprint, the risk corridor will be based on the MEP achieved by each MCO.

The MEP shall be calculated in aggregate as the qualifying directed payments made to eligible providers for qualifying services as a percentage of the medical portion of the add on rates across all applicable COAs and rating regions where the MCO operates. DHCS will perform the risk corridor calculation no sooner than 12 months after the end of the rating period. Further details can be found in the preprint.

Trauma Screening Proposition 56

The Trauma Screening Prop 56 directed payment is a payment arrangement, which directs MCOs to pay no less than a minimum fee schedule payment for specific Adverse Childhood Experiences Screening services to eligible network providers based on the utilization and delivery of qualifying services for eligible enrollees covered under the contract. As this is a minimum fee schedule using State Plan approved rates, there will be no preprint submitted per 42 CFR §438.6(c)(2)(ii). The following provides a brief description of this payment initiative:

- The type of this directed payment arrangement is a minimum fee schedule payment initiative.
- MCOs are required to pay the eligible providers for the applicable incurred period using the following minimum fee schedule for qualifying covered services provided to eligible managed care enrollees up through age 64.

Procedure Code	Description	Minimum Fee Amount
G9919	Adverse Childhood Event Screening	$29.00
G9920	Adverse Childhood Event Screening	$29.00

This payment initiative is included in the capitation rates as a rate adjustment. The following describes the data, assumptions, and methodology used to develop these add-on rates.

The service was newly added in CY 2020, so there was no credible and complete claims experience data available in the base period. Similar to the rate development approach used for the prior period, Mercer identified eligible enrollees in the most recent full year (CY 2019) of eligibility data based on their Medicare coverage status and specific age groups (age group 0–18 and age group 19–64) within each COA across all model types to calculate the percentage of members eligible for this service within each COA. Note enrollees above age 65 or with Medicare Part B coverage are not eligible for this service. Mercer worked together with the State to develop age group specific take-up- assumptions around the percentages of eligible members within each age group who will receive this service within the contract period. Note this service is primarily intended for children, but adults under 65 are also eligible to receive this service if deemed medically necessary. Therefore, the assumed take-up- assumptions are much lower for adults compared to children. Given the assumed utilizations for each group, the age group mix for each COA, and the known unit cost (minimum fee schedule), Mercer then calculated the expected claims PMPM as the benefit cost component of the add-on rate for the calendar year rating period. Lastly, this PMPM amount was adjusted to include half of the plan-specific administrative load, which provides

for the variable component of the expenses while the fixed administrative costs are covered in the base capitation rates, and an underwriting gain of 2.0%. Further detail of these components, including MCO-specific amounts are included within the accompanying rate development detail provided in an Excel format.

See the table below for detailed impacts for the 12-month period.

Trauma Screening (January 2022–December 2022)				
COA	Projected MMs	Prop 56 Add-on Projected Units	Total PMPM	Total Dollars
Child	53,881,813	985,343	$0.56	$30,353,360
Adult	20,737,252	84,702	$0.13	$2,609,313
ACA Expansion	43,823,834	179,893	$0.13	$5,540,505
SPD	9,107,940	48,726	$0.16	$1,501,182
LTC	107,498	258	$0.07	$7,956
WCM	338,871	6,203	$0.56	$189,485
AIDS Non-Duals	4,980	27	$0.17	$847
All COAs	**128,002,188**	**1,305,152**	**$0.31**	**$40,202,647**

The final add-on PMPM amounts are included in the final rate ranges after the application of risk adjustment. There is no variation of the add-on PMPMs across the rate ranges.

Per the preprint, the add-on rate payment for this payment initiative will be subject to a two-sided risk corridor together with the Physician Prop 56 add-on rate payment. As outlined in the preprint, the risk corridor will be based on the MEP achieved by each MCO. The MEP shall be calculated in aggregate as the qualifying directed payments made to eligible providers for qualifying services as a percentage of the medical portion of the add-on rates across all applicable COAs and rating regions where the MCO operates. DHCS will perform the risk corridor calculation no sooner than 12 months after the end of the rating period. Further details can be found in the preprint.

Family Planning Proposition 56

The Family Planning Prop 56 directed payment is a payment arrangement, which directs MCOs to pay a uniform and fixed dollar amount add-on payment for specific family planning services to eligible network providers based on the utilization and delivery of qualifying services for eligible enrollees covered under the contract. The preprints for this payment initiative have been approved for two prior rating periods and the renewal version applicable to the current rating period is anticipated to be submitted to CMS for approval no later than December 31, 2021, with no changes to major terms and conditions.

The following provides a brief description of this payment initiative:

- The type of this directed payment arrangement is a uniform dollar increase payment initiative.
- MCOs are required to pay the eligible providers for the applicable incurred period using the following uniform dollar increase schedule by procedure code for qualifying covered services provided to eligible managed care enrollees.

