Mercer

Government Human Services Consulting

Medi-Cal Managed Care

Capitation Rate Development and Certification

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

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Section 1

Executive Summary

The State of California Department of Health Care Services (DHCS) contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to develop actuarially sound capitation rates for use during the rating period of January 1, 2026 through December 31, 2026 (calendar year [CY] 2026). The capitation rates that are the subject of this certification report are for the Mainstream managed care program, which includes the following models:

- County Organized Health Systems (COHS)
- Geographic Managed Care (GMC)
- Regional
- Single-Plan
- Two-Plan

The Whole Child Model (WCM) is a covered population in the COHS model plans for all COHS counties except Ventura. Future references to the COHS model will be assumed to cover WCM members, unless explicitly noted otherwise.

This report describes the rate development process and provides the certification of actuarial soundness required by 42 Code of Federal Regulations (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 2025–2026 Medicaid Managed Care Rate Development Guide (RDG), published in August 2025. The rate development process includes the historical practice of developing rate ranges. However, this report certifies 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 2026 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 certified capitation rates by immigration status, rating region, and category of aid (COA) groupings (synonymous with rate cell), including a comparison to the prior CY 2025 certified capitation rates, can be found in the attached file, *CY 2026 Medi-Cal Rate Summaries 2025 12.xlsx*.

Mercer has not trended forward the previous year's rates but has, instead, completed 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.

Within the CY 2026 rate development, there were a few notable changes to the development of the capitation rates. These are listed below and described in more detail in subsequent sections:

- The base period for CY 2026 rate development is a 6-month period (January 1, 2024 through June 30, 2024). The base data includes adjustments for seasonality.
- Seniors and persons with disabilities (SPD) members aged 0–20 were included in the Child COA in the base data; however, in the rating period, SPD members aged 0–20 will be excluded from the Child COA and included in the SPD-long-term care (LTC) COA.

Additionally, the State of California provides Medi-Cal coverage to members with unsatisfactory immigration status (UIS), referred to as the UIS population. UIS members are eligible to receive the same State Plan services as members with satisfactory immigration status (SIS), but federally eligible to receive only pregnancy-related and emergency services. Through communication with CMS, DHCS is required to set capitation rates for the UIS and SIS populations separately. Furthermore, the capitation rates for the UIS population are required to be separated by federally eligible services (namely, pregnancy-related and emergency services) and services paid by the State alone (all other services). Within the rates being certified within this certification, the UIS and SIS populations are separated. Finally, the SIS population capitation rates are being certified for all components while only the federally eligible rate component is being certified for the UIS population. The base data for the UIS and SIS populations are separate, and capitation rates are developed using base data already separated for these populations. Unless otherwise noted, all references to the UIS capitation rates are assumed to be for the federal component only.

A comparison of the certified CY 2026 capitation rates to the certified CY 2025 capitation rates is also provided in an attachment. Each certified CY 2026 rate is compared to the capitation rates certified within the CY 2025 rating period. There are instances where there are large changes at the rate cell level in this comparison. There are many potential drivers of this depending on the rate cell being reviewed,

including updated base data, a new enrollment freeze for UIS members, and emerging experience.

It should also be noted there will be a future amendment to this certification that will be submitted to CMS. The potential updates may include, but may not be limited to, changes related to the B1 Flag removal for Newborn Gateway members, the Children and Youth Behavioral Health Initiative (CYBHI) third-party administrator fee add-on, the impacts of Proposition 35, and potential changes to the MCO Tax.

Section 2
General Information

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

- Program history
- Managed Care Plan (MCP) 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 MCP contract information for additional detail.

Program History

California's managed care delivery models have been in existence since the 1980s. There have been various changes in the model types over the years. There are five models within the Mainstream managed care program, listed below:

- COHS — consists of 34 counties (Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Marin, Mariposa, Mendocino, Merced, Modoc, Monterey, Napa, Nevada, Orange, Placer, Plumas, San Benito, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Ventura, Yolo, and Yuba), where one local MCP operates with an option for Kaiser Foundation Health Plan (Kaiser) in certain counties.
- GMC — consists of two counties (Sacramento and San Diego), where four commercial MCPs operate which is inclusive of Kaiser as an option.
- Regional — consists of five counties, (Amador, Calaveras, Inyo, Mono, Tuolumne), where two commercial MCPs operate with an option for Kaiser.
- Single-Plan Model — consists of three counties (Alameda, Contra Costa, and Imperial), where a local MCP operates with an option for Kaiser.
- Two-Plan Model — consists of 14 counties (Alpine, El Dorado, Fresno, Kern, Kings, Los Angeles [LA], Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare), where two MCPs per county (one

local and one commercial) operate with an option for Kaiser in all counties except Alpine.

From 2014 through 2022, DHCS administered the Coordinated Care Initiative (CCI) program within two COHS model counties: Orange and San Mateo; one GMC county: San Diego; and four Two-Plan model counties: LA, Riverside, San Bernardino, and Santa Clara. As part of this initiative, the MCPs in these counties were responsible to cover all LTC services and various long-term services and supports for their members ages 21 or older.

Effective January 1, 2023, the CCI program ended, and members previously covered under CCI transitioned into their respective non-CCI managed care models. The CY 2026 capitation rates were developed inclusive of these (and other) transitioning members; there are no longer rates specific to the CCI program. Now, capitation rate development for CCI Full-Dual eligible members, in addition to non-dual and partial dual members (as in prior years), are covered within this certification.

The Mainstream managed care program encompasses all 58 counties within California. For capitation rate payment purposes, counties are consolidated into rating regions (with rating regions consisting of one or more counties). Within each rating region, MCPs are paid a capitation rate for each county in which they operate. For a list of rating regions and their applicable counties, please refer to the Excel file titled *CY 2026 Medi-Cal Rate Summaries 2025 12.xlsx*.