Procedure Code[4]	Description	Uniform Dollar Amount
J7294	CONTRACEPTIVE VAGINAL RING: SEGESTERONE ACETATE AND ETHINYL ESTRADIOL	$301.00
J7295	CONTRACEPTIVE VAGINAL RING: ETHINYL ESTRADIO AND ETONOGESTREL	$301.00
J7296	LEVONORGESTREL□RELEASING IU COC SYS 19.5 MG	$2,727.00
J7297	LEVONORGESTREL□RLS INTRAUTERINE COC SYS 52 MG	$2,053.00
J7298	LEVONORGESTREL-RLS INTRAUTERINE COC SYS 52 MG	$2,727.00
J7300	INTRAUTERINE COPPER CONTRACEPTIVE	$2,426.00
J7301	LEVONORGESTREL-RLS INTRAUTERINE COC SYS 13.5 MG	$2,271.00
J7307	ETONOGESTREL CNTRACPT IMPL SYS INCL IMPL & SPL	$2,671.00
J3490U8	DEPO-PROVERA	$340.00
J7304U1	CONTRACEPTIVE PATCH: NORELGESTROMIN AND ETHINYL ESTRADIOL	$110.00
J7304U2	CONTRACEPTIVE PATCH: LEVONORGESTREL AND ETHINYL ESTRADIOL	$110.00
J3490U5	EMERG CONTRACEPTION: ULIPRISTAL ACETATE 30 MG	$72.00
J3490U6	EMERG CONTRACEPTION: LEVONORGESTREL 0.75 MG (2) & 1.5 MG (1)	$50.00
11976	REMOVE CONTRACEPTIVE CAPSULE	$399.00
11981	INSERT DRUG IMPLANT DEVICE	$835.00

[4] Note: Services billed for the following CPT codes with modifiers UA or UB are excluded from these directed payments: 11976, 11981, 58300, 58301, 55250, 58340, 58555, 58565, 58600, 58615, 58661, 58670, 58671, and 58700.

Procedure Code[4]	Description	Uniform Dollar Amount
58300	INSERT INTRAUTERINE DEVICE	$673.00
58301	REMOVE INTRAUTERINE DEVICE	$195.00
81025	URINE PREGNANGY TEST	$6.00
55250	REMOVAL OF SPERM DUCT(S)	$521.00
58340	CATHETER FOR HYSTEROGRAPHY	$371.00
58600	DIVISION OF FALLOPIAN TUBE	$1,515.00
58615	OCCLUDE FALLOPIAN TUBE(S)	$1,115.00
58661	LAPAROSCOPY REMOVE ADNEXA	$978.00
58670	LAPAROSCOPY TUBAL CAUTERY	$843.00
58671	LAPAROSCOPY TUBAL BLOCK	$892.00
58700	REMOVAL OF FALLOPIAN TUBE	$1,216.00

Further details about the funding source, eligible providers, and eligible enrollees for this payment initiative can be found in the preprint.

This payment initiative is included in the capitation rates as a rate adjustment. The following describes the data, assumption, and methodology used to develop these add-on rates.

There was relatively complete and credible claims experience data available in the base period, though it is subject to encounter under-reporting and other data issues. Similar to the rate development approach used for the prior period, Mercer leveraged the most recent full year (CY 2019) of existing claims data using the list of procedure codes to develop the base utilization by COA for each procedure code across all model types. Mercer adjusted the base utilization for estimated encounter under-reporting and anticipated ramp-up due to the enhanced payment under this payment initiative based on literature review of expected national utilization levels of family planning services by the following major service types among child bearing age females:

- Long-acting contraceptives
- Other contraceptives (other than oral contraceptives) when provided as a medical benefit
- Emergency contraceptives when provided as a medical benefit
- Pregnancy testing
- Sterilization procedures (for females and males)

Given the assumed utilizations for each code by COA and the known additional unit cost (uniform dollar increase schedule), Mercer then calculated the expected claims PMPM on a statewide basis as the benefit cost component of the add-on rate. Services provided within

FQHC/RHC facilities are also excluded from the add-on payments due to the wrap-around payment structure associated with these types of facilities. Additional payments to AIHS providers and CBRCs are also excluded. In addition, because the network provider mix varies substantially across individual MCOs and individual rating regions, Mercer further adjusted the statewide claims PMPM using rating region specific and MCO-specific provider exclusion factors to develop the final claims PMPM, which vary by MCO and rating region. Lastly, this PMPM amount was adjusted to include half of the plan-specific administrative load, which provides for the variable component of the expenses while the fixed administrative costs are covered in the base capitation rates, and an underwriting gain of 2.0%. Further detail of these components, including MCO-specific amounts are included within the accompanying rate development detail provided in an Excel format.

See the table below for detailed impacts for the 12-month period.

Family Planning (January 2022–December 2022)				
COA	**Projected MMs**	**Prop 56 Add-on Projected Units**	**Total PMPM**	**Total Dollars**
Child	53,881,813	206,292	$0.68	$36,778,088
Adult	20,737,252	938,557	$10.71	$222,060,839
ACA Expansion	43,823,834	765,002	$3.09	$135,631,782
SPD	9,107,940	74,289	$0.97	$8,826,119
LTC	107,498	239	$0.24	$26,336
WCM	338,871	1,233	$0.64	$217,807
AIDS Non-Duals	4,980	45	$1.10	$5,478
All COAs	**128,002,188**	**1,985,657**	**$3.15**	**$403,546,448**

The final add-on PMPM amounts are included in the final rate ranges after the application of risk adjustment. There is no variation of the add-on PMPMs across the rate ranges.

Per the preprint, the add-on rate payment for this payment initiative will be subject to a two-sided risk corridor specific to Family Planning. As outlined in the preprint, the risk corridor will be based on the MEP achieved by each MCO. The MEP shall be calculated in aggregate as the qualifying directed payments made to eligible providers for qualifying services as a percentage of the medical portion of the add-on rates across all applicable COAs and rating regions where the MCO operates. DHCS will perform the risk corridor calculation no sooner than 12 months after the end of the rating period. Further details can be found in the preprint.