Mercer has served as California's contracted actuarial firm supporting the Medi-Cal managed care program and rate development since 2005.

Medi-Cal Plan Participation

For CY 2026, there are 22 distinct MCPs operating in the Mainstream managed care program. Each MCP has different regions in which they operate. Some MCPs only operate in one region while other MCPs operate in multiple regions. For a complete list of the MCPs and regions in which they operate, please see the rate summary sheets, which can be found in the attached Excel file titled *CY 2026 Medi-Cal Rate Summaries 2025 12.xlsx*. Capitation rates are set at the regional level and risk adjusted to create capitation rates for each MCP at the rate cell level.

Covered Services

Generally, services covered through the Mainstream managed care program include hospital services (including inpatient [IP], outpatient [OP], and emergency room [ER] services), physician services, applied behavioral analysis services, transportation services, laboratory and radiology services, hospice care services, and community-based adult services (CBAS). Additionally, mental health (MH) services for members with mild to moderate MH needs and conditions are covered.

Historically, there have been differences in covered services between the COHS and non-COHS managed care models; most notably, LTC services. Effective January 1, 2023, pursuant to the CalAIM initiative, LTC services are covered for the

entire period in which a member resides in an LTC facility in all models within the Mainstream managed care program. Effective January 1, 2024, all MCPs became responsible for covering members in Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) and subacute facilities.

Notable services carved out of the Mainstream managed care program (with exceptions listed below) include the following:

- Specialty MH services (including IP and OP behavioral health [BH] services).
- Alcohol and substance use disorder treatment services.
- Home- and Community-Based Services (HCBS) (apart from 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, apart from members covered by the Health Plan of San Mateo (HPSM) under their pilot dental program.
- Administration and ingredient costs of Coronavirus Disease 2019 vaccines.
- Services covered under the California Children's Services (CCS) program in one COHS and all GMC, Regional, Single-Plan, and Two-Plan counties. In all COHS counties excluding Ventura, CCS services are a managed care covered benefit. CCS-eligible members in these counties make up the WCM COA.

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.

Effective January 1, 2026, transitional rent, a new community supports (CS) service, covering up to six months of rental assistance in permanent or interim housing for Medi-Cal members who are experiencing or at risk of homelessness and meet additional service eligibility criteria, will be a covered benefit. The MCPs will manage these services under a non-risk arrangement with DHCS.

As part of the aforementioned CalAIM initiative and referenced in prior certification letters, there were three major benefit/service changes effective January 1, 2022. These include the following:

- Major organ transplants (MOT) in GMC, Regional, Single-Plan, and Two-Plan counties (these were already covered in COHS counties and only kidney and corneal transplants were covered in non-COHS counties)
- Enhanced care management (ECM) services
- 14 CS services are allowable in the MCP contracts in accordance with 42 CFR § 438.3(e) and/or the terms and conditions of California's 1115 waiver.

Covered Populations

The program currently covers children, parents/caretakers, adults without dependent children, pregnant women, and SPD, including those dually eligible for Medicare. Individuals served through California's Children's Health Insurance Program (CHIP) are covered under the same MCP contracts. Generally, managed care enrollment is mandatory for the Mainstream managed care program. Managed care enrollment became mandatory for dual eligible members in non-CCI and non-COHS counties effective January 1, 2023 (previously these members were voluntary). Furthermore, enrollment became mandatory for members residing in San Benito County effective January 1, 2024 (previously these members were voluntary).

As part of the CalAIM initiative, various additional populations have or will become enrolled in managed care effective from CY 2022 through CY 2025, notably including mandatory managed care enrollment for dual eligible members and members residing in an LTC facility.

For the SPD/Full-Dual COA group, Medi-Cal managed care only covers non-qualified Medicare beneficiaries (non-QMB) and non-specified low-income Medicare beneficiaries (non-SLMB) qualified duals. The same aid codes for the non-dual SPD population are utilized for the dual population. The QMB Plus and SLMB Plus qualified duals are not part of the non-dual managed care population and are in fee-for-service (FFS).

Rate Structure

The base data sets used to develop the Mainstream CY 2026 capitation rate ranges were divided into cohorts representing consolidated COA (or aid code) or supplemental groupings, which inherently represent differing levels of risk. Rate ranges are developed for each of these cohorts by immigration status and rating region. As noted for the COA and supplemental payment groupings below, there are differences that exist across the various counties. The COA groups for which capitation rates are paid and supplemental payment groupings are listed below (with variations noted as well).

Capitation Rate Category of Aid Groups

- Child
- Adult
- Affordable Care Act (ACA) Expansion
- SPD-LTC
  - This COA consists of non-dual SPD members, partial dual eligible members with an SPD, LTC, or ACA Expansion aid code, and non-dual LTC aid code members
- SPD-LTC/Full-Dual

  - This COA consists of Full-Dual SPD members, Full-Dual eligible members with an ACA Expansion aid code, and Full-Dual members with an LTC aid code.

- WCM (applicable in all COHS counties except Ventura County)

Beginning in CY 2025 and continuing for CY 2026, in all regions, the SPD and LTC COA groups were blended into one capitation rate payable for members in either COA group and the SPD/Full-Dual and LTC/Full-Dual groups were blended into one capitation rate payable for members in either COA group.

Further, capitation rates for all COA groups listed above are separated for the UIS and SIS populations, to satisfy CMS requirements. Capitation rates for the UIS population consist of federally eligible services only.

Maternity Supplemental Payment

MCPs are compensated through monthly capitation payments for the COA cohorts noted above. The capitation rates for the COA cohorts include all services under the MCP contract, apart from services specific to those covered under a supplemental payment (maternity). Services specific to the maternity supplemental payment are carved out of the monthly capitation rates and reimbursed to the MCPs only when applicable members meet the criteria necessary for the MCPs to receive the supplemental payment. More detail on this supplemental payment is provided later in this certification report.

Federal Medical Assistance Percentage

Depending on the Medicaid managed care program, some services or populations may be subject to a different FMAP than California's regular 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.

Populations that receive a higher FMAP than the regular FMAP include the Breast and Cervical Cancer Treatment Program (BCCTP) population (a subset of the SPD-LTC population) who meet federal standards, the CHIP population, and the ACA Expansion population. For CY 2026, the BCCTP and CHIP populations receive 65% FMAP. For CY 2026, the ACA Expansion population receives 90%.

DHCS uses aid codes in its capitation payment system to identify qualifying recipients for higher FMAP. The full capitation rate for these recipients receives the

higher FMAP, except for portions attributable to services subject to service-specific rates of FMAP.

The COA groups for which capitation rates are paid are tied to the aid codes, and since FMAP is also tied to these aid codes, there is an apparent but non-substantive relationship between FMAP and the COA groups. The most expensive COA groups are the SPD-LTC and SPD-LTC/Full-Dual, which all receive the standard 50% FMAP apart from the BCCTP group (a subset of SPD-LTC), which receives 65% FMAP. The next most expensive COA groups are the Adult and ACA Expansion, with the Adult receiving a 50% FMAP and the ACA Expansion COA receiving the FMAP detailed above. The least expensive COA group is the Child COA, which receives a combination of the standard FMAP for the non-CHIP population and an enhanced FMAP for the CHIP population.

Rates are developed for each population based on expected cost and homogeneity of risk. The FMAP for each population 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 population-based FMAP. 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.

For the federal capitation rates for the UIS population, pregnancy-related services and emergency services are subject to different FMAP levels. Pregnancy-related services for all UIS members are subject to a 65% FMAP, while emergency services are subject to a 50% FMAP for all populations with the exception of ACA Expansion, which is subject to a 90% FMAP through September 30, 2026 and 50% beginning October 1, 2026. The portion of the UIS capitation rates for pregnancy-related and emergency services is shown within the attachments provided.

Rate Methodology Overview

Capitation rates for the Mainstream managed care program were developed in accordance with rate setting guidelines established by CMS. As noted previously, Mercer continued the historical practice of rate range development; however, this report certifies to a final rate within the developed rate ranges as federally required.

For rate range development for the Mainstream managed care program, Mercer used January 1, 2024 through June 30, 2024 (1H 2024) MCP-reported encounter data, the 1H 2024 rate development template (RDT) data (from direct contractors with DHCS and also the MCPs' global subcontractors) and other ad hoc claims data reported by DHCS and the MCPs. The most recently available, quarterly submitted, Medi-Cal-specific financial reports 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 each MCP within the Medi-Cal managed care program separately for each rating region in which each MCP operates. The data requested from each MCP is completed by the MCPs at the level of detail needed for rate setting purposes, which includes membership, medical utilization, and medical cost data for the most recent time periods (1H 2024 for the CY 2026 rates) by immigration status, region, 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 2026, and to account for seasonality present in the base data period. Additional adjustments were then applied to the selected base data to incorporate:

- Prospective and historic (retrospective) program changes not reflected (or not fully reflected) in the base data.
- Budget-neutral relational modeling for smoothing.
- Any observed changes in the population case mix and underlying risk of the MCPs from the base data period.
- 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.
- Application of risk-adjusted region average rates (where applicable).

The above approach has been utilized in the development of the rate ranges for the CY 2026 Mainstream managed care program. DHCS will offer the final certified rates within the actuarially sound rate ranges by region, with MCP-specific risk-adjustment factors applied. Each MCP 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 MCPs are assumed to reasonably achieve a medical loss ratio (MLR) greater than 85%. Mercer reviewed available annual MLR reports for CY 2022 and CY 2023 as well as recent quarterly financial information. While some select MCPs' reported MLRs were under 85% in recent years, the program-wide MLR has been greater than 85%. In addition, Mercer's review of recent quarterly

financial information and emerging experience has demonstrated an overall recent increase in MLRs and indicates MCPs have a reasonable likelihood of achieving an MLR of at least 85% for CY 2026. This recent experience was considered in the development of rates as described in the "Trend" subsection of Section 4. *Projected Benefit Costs and Trends*.

The CY 2026 internal rate ranges utilize a full rebase incorporating the most complete and current data period (1H 2024). This rebase, along with the non-medical loads, result in aggregate priced-for effective MLRs greater than 85%.

The aggregate priced-for effective MLR is greater than 85% and varies by region:

- Assumed upper bound MLR: 100%–12.9% (highest upper bound non-medical load across regions) = **87.1%.**
- Assumed lower bound MLR: 100%–9.5% (highest lower bound non-medical load across regions) = **90.5%.**

For CY 2026, the State will impose remittance provisions related to this MLR. Any revenue will be remitted to the State up to 85% MLR, if the calculated actual MLR is less than 85% for an MCP.

Rate Ranges

To assist DHCS during its rate discussions with each MCP, Mercer provides DHCS with rate ranges developed using an actuarially sound process. The rate ranges for each rate cell 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 "Mercer 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 MCP. 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 rate range development was MCP encounter data, requested MCP RDT data (including global subcontracting MCP RDTs), and FFS data for regions impacted by the expansion of the WCM program. 1H 2024 served as the base data period. The 1H 2024 encounter and RDT claims data included utilization and unit cost detail by COA grouping, immigration status, region, MCP, and 18 consolidated provider types or COS, including:

- IP Hospital
- OP Facility
- ER
- LTC
- Primary Care Physician (PCP)
- Specialty Physician
- Federally Qualified Health Center (FQHC)
- Other Medical Professional (NPP)
- Mental Health Outpatient (MHOP)
- Behavioral Health Treatment (BHT) Services
- Laboratory and Radiology
- Transportation
- CBAS
- Hospice
- CS
- ECM
- Other HCBS
- All Other

The COA groupings included in the RDT reporting reflected the following:

- Child (including SPD members aged 0–20)

- Adult
- ACA Expansion
- SPD (excluding SPD members aged 0–20)
- LTC
- SPD/Full-Dual
- LTC/Full-Dual

SPD members aged 0–20 were reflected in the Child COA through the base data development. These members were grouped in the Child COA within the RDT data since it was initially planned to move these members from the SPD-LTC COA to the Child COA for payment purposes effective with the CY 2026 rates. However, operational barriers necessitated the members to be moved back to the SPD-LTC COA for payment purposes. A rate adjustment to shift these members from the Child COA into the SPD-LTC COA is described in Section 4. *Projected Benefit Costs and Trends*.