Value-Based Payment Proposition 56

VBP Prop 56 Directed Payment is a payment arrangement, which directs MCOs to make value-based enhanced payments to eligible network providers for specific events tied to performance on 17 core measures across four domains:

- Prenatal/postpartum care
- Early childhood preventive care
- Chronic disease management
- BH care

This arrangement directs MCOs to make additional enhanced payments for events tied to beneficiaries diagnosed with a substance use disorder, serious mental illness, or who are homeless (also referenced as "At Risk Users" in the following VBP schedule). A multi-year preprint for this payment initiative was approved for the prior rating period and the renewal version applicable to the current rate period on May 5, 2020.

The following provides a brief description of this payment initiative:

- The type of this directed payment arrangement is a VBP initiative.
- MCOs are required to pay the eligible providers for the applicable incurred period using the following VBP schedule by core measure for specified services provided to eligible managed care enrollees.

Measure	Measure	Uniform Dollar Amounts for All Users	Uniform Dollar Amount for At Risk Users
1	Prenatal Pertussis ('Whooping Cough') Vaccine	$25.00	$37.50
2	Prenatal Care Visit	$70.00	$105.00
3	Postpartum Care Visit (First Visit)	$70.00	$105.00
3	Postpartum Care Visit (Second Visit)	$70.00	$105.00
4	Postpartum Birth Control	$25.00	$37.50
5	Well Child Visits in First 15 Months of Life (Six Month Visit)	$70.00	$105.00
5	Well Child Visits in First 15 Months of Life (Nine Month Visit)	$70.00	$105.00
5	Well Child Visits in First 15 Months of Life (12 Month Visit)	$70.00	$105.00
6	Well Child Visits Year Three	$70.00	$105.00
6	Well Child Visits Year Four	$70.00	$105.00
6	Well Child Visits Year Five	$70.00	$105.00
6	Well Child Visits Year Six	$70.00	$105.00

Measure	Measure	Uniform Dollar Amounts for All Users	Uniform Dollar Amount for At Risk Users
7	Childhood Vaccine — Two Year Olds (DTaP)	$25.00	$37.50
7	Childhood Vaccine — Two Year Olds (PCV)	$25.00	$37.50
7	Childhood Vaccine — Two Year Olds (IPV)	$25.00	$37.50
7	Childhood Vaccine — Two Year Olds (Hepatitis B)	$25.00	$37.50
7	Childhood Vaccine — Two Year Olds (Rotavirus)	$25.00	$37.50
7	Childhood Vaccine — Two Year Olds (Influenza)	$25.00	$37.50
7	Childhood Vaccine — Two Year Olds (HiB)	$25.00	$37.50
8	Blood Lead Screening	$25.00	$37.50
9	Dental Fluoride Varnish	$25.00	$37.50
10	Controlling Blood Pressure	$40.00	$60.00
11	Diabetes Care	$80.00	$120.00
12	Control of Persistent Asthma	$40.00	$60.00
13	Tobacco Use Screening	$25.00	$37.50
14	Adult Influenza ('Flu') Vaccine	$25.00	$37.50
15	Screening for Clinical Depression (CDF)	$50.00	$75.00
16	Management of Depression Medication	$40.00	$60.00
17	Screening for Unhealthy Alcohol Use	$50.00	$75.00

Further details about the funding source, eligible providers, and eligible enrollees for this payment initiative can be found in the preprint.

This payment initiative is included in the capitation rates as a rate adjustment. The following describes the data, assumptions, and methodology used to develop these add-on rates.

There was limited claims experience data available in the base period to support add-on rate development. Similar to the rate development approach used for the prior period, Mercer

leveraged existing eligibility data in the most recent full year (CY 2019) of eligibility data to identify the eligible group within each COA for each targeted service or event as defined under this payment initiative and then worked together with the State to develop the utilization assumption for each eligible group for each targeted service on a statewide basis. Given the assumed utilizations for each targeted service by each eligible group, eligible member mix within each COA, and the known enhanced payment (VBP schedule), Mercer calculated the expected claims PMPM on a statewide basis by COA for each core measure as the benefit cost component of the add-on rate. Services provided within FQHC/RHC facilities are also excluded from this add-on payment due to the wrap-around payment structure associated with these types of facilities. Additional payments to AIHS providers and CBRCs are also excluded. In addition, because the network provider mix varies substantially across individual MCOs and individual rating regions, Mercer further adjusted the statewide claims PMPM using rating region specific and MCO specific provider exclusion factors to develop the final claims PMPM that varies by MCO and rating region. Lastly, this PMPM amount was adjusted to include half of the plan-specific administrative load, which provides for the variable component of the expenses while the fixed administrative costs are covered in the base capitation rates, and an underwriting gain of 2.0%. Further detail of these components, including MCO-specific amounts are included within the accompanying rate development detail provided in an Excel format.

See the table below for detailed impacts for the six-month period.

VBP (January 2022–June 2022)				
COA	**Projected MMs**	**Prop 56 Add-on Projected Units**	**Total PMPM**	**Total Dollars**
Child	27,280,484	1,379,584	$2.29	$62,600,257
Adult	10,663,177	893,957	$3.61	$38,501,048
ACA Expansion	22,556,916	1,690,040	$3.02	$68,213,123
SPD	4,488,787	352,984	$3.59	$16,119,643
LTC	53,756	4,505	$3.69	$198,430
WCM	172,048	8,264	$2.16	$371,569
AIDS Non-Duals	2,490	217	$4.10	$10,209
All COAs	**65,217,658**	**4,329,552**	**$2.85**	**$186,014,279**

The final add-on PMPM amounts are included in the final rate ranges after the application of risk adjustment. There is no variation of the add-on PMPMs across the rate ranges.