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, MCP RDT and encounter data served as the starting base data for rate setting as well as FFS data for the WCM expansion described later in this section. Mercer assessed the quality, timeliness, and completeness of the data per Actuarial Standard of Practice number 23, *Data Quality,* to deem the data sufficient to support rate setting. This assessment included reviewing the submitted MCP RDT and encounter data for changes year-over-year, and inclusive of the FFS data, for errors in reporting, overall reasonableness, and consistency across data sources to ensure it was appropriate to incorporate into rate development. The RDT data submissions are thoroughly reviewed, vetted, and discussed with each MCP 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 MCP eligibility (described below) and encounter data were pulled consistent with service code mappings from DHCS, including lists of excluded services, such as state-only funded abortion services. Mercer has relied on data and other information provided by the MCPs and DHCS in the development of these rate ranges. 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.

The RDT submissions already include incurred but not reported (IBNR) adjustments which are reviewed for appropriateness and discussed with the MCPs as part of the rate development process. If necessary, adjustments were applied to amounts reported by the MCPs based on this review. The encounter data received adjustments to reflect potential underreporting and additional runout and was ultimately completed to align with the RDT reported information across all service categories. These factors are applied to recognize that the encounter data may be

underreported by the MCPs (e.g., encounters from providers who are paid via a capitation arrangement may be understated), and potentially not reflective of all liabilities still outstanding for the base period.

Ultimately, Mercer deemed the RDT data as the most reliable base data source. Therefore, when a region-specific rate cell was deemed fully credible, the base data was tied back to the RDT experience after the adjustments and smoothing process detailed below. When a region-specific rate cell did not reach full credibility, the adjusted RDT data was blended with other data sources and are detailed further within the smoothing section. In these instances, the base data does not tie back to RDT experience. Similar to prior rate development periods, there are some exceptions (Kaiser in all rating regions), which are described below.

Additionally, it should be noted that a 6-month base data period was used for the CY 2026 rate development, a deviation from the 12-month base data period utilized in typical rate development processes. The 6-month 1H 2024 base data period was chosen due to the multitude of major program changes that occurred on January 1, 2024, including but not limited to the following:

- MCP re-procurement effective January 1, 2024
- The Targeted Rate Increase directed payment was implemented January 1, 2024
- The last of the LTC populations to move into managed care (members in ICF-DD and subacute facilities) was effective January 1, 2024
- Expansion of UIS members aged 26–49 into full scope Medi-Cal managed care effective January 1, 2024
- The 1H 2024 time period is later into the continuous coverage unwind of Medicaid enrollees as a result of the end of the Public Health Emergency (PHE)

By using base data after all of these policy changes have occurred (or further into the continuous coverage unwind), Mercer was able to rely on actual experience with these changes inherent within the base data, versus the use of assumptions for these policy changes that would have been necessary had the 12 months ending June 2024 been used. In Mercer's professional judgement, the use of the 6-month base data period was deemed more applicable and reflective of future cost levels into CY 2026. A seasonality adjustment was also applied to the base data, described later in this section.

As mentioned in earlier sections, the base data is separated by immigration status before the application of any base data adjustments. Global subcontractor RDT reporting also played a large role in the development of the region average base. The final base data, after base data adjustments and smoothing, is further adjusted to reflect the impact of historical program changes, trend applications, and potential managed care adjustments. This is discussed in later sections in the certification report.

The base data utilized was managed care data without any disproportionate share hospital payments or adjustments for FQHCs or Rural Health Clinic (RHC) reimbursements. FQHC costs considered in rate development, are the costs incurred by the MCPs, net of any wrap-around payment by DHCS to reimburse the FQHC at their Prospective Payment System (PPS) rate. Except in one specific instance in the Rural Central region, the data did not include any adjustments for catastrophic claims. MCPs report this information as part of the base data, and it is included in the aggregate rates. Information on catastrophic claims is reviewed and discussed with the MCPs. The data smoothing subsection below illustrates how these events were handled in the rate range development.

Base Data Adjustments — Medi-Cal Managed Care Plan-Specific

The MCP-reported RDT experience was adjusted with several utilization and unit cost base data adjustments. As detailed below, these MCP-specific adjustments were necessary to appropriately reflect reasonable medical cost and utilization for the covered populations and services. Any adjustments quantified are based on the total population, regardless of immigration status, and represent the amounts added to or removed from claims experience for direct members as reported by the direct contractor and global member experience (where applicable) as reported by the global contractor, unless otherwise stated.

Maternity Base Data Carve-Out

The RDT-reported experience for maternity delivery events was removed from the 1H 2024 base data by rate cell and COS. This was done since costs for delivery events are covered through a supplemental payment. The RDTs required MCPs to separately report maternity utilization and cost data for each of the COAs (Child, Adult, ACA Expansion, and WCM) that are subject to the maternity supplemental payment. The data was reviewed for reasonableness, compared to prior year values, and deemed reasonable to use in this adjustment. This adjustment removed approximately $613.7 million from the 1H 2024 base data.