According to the preprint, the add-on rate payment for this payment initiative will be subject to a two-sided risk corridor specific to VBP. As outlined in the preprint, the risk corridor will be based on the MEP achieved by each MCO. The MEP shall be calculated in aggregate as the qualifying directed payments made to eligible providers for qualifying services as a percentage of the medical portion of the add-on rates across all applicable COAs and rating

regions where the MCO operates. DHCS will perform the risk corridor calculation no sooner than 12 months after the end of the rating period. Further details can be found in the preprint.

Hospital Directed Payments

The following directed payments outlined below are paid as separate payment terms, and the actual payments associated with these directed payments will be paid in the future. A summary of the separate payment term directed payments is provided in the table below.

Control Name of the State Directed Payment	Aggregate Amount Included in the Certification	Statement that the Actuary is Certifying the Separate Payment Term	The Magnitude on a PMPM Basis	Confirmation the Rate Development is Consistent with the Preprint	Confirmation that the State and Actuary will Submit Required Documentation at the End of the Rating Period (as applicable)
Control Name TBD–PHDP	$3,708.34 million	The actuary certifies the incorporation of the separate payment term	See pink labeled columns in file titled *CY 2022 Medi-Cal Hospital Directed Payment Summary 2021 12.xlsx* for the PMPM estimates.	Confirmed. The preprint is anticipated to be submitted to CMS in December 2021.	Confirmed
Control Name TBD–EPP	$1,878.64 million	The actuary certifies the incorporation of the separate payment term	See exhibit referenced above	Confirmed. The preprint is anticipated to be submitted to CMS in December 2021.	Confirmed
CA 438.6(c) Proposal J–2021–DPH QIP	$1,896.66 million	The actuary certifies the incorporation of the separate payment term	See exhibit referenced above	Confirmed. The preprint is pending CMS approval	Confirmed

Control Name of the State Directed Payment	Aggregate Amount Included in the Certification	Statement that the Actuary is Certifying the Separate Payment Term	The Magnitude on a PMPM Basis	Confirmation the Rate Development is Consistent with the Preprint	Confirmation that the State and Actuary will Submit Required Documentation at the End of the Rating Period (as applicable)
CA 438.6(c) Proposal I–2021–DMPH QIP	$161.35 million	The actuary certifies the incorporation of the separate payment term	See exhibit referenced above	Confirmed. The preprint is pending CMS approval	Confirmed

Information included in the attached spreadsheet *(CY 2022 Medi-Cal Hospital Directed Payment Summary 2021 12.xlsx)* includes the estimated PMPM impacts associated with each of these separate payment term directed payments by rate cell.

The approach for developing the estimated PMPM impacts of each directed payment is similar to prior years. Mercer collected supplemental data from each health plan on historical utilization and expenditures by COS and provider class as well as the contracted share of those expenditures (payments associated with the MCO having a contract in place with the facilities). Based on a review of this supplemental data, for each directed payment provider class within each applicable COS, Mercer estimated the contracted share of revenue as well as the unit cost differential compared to the average unit cost across all providers, by rate cell. These metrics were utilized to estimate the PMPM impacts for each directed payment as described below.

Private Hospital Directed Payment Uniform Dollar Increase

The PHDP preprint is anticipated to be submitted to CMS for approval no later than December 31, 2021. The PHDP is a uniform dollar add-on payment for services provided by the class of network private hospitals, limited to a predetermined pool amount, with 70% designated to IP services, and 30% to OP/ER services. The PHDP is a separate payment term; the actual uniform dollar increase will be calculated after the end of each half of the CY 2022 period based on actual contracted IP and OP/ER services utilized within the class.

The approach for developing the estimated PHDP uniform dollar increases and PMPM impacts is similar to prior years. The estimated contracted share of revenue and unit cost differential for the private hospital class were applied to the gross medical expense (GME) PMPM component of the capitation rate by rate cell for each impacted COS (IP and OP/ER). These calculations produced estimated private contracted days (for IP) or visits (for non-IP), by rate cell and in total, that formed the basis for creating estimated uniform dollar add-on payment for each COS that would total the intended directed payment target.

The directed payment target for PHDP was $3,708.34 million for the entire 12-month rating period. The IP uniform dollar add-on payment estimate of $972 and the OP/ER estimate of $104 produced impacts of $2,595.85 million and $1,112.48 million for the respective COS. The attached exhibit (*Exhibit I CY 2022 Directed Payments PHDP 2021 12.pdf*) contains the full detail of these calculations for each COS. The resulting estimates on a PMPM basis by rate cell are provided in the attached spreadsheet (*CY 2022 Medi-Cal Hospital Directed Payment Summary 2021 12.xlsx*) as noted previously.

The methodology that will be used to allocate actual payments associated with this directed payment will be consistent with the methods discussed in this certification and the §438.6(c) preprint.

Enhanced Payment Program

The EPP directed payment preprint is anticipated to be submitted to CMS for approval no later than December 31, 2021. The EPP consists of two parts: (1) uniform dollar add-on payment for services provided by the four classes of DPHs and (2) uniform percentage increase to subcapitation (capitation) payments made to Class A and Class B DPHs. Payments are limited to predetermined pool amounts by DPH provider class. The pool amounts are split into capitation and FFS service sub-pools for applicable DPH classes, and non-capitation pool amounts are further split into IP and non-IP sub-pools. The EPP is a separate payment term; the actual uniform dollar add-on payments and uniform percentage increases will be calculated after the end of each half of the CY 2022 period based on actual contracted services utilized within the applicable provider classes and COS.