Institution 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 or lower costs than other members not utilizing IMDs. Within the development of the base data, members in an IMD for more than 15 days in a given month were identified, and their associated costs and member months were removed from the base data. This adjustment had very minimal impact on the base data.

Value-Added Services Carve-Out

As part of the RDT data submissions, the MCPs were required to report costs for services that were not a part of the State Plan benefit package during the 1H 2024 base data period but were provided as value-added services. This adjustment removed all costs for the entire 1H 2024 base data period for value-added services. Approximately $6.2 million was removed from the 1H 2024 base data through this adjustment.

Emergency Department Efficiency Adjustment

Mercer performed a retrospective analysis of the 1H 2024 encounter data to identify emergency department (ED) visits considered preventable or preemptive. For the CY 2026 rate development, Mercer analyzed preventable or preemptive low acuity non-emergent (LANE) visits. This analysis was not intended to imply members should be denied access to EDs or MCPs should deny payment for ED visits. Instead, the analysis was designed to reflect DHCS' objective that MCPs provide effective, efficient, and innovative managed care — care that could have prevented or preempted some members' need to seek care in the ED setting for low acuity, primary care treatable conditions.

The criteria used to define LANE ED visits were based on publicly available studies, as well as input and evaluation from Mercer's licensed clinicians, including practicing ED physicians and those with primary and urgent care experience. International Classification of Diseases (ICD)-10 primary diagnosis code information was the basis for identifying a LANE ED visit. Preventable percentages ranging from 5% to 95% (opioid codes were set at 0% and excluded from the analysis) were assigned to each diagnosis code to account for external factors that can influence and impact variation in ED use.

The percent preventable is only applied to a LANE ED event that includes an Evaluation & Management (E&M) Code of 99281–99283. E&M codes 99284 or 99285 are excluded due to the higher clinical complexity of the patients receiving this service.

Replacement cost offsets (average cost physician visit, and if applicable, average laboratory and radiology costs) were made for the majority of LANE visits deemed potentially preventable to reflect the costs associated with ambulatory OP care for the conditions. Replacement offsets vary depending on accepted clinical interventions expected for a LANE diagnosis.

The components of the replacement cost offset include:

- Physician office visit
- Laboratory
- Radiology

These replacement cost offsets are calculated by determining the cost of an average E&M visit (statewide) using Current Procedural Terminology (CPT) codes 99201–99215, average costs of common laboratory tests, and average costs of common radiology testing. The replacement cost offsets dampen the value of potentially preventable LANE visits by adding costs back into the rate in recognition that care, and services would still need to be rendered in an OP setting.

The adjustment is applied to the Child, Adult, ACA Expansion, and SPD COAs, and varies by each region and immigration status (SIS and UIS). This adjustment reduced the base by approximately $49.2 million.

Potentially Preventable Admissions

For CY 2026, DHCS is utilizing an adjustment to the managed care IP base data that analyzes levels of inefficiency and/or potentially avoidable expenses present in the MCP encounter data.

Potentially preventable admissions were identified through the 1H 2024 Medi-Cal MCP encounter data using criteria from the Agency for Healthcare Research and Quality (AHRQ) Guide to Prevention Quality Indicators (PQI) and Pediatric Quality Indicators (PDI). Additional exclusions for enrollment duration and risk were made as part of the analysis.

This analysis represents a reasonable approach to identifying and quantifying potentially unnecessary expenditures utilizing the AHRQ definitions for each PQI and PDI and their specific exclusions (e.g., deaths and transfers to other facilities). After the relevant services were identified and exclusions applied, Mercer applied a targeted efficiency level of 50%; that is, of the services post exclusions, Mercer is only considering 50% of them for the adjustment. Lastly, credibility in the form of member size for the rate cell was considered. For those instances lacking full credibility, the adjustment was blended with the statewide average.

The adjustment is applied to the Child, Adult, ACA Expansion, and SPD-LTC COAs, and varies by each region and immigration status (SIS and UIS). This adjustment reduced the base by approximately $189.1 million.

Physician Administered Drugs

The final efficiency adjustment Mercer completed was to identify potentially avoidable costs due to reimbursement inefficiencies for physician-administered medications. Mercer reviewed the MCP 1H 2024 professional and OP encounter data to identify drug-related Healthcare Common Procedure Coding System (HCPCS) codes and potential savings associated with those codes.

To identify the potentially avoidable costs, Mercer compared the MCP per unit reimbursement rate to an industry benchmark. For the industry benchmark, Mercer used the Medicare Part B reimbursement rate (CMS average sales price plus 6%) for the same period. Prior to calculating the avoidable dollars, Mercer adjusted for outlier

claims for which MCP unit prices were not consistent with the benchmark unit price or other MCP unit prices for a given HCPCS code.

Inefficient MCP spend is defined as the amount the MCP paid above the re-priced benchmark of average sales price plus 6%. Mercer recognizes MCPs may be able to price more aggressively than the benchmark for some drugs. In these cases, inefficient spend is offset. Total net potential savings reflect the overall inefficient spend by MCPs when compared to the benchmark.

This adjustment was applied to both the OP and Specialty Physician COS' to reflect where physician administered drugs are expected to occur. This adjustment reduced the base by approximately $95.2 million.

Whole Child Model Expansion into New COHS Regions

The WCM program expanded into Mariposa, San Benito, and the Rural Upper Central region effective January 1, 2025. As a result, eligible CCS children in these regions and their associated managed care paid costs were shifted out of their existing rate cell to the respective WCM rate cell. To account for the new managed care coverage of this benefit, FFS-specific CCS costs for these members from the 1H 2024 time period were added to the WCM base data in these three regions. The inclusion of these CCS services added approximately $24.8 million to the base.