Classes A through D are outlined below:

- Class A is comprised of non-University of California (UC) DPHs in Santa Clara and San Francisco counties
- Class B is comprised of non-UC DPHs in Los Angeles County
- Class C is comprised of non-UC DPHs in Alameda, San Bernardino, Kern, Monterey, Riverside, Contra Costa, San Joaquin, and San Mateo counties
- Class D is comprised of UC facilities

Fee-For-Service Uniform Dollar Increase

The approach for developing the estimated EPP FFS uniform dollar increases and PMPM impacts is similar to prior years. The estimated contracted share of revenue and unit cost differential for each DPH provider class was applied to the capitation GME PMPM by rate cell for each impacted COS (IP, LTC, OP/ER, and Professional [PCP, Specialist, and other providers {FQHCs are excluded}]). These calculations produced estimated DPH contracted days or visits, by rate cell and in total, that formed the basis for creating estimated uniform dollar increases that would total the intended directed payment target for the given provider class and COS.

The methodology that will be used to allocate actual payments associated with these directed payments will be consistent with the methods discussed in this certification and the §438.6(c) preprint. As described in the EPP preprint, acuity factors will be applied within the

final calculations. The application of the acuity factors will be done in a budget neutral fashion whereby the pooled amounts will still be distributed in total. The exclusion of an adjustment for acuity within these current calculations was driven by the insufficient level of detail within the base data and supplemental data utilized in this estimated impact development. However, the resulting estimates produced are considered appropriate for this process.

Capitation Uniform Percentage Increase

The approach for producing the estimated uniform percentage increase to capitation is similar to prior years. Mercer collected supplemental data from each health plan participating in Class A and Class B counties on historical capitation payments to DPHs and volume of DPH-assigned members. Based on a review of this supplemental data, Mercer estimated the capitation payments for DPH-assigned members anticipated during the rating period and the projected MMs for the DPH assigned members by class and rate cell. These calculations produced estimated DPH capitation expenditures, by rate cell and in total, that formed the basis for creating estimated uniform percentage increases that would total the intended directed payment target for the given provider class. The methodology used to allocate actual payments associated with these directed payments will be consistent with the methods discussed in this certification and the §438.6(c) preprint.

The total impact of the EPP directed payment across the classes is targeted to be approximately $1,878.64 million. The attached exhibits (*Exhibit II CY 2022 Directed Payments EPP 2021 12.pdf*) contain the full detail of these calculations by Class, sub-pool, and impacted COS. The resulting estimates on a PMPM basis by rate cell are provided in the attached spreadsheet (*CY 2022 Medi-Cal Hospital Directed Payment Summary 2021 12.xlsx*).

Designated Public Hospital Quality Incentive Pool

The Quality Incentive Program (QIP) DPH directed payment preprint encompassing the CY 2022 rating period was submitted to CMS on December 31, 2020 under control name CA 438.6(c) Proposal J–2021. The DPH QIP directed payment provides VBPs to DPHs for meeting specified performance measures linked to the utilization and delivery of services under the managed care contracts. Each county with an applicable non-UC DPH is designated a specified maximum allowable pool payment amount, and the UC facilities statewide are designated a maximum allowable pool payment amount.

The approach for producing the estimated impact is similar to prior years. The QIP DPH directed payment estimates are calculated as a uniform percentage increase to anticipated DPH expenditures in CY 2022 by rate cell; the uniform percentage estimate is modeled on a county-specific basis for the counties with non-UC DPHs and a statewide basis for the UC facilities. Each county/region and UC facilities are allocated a portion of the total respective QIPs. The estimated contracted share of revenue was applied to the capitation GME PMPM by rate cell for the non-UC DPHs and the UC DPHs. These calculations produced estimated DPH capitation expenditures, by rate cell and in total, which formed the basis for creating uniform percentage increases that would total the intended directed payment maximum allowable payment target for each non-UC county and for the UC facilities.

The total impact of the QIP DPH directed payment is targeted to be approximately $1,896.66 million. The attached exhibits (*Exhibit III CY 2022 Directed Payments DPH QIP 2021 12.pdf*) contain the full detail of these calculations. The resulting estimates on a PMPM basis by rate cell are provided in the attached spreadsheet (*CY 2022 Medi-Cal Hospital Directed Payment Summary 2021 12.xlsx*).

The methodology that will be used to allocate actual payments associated with these directed payments will be consistent with the methods discussed in this certification and the §438.6(c) preprint.

District and Municipal Public Hospital Quality Incentive Pool

The QIP DMPH directed payment preprint encompassing the CY 2022 rating period was submitted to CMS on December 31, 2020 under control name CA 438.6(c) Proposal I–2021. The DMPH QIP directed payment provides VBPs to DMPHs for meeting specified performance measures linked to the utilization and delivery of services under the managed care contracts. Each county with an applicable DMPH is designated a specified maximum allowable pool payment amount.

The approach for producing the estimated impact is similar to prior years and similar to the calculation of the non-UC QIP DPH estimates. The QIP DMPH directed payment estimates are calculated as a uniform percentage increase to anticipated DMPH expenditures in CY 2022 by rate cell; the uniform percentage estimate is modeled on a county-specific basis for the counties with DMPHs. Each county/region is allocated a portion of the total respective QIP. The estimated DMPH contracted share of revenue was applied to the capitation GME PMPM by rate cell. These calculations produced estimated DMPH capitation expenditures, by rate cell and by county, which formed the basis for creating uniform percentage increases that would total the intended directed payment maximum allowable payment target for each DMPH county.

The total impact of the QIP DMPH directed payment is targeted to be approximately $161.35 million. The attached exhibits (*Exhibit IV CY 2022 Directed Payments DMPH QIP 2021 12.pdf*) contain the full detail of these calculations. The resulting estimates on a PMPM basis by rate cell are provided in the second tab of the attached spreadsheet (*CY 2022 Medi-Cal Hospital Directed Payment Summary 2021 12.xlsx*).