Long-Term Care Ramp Up

The transition of the ICF-DD population into managed care was effective January 1, 2024; however, a slight delay in the transition of these members was observed, making this population understated in the 1H 2024 base period. In addition, although the majority of long-term LTC utilizers transitioned in CY 2023, further transitions of utilizers from FFS to managed care, beyond the ICF-DD population, were observed in early 2024. A review of these populations and their experience and an appropriate ramp-up adjustment for each was applied to the base data to account for the under-representation of utilizers in the base period. This adjustment added approximately $85.4 million to the 1H 2024 base.

Kaiser Base Data Development

Consistent with prior rating periods, Kaiser's RDT-reported information was not deemed fully credible to use in the development of base data. For CY 2026, two sources for Kaiser base data were utilized, each described below:

1. A base data derived from averaging all MCPs in Kaiser's regions excluding Kaiser and applying a Chronic Illness and Disability Payment System and Medicaid Rx (CDPS+Rx) risk-adjustment factor calculated as Kaiser's unadjusted risk score divided by the average of other MCP's unadjusted risk score.

    A. In developing this base data, adjusted RDT data from the other MCPs in Kaiser's regions was averaged together to form a region-average base data excluding any Kaiser experience. In this process, BHT, CBAS, long-term LTC,

CS, and ECM costs were removed from the base data derived from the other MCPs.

B. Next, a Kaiser relative risk score was calculated as Kaiser's unadjusted risk score divided by the remaining MCPs' unadjusted risk score, using the CDPS+Rx model. This relative risk score was applied to the region-average base data excluding Kaiser experience. For the BHT, CBAS, LTC, CS, and ECM COS lines, Kaiser's reported data was added to this risk-adjusted region-average data to form the base data specific to Kaiser's members for this data source. This process was only used for the Child, Adult, ACA Expansion, and SPD COAs.

2. A repriced version of the Kaiser RDT data

   A. In repricing Kaiser's RDT-reported information, Kaiser's utilization experience was used for all COS lines with adjustments to reported unit cost levels for service categories which were clear outliers and not representative of the costs associated with the Medi-Cal population.

      i. ER — Kaiser ER unit costs were repriced with a 50% blend of region average unit cost data and 50% blend of Kaiser reported data.

      ii. Professional (PCP, Specialty, FQHC, NPP, MH OP) and Laboratory and Radiology service categories — Kaiser reported unit costs were repriced with reasonable region average unit costs.

The repriced RDT source was then given a 25% credibility weight, and the risk-adjusted region average source was given a 75% credibility weight for the Child, Adult, ACA Expansion, and SPD COAs. All other rate cells received 100% credibility on the repriced RDT data source. This adjustment reduced the base by approximately $666.6 million.

Seasonality

As noted previously, a seasonality adjustment was applied to the base data, since the base data is a 6-month time period. Quarterly RDT data from CY 2019, CY 2021, CY 2022, and CY 2023 RDT data was reviewed to help inform the seasonality adjustment applied to the 1H 2024 base. A positive adjustment was applied to the LTC COS across all rate cells, accounting for the average number of days per month during the 1H 2024 base period relative to the CY 2026 rating period. With the exception of members with dual eligible coverage, Mercer did not identify any consistent and material seasonality patterns when comparing claims experience for the first half of the calendar year with the second half of the calendar year. For the dual population, seasonality patterns were observed likely due to the cost sharing provisions for Medicare services, with higher Medicaid liability observed in the first half of the calendar year as deductibles are being met. Statewide seasonality assumptions by COS were applied with variation by region for the number of partial duals within SPD and LTC. In general, there were slight reductions applied to the dual rate cells due to this adjustment. The final adjustment for seasonality was

relatively small to the overall rates, removing approximately $3.9 million from the 1H 2024 base.

Aggregate Region and SPD-LTC

All adjustments noted above were done to MCP-specific data at the population, region and COA level consistent with RDT reporting. In this step, the base data, after the adjustments described in this section, was aggregated to the region level, consistent with the regions that capitation rates are paid out to the MCPs. Further, the SPD and LTC, as well as, SPD/Full-Dual and LTC/Full-Dual COAs were collapsed into SPD-LTC and SPD-LTC/Full-Dual respectively, for each region. Both of these were done in a budget-neutral application at the base data level.

Data Smoothing

After the base data adjustments described above, a smoothing and data credibility adjustment process was applied in a manner consistent with the process applied historically within the Medi-Cal managed care rate setting process.

Smoothing and Data Credibility Adjustment Process

Utilization and unit cost information from encounters and the adjusted and consolidated RDT data was reviewed at the rate cell and COS detail levels for reasonableness. For the majority of the COS listed previously, ranges of reasonable and appropriate levels of utilization and unit cost were then established for each COS within each rate cell. Averages of the reasonable and appropriate levels for these services were also established for the encounter and the RDT data. This process, in essence, produced four potential data elements of utilization and unit cost for each COS within each rate cell:

- Region-specific encounter data
- Region-specific RDT data
- Average (smoothed) encounter data
- Average (smoothed) RDT data

These four data elements were then adjusted using credibility factors dependent upon the region-specific data being reasonable and appropriate, as well as based on the enrollment size of the population.

The credibility factors can be different for rate cell and COS. Depending on the member months for the base data period (1H 2024) for a given rate cell, base factors are established, giving credibility to the region-specific RDT data, region-specific encounter data, smoothed RDT data, and smoothed encounter data. Larger member month counts correspond to more credibility given to the region-specific RDT and encounter data and less to the smoothed amounts. For example, for a fully credible region based on member months exceeding 24,000, these amounts would be 45% region-specific RDT data, 45% region-specific encounter data, 5% smoothed RDT

data, and 5% smoothed encounter data. For a smaller rate cell, having less than 2,500 but greater than 1,000 member months, these amounts would be 10% region-specific RDT data, 10% region-specific encounter data, 40% smoothed RDT data, and 40% smoothed encounter data.