The methodology that will be used to allocate actual payments associated with these directed payments will be consistent with the methods discussed in this certification and the §438.6(c) preprint.

Major Organ Transplant Hospital Directed Payment

The MOT directed payment preprint encompassing the CY 2022 rating period is anticipated to be submitted to CMS for approval no later than December 31, 2021. This directed payment is specific to hospital stays incorporating the MOT event and only applies to transplants transitioning from FFS to managed care. This directed payment directs MCOs to pay hospitals at levels that would be paid in the Medi-Cal FFS delivery system.

To facilitate CMS rate review for the MOT directed payment, the table below summarizes the directed payment, since it is incorporated into the capitation rates as a rate adjustment.

Control Name of the Directed Payment	Rate Cells Affected	Impact	Description of the Adjustment	Confirmation the Rates are Consistent with the Preprint	For Maximum Fee Schedules, Provide the Information Requested
Control Name TBD-MOT	All COAs	$0	Adjustment is applied in the base capitation rates and is a portion of the MOT PMPM add-on.	Confirmed. The preprint is anticipated to be submitted to CMS in December 2021.	Not applicable

Pass-Through Payments

Pass-through payments, as described below, are applied in the AHF CY 2022 capitation rates.

The approach for developing the PMPM impacts of each pass-through payment is similar to prior years. Mercer collected supplemental data from each health plan on historical utilization and expenditures by COS and provider class. Based on a review of this supplemental data, for each impacted provider class within each applicable COS, Mercer estimated the share of revenue by rate cell. These metrics were utilized to develop the PMPM impacts for each pass-through payment as described below.

Private Hospital — Hospital Quality Assurance Fee and District and Municipal Public Hospitals

Historical adjustments associated with the private HQAF and DMPHs are continuing for CY 2022. The approach for making these adjustments within the capitation rates are being addressed through two paths: 1) Pass-through payments as defined by 42 CFR 438.6(d), and 2) Directed payments as defined by 42 CFR 438.6(c). The directed payment approach is described earlier within this certification report and is paid through a separate payment term. The pass-through components of the HQAF/DMPH adjustments are paid as a PMPM add-on amount by rate cell, included within the certified rates. These have been developed in a fashion similar to historical approaches.

The estimated share of revenue for the private hospitals and DMPHs was applied to the capitation GME PMPM by rate cell for each impacted COS (IP and OP/ER). These calculations produced estimated private/DMPH PMPMs, by rate cell and in total. It should be noted the GME amounts utilized to produce the baseline amounts were prior to the removal of maternity costs. This approach was taken so these adjustments did not impact the maternity supplemental payments (this is consistent with historical practice). The private

hospital/DMPH components of the capitation rates were increased by a uniform percentage increase to the IP component (13.69%) and a uniform percentage increase to the OP/ER component (14.28%), such that the total target impact of $1,797.4 million is projected across all of the California managed care models (Two-Plan, GMC, County Organized Health Systems, Regional, and AHF models) for the 12-month rating period. The development of these add-on amounts did not impact the underlying data or assumptions associated with the regular development of the capitation rates. Consistent with historical approaches, no additional administrative load or underwriting gain is included within these add-on amounts for HQAF/DMPH. The DMPH targeted expenditure is approximately $97.4 million across the 12-month period. The DMPH total is a subset of the IP factor and the DMPH targeted expenditure of $97.4 million is part of the $1,797.4 million total impact.

The aforementioned private/DMPH pass-through PMPM adjustments are added to the post risk-adjusted rates.

Included attachments labeled *Exhibit A CY 2022 Private Hospital DMPH IP HQAF Pass-through 2021 12.pdf and Exhibit B CY 2022 Private Hospital OP ER HQAF Pass-through 2021 12.pdf* contain the detailed components behind these calculations. The resulting PMPM add-on rates by rate cell are provided in the “Sum - Add-On Details” tabs within the attached spreadsheet *CY 2022 AIDS Healthcare Foundation Rates 2021 12.xlsx*.

The development of these add-on amounts did not impact the underlying data or assumptions associated with the regular development of the capitation rates.

These pass-through payments are paid to private hospitals and DMPHs.

For the private hospital HQAF, the non-federal share of this payment arrangement will consist of the State’s HQAF revenue, which is continuously appropriated by the California Legislature to DHCS for this purpose. There are no intergovernmental transfers (IGTs) related to this payment arrangement. As the final payments will be based upon actual MMs realized by MCOs, the total amount of the HQAF revenue that ultimately will be necessary for the payments will not be known until after the rating period has ended. Note, the amount of HQAF revenue collected by the State will follow the CMS-approved fee model and is independent of the final amount of pass-through payments.

For the DMPH pass-through, the nonfederal share of this payment arrangement will consist of voluntary IGTs from eligible public entities. The entities transferring funds are DMPHs — public hospitals as defined by Welfare & Institutions Code §14105.98(a)(25) excluding DPHs as defined by Welfare & Institutions Code §14184.10(f)(1). The expected transferring entities will consist of cities, counties, and special health care districts; in general, the funding entities have general taxing authority, either directly or through receipt of property taxes from counties. The IGTs for the nonfederal share of the payments are voluntary, and the State solicits letters of intent from eligible transferring entities that will identify the approximate amount of IGTs they plan to provide. As the final payments will be based upon actual encounters received by the State, the total amount of IGTs that ultimately will be necessary for the payments will not be known until after the rating period has ended. To the best of our knowledge, the entities have not received State appropriations specific to this program at this time. As stated above, the nonfederal share of this payment will consist of voluntary IGTs for which the transferring entity will certify that the transferred funds qualify for federal financial participation. The State has yet to enter into any written agreements with

the funding entities relating to the non-federal share of this payment arrangement. The State is not aware of any additional written agreements that currently exist between healthcare providers and/or related entities to finance the non-federal share specific to this payment arrangement. If approved, the State intends to enter into separate agreements with the transferring entities regarding the provision of IGTs for this purpose, including a mechanism whereby the transferring entities certify that the funds transferred are public funds and eligible for federal financial participation pursuant to applicable federal regulations.

Martin Luther King, Jr. Community Hospital in Los Angeles County

Historical program change adjustments for the MLK IP component of the Los Angeles County SPD and ACA Expansion rate cells are being presented as pass-through payments based upon the definition of a pass-through within 42 CFR 438.6(d). In alignment with the prior program change adjustment, additional costs not included within the base data are added to the IP COS to meet the requirements of Senate Bill 857 that establishes IP payment levels for MLK.

The estimated share of IP revenue for MLK was applied to the capitation IP GME PMPM by rate cell. These calculations produced estimated MLK PMPMs by rate cell and in total. It should be noted the GME amounts utilized to produce the baseline amounts were prior to the removal of maternity costs. This approach was taken so these adjustments did not impact the maternity supplemental payments (this is consistent with historical practice). A uniform percentage increase for the MLK component of the IP COS was established to provide the needed adjustments to reflect the required costs. The development of these adjustments also include a 4.025% administrative load, which aligns with administrative costs assigned to supplemental payments such as the maternity payment as well as the administrative load included with the Prop 56 physician directed payment add-on payments. An underwriting gain of 2%, also consistent with the other payment mechanisms previously mentioned, is included as part of the add-on payment. The total adjustment including administrative load and underwriting gain is estimated to be $29.15 million across CY 2022 based upon enrollment projections.

Included attachment labeled *Exhibit C CY 2022 MLK IP Pass-through 2021 12.pdf* contains the detailed components behind these calculations. The resulting PMPM add-on rates by rate cell are provided in the “Sum - Add-On Details” tabs within the attached spreadsheet *CY 2022 AIDS Healthcare Foundation Rates 2021 12.xlsx.*

This pass-through payment is paid to MLK, a hospital provider.

The non-federal share of this payment arrangement will consist of the State’s general fund revenue, which is appropriated by the California Legislature to DHCS for this purpose. There are no IGTs related to this payment arrangement. As the final payments will be based upon actual MMs realized by MCOs, the total amount of the general fund revenue that ultimately will be necessary for the payments will not be known until after the rating period has ended.

Pass-Through Payments Base Amount Calculation

For the CY 2022 rating period, DHCS has confirmed the projected aggregate amount of pass-through payments to hospitals does not exceed either of:

1. The amount specified by 42 CFR § 438.6(d)(3)(i), which was calculated by DHCS in accordance with the methodology described below.
2. The amount specified by § 438.6(d)(3)(ii).

For this determination, Mercer has relied upon the methodology applied and calculations performed by DHCS.

Amount of Historical Pass-Through Payments, § 438.6(d)(3)(ii)

The amount of historical pass-through payments to hospitals identified in managed care contract(s) and rate certification(s) in accordance with § 438.6(d)(1)(i) is $2,405,046,774. This amount is unchanged from prior rating periods.

Phased-Down Base Amount, § 438.6(d)(3)(i)

General Methodology

DHCS calculated the phased-down base amount as the sum of:

1. Sixty percent of the base amount defined at § 438.6(d)(2) applicable to the period of January 1, 2022 through June 30, 2022;
2. Fifty percent of the base amount defined at § 438.6(d)(2) applicable to the period of July 1, 2022 through December 31, 2022.

The aggregate amount resulting from this calculation is $2,368,915,393 as displayed in the exhibit *CY 2022 Base Amount Calculation 2021 12.pdf*.

The § 438.6(d)(2)(i) component of the base amount is equal to the aggregate difference between the amounts calculated in accordance with § 438.6(d)(2)(i)(A) and (d)(2)(i)(B). This amount is the differential between the amount paid under Medicaid managed care and the amount Medicare FFS would have paid for IP and OP hospital services provided to eligible populations under the Medicaid managed care contracts for the 12-month period immediately two years prior to the CY 2022 rating period, which corresponds to CY 2020.

The § 438.6(d)(2)(i)(A) calculation includes two elements: unit cost and utilization. Unit costs were based on Office of Statewide Health Planning and Development statewide data for Medicare FFS beneficiaries. CY 2019 data was leveraged to arrive at estimated CY 2020 average unit costs for IP and OP hospital services. To maintain consistency with the approach used for the § 438.6(d)(2)(i)(B) component, unit cost trend was applied to the CY 2019 data in order to determine a reasonable estimate of CY 2020 unit costs. The trend applied was based on the average consumer price index for all urban consumers for hospital related services over the five recent state fiscal years (SFY 2015–2016 through SFY 2019–2020). The resulting estimated IP and OP unit costs are 3.97% higher year-over-year compared to the CY 2019 unit costs.

Utilization was calculated based on CY 2019 base data used in Medi-Cal managed care rate development that was trended forward to CY 2020. Distinct trends were applied for IP and OP hospital services based on the average base data utilization change over the previous four calendar years (CY 2016 through CY 2019). For simplicity, the base period data was not

trended to the rating period; however, the state may elect to apply trend adjustments, as appropriate, in the calculation of the base amount applicable to future rating periods.