Another component of this process includes having the RDT and encounter data run through smoothing ranges, based on reasonable ranges of per member per month (PMPM) and unit cost. If the region-specific data (separate by immigration status, COA and COS) is not deemed reasonable (i.e., does not fit into the smoothing ranges), that region-specific data element is given zero credibility, and the base factors are renormalized to add to 100%. For example, if the region-specific encounter data was not deemed reasonable, but the RDT was reasonable, these amounts would be 81.8% region-specific RDT data, 0% region-specific encounter data, 9.1% smoothed RDT data, and 9.1% smoothed encounter data for a fully credible rate cell. Based on this, it is possible for either or both region-specific RDT and encounter data to be deemed unreasonable. For the latter, all credibility would be given to the smoothed values.

After this, all credibility factors are renormalized based on the region-specific data elements that were deemed reasonable. Also note, the smoothed RDT and encounter data are based on averages of the data (across multiple regions) that fell within the smoothing ranges for each rate cell and COS combination. Further, while the region-specific smoothing ranges help account for some region nuances, there are some instances where a region-specific data element may be perfectly reasonable for that region (this is often the case for counties that have higher than normal volume of FQHC activity) but fall outside of the smoothed averages. In these cases, an exception was made to include this otherwise excluded data point. These exceptions, while given credibility for that rate cell and COS combination, are excluded from the smoothed averages.

This smoothing and credibility process was applicable for all COS listed above apart from the following: LTC, BHT services, and CBAS. Access to CBAS services varies widely by region within the Medi-Cal managed care program — some regions have many CBAS facilities while others have none. Due to these differences, both RDT and encounter utilization and cost data were reviewed separately for each region. Ultimately, the base data solely relied on the RDT reported information for these COS.

The result of this process is a credibility adjusted base data by rate cell and COS. However, this data does not tie back to the adjusted RDT data at this point. As noted previously, as long as the population was deemed credible, the final base data was ultimately tied back to the RDT. In order to be fully credible, member months needed be at least 24,000 for a rate cell during the 1H 2024 base period. If the specific rate cell was fully credible, the credibility adjusted RDT was adjusted to tie back to the RDT data source in total across all COS lines, while not necessarily tying exactly by COS line. If the rate cell was not fully credible (i.e., had less than 24,000 member months in the 1H 2024 time period), the credibility adjusted was adjusted to tie back to a blended data source that varied depending on immigration status:

- For the SIS population, the blended data source was the RDT data source blended with an even split of the credibility adjusted data and a broader regional average of the credibility adjusted RDT data.
- For the UIS population, the blended data source was the RDT data source blended with an even split of the credibility adjusted data and each region's SIS data adjusted by a statewide relativity factor of UIS PMPM relative to SIS PMPM.

The RDT data source was given credibility depending on the 1H 2024 member month counts, with higher member month counts resulting in higher credibility given to the RDT data source, while lower member counts resulting in more credibility to the other data sources.

As part of the smoothing and credibility adjustment process, there was one instance where an adjustment was made for a member with catastrophic claims experience within the SIS SPD-LTC rate cell in the Rural Central region. One member within the 1H 2024 base data had claims experience of approximately $6 million. The inclusion of this member resulted in PMPM costs for this rate cell to be significantly higher than expected cost levels going forward. As a result, an adjustment to remove a significant portion of this member's experience was made in the development of the base data for this rate cell.

Base Data Adjustments — Region-specific

After the smoothing process described above, the following adjustments were applied at the CY 2026 region level.

Unsatisfactory Immigration Status Federal Percentage Development

The base data for the UIS population contained all services, including federally eligible and state-only services. As a result, an adjustment was needed to limit the UIS base data to federal services only. In the development of the percentage of the UIS base data for federally eligible services, 1H 2024 encounter data for the UIS population was utilized by analyzing both pregnancy-related and emergency services PMPM spend as a percentage of total UIS PMPM spend. The percentage of UIS dollars for pregnancy-related services and the percentage of UIS dollars for emergency services were analyzed and developed separately. However, the total of the two components makes up the total federal percentage that drives the base data calculation. Within the coding logic, various flags in the data were derived and services were flagged as either pregnancy-related or emergency using a hierarchy logic so each encounter only flagged once as either pregnancy-related or emergency. No encounters were flagged twice in the event that a service was flagged as both pregnancy-related and emergency. The coding logic used to derive the federal percentages (both emergency and pregnancy-related services) can be found in Appendix A.

In terms of the hierarchy used for the federal percentages, the first service flagged in the hierarchy was labor and delivery services, and these services were identified as emergency services. Then, pregnancy-related services were identified next in the

hierarchy, and the remaining emergency services were last in the hierarchy. Using this hierarchy logic, pregnancy-related and emergency services were grouped and separated in the analysis, in order to derive the applicable pregnancy-related and emergency percentages.

The result of this was PMPM amounts by rate cell and COS for the UIS population for pregnancy-related and emergency services, as a percentage of the total UIS PMPMs, separately. In the development of the percentages utilized for the federal capitation rate development, smoothing ranges were developed at the COA and COS level separately for pregnancy-related and emergency services. The smoothing ranges were developed based on a review of each region's data points for the same COA and COS combination. In the smoothing process, if a region-specific percentage fell within the smoothing range, this value was accepted and used in the calculation of a statewide average percentage of total UIS dollars. This was done separately for pregnancy-related and emergency percentages. The result of this was a statewide average percentage of total UIS PMPM spend that is for pregnancy-related and emergency services, by COA and COS. These statewide federal percentages (the sum of pregnancy-related and emergency percentages) were then blended with the region-specific federal percentages to derive the federal percentages applied for each region, by COA and COS. A 50% factor was used for the region percentages and the remaining 50% factor was used for the statewide average percentages. This blend was done to introduce variation seen in the percentages by region. These final blended percentages were then applied to the UIS base data in total by rate cell and COS to derive the UIS base data for federal services only. Remaining services for the UIS population are included in the state-only rates that are not part of this certification.