Unit cost was multiplied by utilization for both IP and OP hospital services, respectively. The resulting IP and OP amounts were then summed to determine the total amount for the § 438.6(d)(2)(i)(A) component of the calculation.

The § 438.6(d)(2)(i)(B) calculation includes three elements: unit cost, utilization, and directed payments. CY 2019 data was trended to arrive at estimated CY 2020 average unit costs for IP and OP hospital services. The same trend used for the § 438.6(d)(2)(i)(A) component of the calculation was utilized here. Utilization is identical to that used for the § 438.6(d)(2)(i)(A) component of the calculation. Unit cost was multiplied by utilization for both IP and OP hospital services, respectively. The resulting amounts were then summed and further increased by the amount of applicable directed payments for IP and OP hospital services for the CY 2020 base period. The applicable directed payments were made as part of the EPP and PDHP. These directed payments were first implemented beginning on July 1, 2017.

Aggregate Difference

The aggregate difference between the total amounts of §§ 438.6(d)(2)(i)(A) and (d)(2)(i)(B) is $4,307,118,897. This amount was multiplied by a factor of 0.55 to account for the 60% and 50% phase-down levels associated with the fifth and sixth fiscal years, respectively, occurring after July 1, 2017.

Trend Adjustments

At the time of this calculation, CY 2020 cost and utilization data specific to Medi-Cal managed care was not readily available for use in this calculation. As per the standard Medi-Cal managed care rate development process, and to allow adequate time for claims completion and MCO reporting, CY 2020 base data had not been fully collected from MCOs and had not been reviewed, validated, or aggregated yet.

Therefore, both unit cost and utilization trends were applied in the calculation of the amount specified by § 438.6(d)(2)(i). Trends were applied consistently for both § 438.6(d)(2)(i)(A) and (d)(2)(i)(B).

The unit cost trend adjustment is based on the consumer price index for all urban consumers: Hospital and Related Services. The average year-over-year growth from July 1, 2015 through July 1, 2020 was used to determine an annual trend percentage of 3.97%. This source of growth is consistent with the annual growth rate historically approved by CMS in the preprint for the state's QIP. Based on CMS' approval of this data source for determining unit cost growth, DHCS believes this source is reasonable and appropriate. While alternative trends are possible and may be reasonable, that fact does not diminish the reasonableness of the state's approach in utilizing an established cost index to inform the trend assumption.

The utilization trend adjustment is based on the average year-over-year growth from CY 2016 through CY 2019 of the base data used for rate development. This data source remains consistent with the utilization driving the base amount calculation beginning with the SFY 2017–18 rating period.

Fiscal Impact

The following displays the fiscal impact of applying unit cost and utilization trends on the phased-down base amount:

Phased-Down Base Amount with Trends = $2,368,915,393

Unit Cost Trend removed = $2,187,140,571

Utilization Trend removed = $2,180,768,969

Unit Cost Trend and Utilization Trend removed = $2,006,095,978

DHCS believes both the unit cost and utilization trends applied in this calculation are reasonable and appropriate. However, of note, the removal of either utilization or unit cost trend, or both, would not change the fact that the phased-down based amount exceeds the projected aggregate amount of pass-through payments for the CY 2022 rating period.

The 42 CFR 438.6(d)(2)(ii) component of the base amount is assumed to be equal to $0, consistent with the approach used for prior rating periods. The amount in accordance with 42 CFR 438.6(d)(2)(ii) is the differential between the amount paid under Medicaid FFS and the amount Medicare FFS would have paid for IP and OP hospital services provided to eligible populations through the Medicaid FFS delivery system for the 12-month period immediately two years prior to the CY 2022 rating period that have subsequently shifted to the Medicaid managed care delivery system. There were no major shifts of IP and OP hospital services, and of eligible populations, from Medicaid FFS to Medicaid managed care for the applicable time periods, such as for MOT services in Two-Plan, GMC, and Regional counties and for various transitioning populations as previously described in this certification. However, for simplicity, given the § 438.6(d)(2)(i) component on its own exceeds the projected aggregate amount of pass-through payments for the CY 2022 rating period, DHCS did not utilize a non-zero amount for the 438.6(d)(2)(ii) component at this time. The state reserves the right to utilize this component of the calculation in a future amendment of this certification or for future rating periods.

Section 7

Certification and Final Rates

This certification assumes items in the Medicaid State Plan or Waiver, as well as the AHF contract, have been approved by CMS.

In preparing the capitation rates 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 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 capitation rates, for CY 2022, January 1, 2022 through December 31, 2022, 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. Capitation rates are "actuarially sound" if, for the 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. The undersigned actuaries are members of the American Academy of Actuaries and meet its qualification standards to certify to the actuarial soundness of these Medicaid managed care capitation rates.

Capitation rates 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 MCO costs will differ from these projections. Mercer has developed these rates on behalf of DHCS to demonstrate compliance with the CMS requirements under 42 CFR 438.4 and in accordance with applicable law and regulations. There are no stop loss or reinsurance arrangements in these rates. Use of these rates for any purpose beyond that stated may not be appropriate.

MCOs are advised that the use of these rates may not be appropriate for their particular circumstance, and Mercer disclaims any responsibility for the use of these rates 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 rates 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 report, 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 secure the advice of competent legal and taxation counsel with respect to any legal or taxation matters related to this report or otherwise.

This certification report assumes the reader is familiar with the Medi-Cal program, 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.

To the best of Mercer's knowledge, there are no conflicts of interest in performing this work.

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 you have any questions on the above or the certification report, please feel free to contact Mike Nordstrom at mike.nordstrom@mercer.com.

Sincerely,

Mike Nordstrom, ASA, MAAA
Partner

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