A further step was then applied to remove services and associated costs specific to IP services after the stabilization of a patient, for IP admissions that originated as an emergency. To derive the adjustment to the federal percentages as a result of this change, only IP records that originated through the ED or had an IP admission code indicating an emergency were reviewed. IP days from these records were then grouped as emergency and non-emergency on a statewide basis based on the definition of an emergency as defined in Appendix A (days when the member is in the intensive care unit [ICU] plus the first two days outside the ICU, for IP admissions that originated through the ED). Based on this review of ICU days to non-ICU days, an assumed cost associated with emergency days and non-emergency days was developed on a statewide basis. The final federal percentage for the IP COS is the emergency IP percentage before this adjustment multiplied by the percentage of IP dollars assumed to be for IP days defined as an emergency based on this analysis.

Provider Contracting Adjustments

Several MCPs communicated to DHCS/Mercer of significant contract changes going into effect after the 1H 2024 base period and as such not reflected within the base. As these contract changes were viewed as above and beyond the assumed trend, they were included within base development and are as follows:

- St. Rose Hospital, Alameda — Effective November 1, 2024, Alameda Health Systems acquired St. Rose Hospital. The estimated rate variance as a result of this acquisition was adjusted for through an IP and ER unit cost adjustment in Alameda, adding approximately $5.6 million to the base.
- San Jose Regional Medical Center, Santa Clara — Effective April 1, 2025, the San Jose Regional Medical Center acquisition by the County of Santa Clara resulted in increased reimbursement levels to the County. This was adjusted for through an IP and ER unit cost adjustment in Santa Clara, adding approximately $11.5 million to the base.
- FQHC Parity, Contra Costa — To meet contract requirements surrounding FQHC payment parity, Contra Costa Health Plan increased payments to FQHC providers. These contract changes, effective January 1, 2026, were reflected through unit cost adjustments to the FQHC and MHOP service categories in Contra Costa, adding approximately $12.4 million to the base.

Whole Child Model Adjustment in San Benito and Rural Upper Central

The WCM rate cells for new COHS counties (San Benito, Rural Upper Central counties, and Mariposa) were new to the CY 2025 rating period for these counties. In review of the base data information (including managed care experience as well as CCS-covered FFS costs), it was noted that the PMPM amounts were significantly lower than other WCM PMPMs in existing WCM counties. This, coupled with contracting difficulties in these regions previously indicated by Partnership Health Plan and Central California Alliance for Health, necessitated an adjustment in order to ensure that costs built in for these rate cells are reasonable, appropriate, and attainable for these rate cells. This ultimately resulted in utilization and unit cost adjustments impacting the Facility (IP, OP, ER), Professional (PCP, Specialty, FQHC, NPP), MHOP, and Transportation service categories in Rural Upper Central and San Benito regions. The adjustments were based on a review of WCM experience in these new COHS counties compared to the existing COHS regions that have more mature WCM programs and similar MCPs due to feedback on similar contracting across their regions. The UIS WCM PMPMs in these regions were not adjusted due to the small population size and reasonable costs. No adjustment was deemed necessary for Mariposa within the Central California region, as this county represents a very small portion of members in this region. This adjustment added approximately $24.1 million to the base.

Maternity Supplemental Payment

To further enhance the measured matching of payment to risk, DHCS utilizes a maternity supplemental payment for all MCPs. Pertaining to gender, the primary issue that could result in significant variance among the MCPs' 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 rate cell. An MCP receives the lump sum maternity supplemental payment when one of its current members within the Child, Adult, ACA Expansion, or WCM COAs gives birth, and DHCS is appropriately notified a birth event has occurred. 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 2026 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. Separate maternity supplemental payments enhance matching payment to risk in large part because they mitigate potential adverse selection effects across MCPs.

Maternity Supplemental — Design

- Payment made on delivery event that generates a state vital record.
- One supplemental payment per delivery regardless of number of births.
- One blended supplemental payment combining caesarean and vaginal deliveries.
- Supplemental payment varies by region, but not by MCP within a region.
- Supplemental payment reflects cost of delivery event only (mother and baby, excluding prenatal and postpartum care).
- Supplemental payment is for the entire CY 2026 time period.
- Same supplemental payment is utilized for the Child, Adult, ACA Expansion, and WCM COAs if a delivery event occurs.
- Inclusion of both direct and global member experience.

Maternity Supplemental — Base Data Development Approach

In general, a similar process used for the development of the base data by rate cell is utilized in the development of the base data for the maternity supplemental payment. The RDT data for maternity for the 1H 2024 base data includes both direct and global members as the main source for this base data development. In addition, only the SIS population was used for the maternity base data development which is consistent with the development of base data for CY 2024. The UIS population data was reviewed but the base data for the UIS population is the same as the SIS population. The actual UIS maternity data for 1H 2024 suggested no major differences in per member delivery costs. The general process for the development of the maternity base data is described below:

- Calculate per delivery costs and utilization from 1H 2024 MCP RDT data by delivery type and COS.

- Same general data selection process used as in regular rate range development. Smoothing and data selection process done by delivery type (caesarean and vaginal).
- Develop smoothed data points to replace missing or unreasonable data.
- Blend reported and smoothed base costs from the MCPs to generate base data by MCP, delivery type, and COS.
- Aggregate base data across region and delivery type.

In the final step of the base data development process, the MCP-specific data (after smoothing and credibility adjustments) is blended across MCPs in each region and across caesarean and vaginal deliveries. As part of this process, the caesarean and vaginal ratios reported by each MCP are reviewed, and appropriate adjustments are made when the reported ratios are unreasonable. In studying historical averages in birth rate types, as well as applying actuarial judgement, an acceptable range of caesarean births as a percentage of total birth count was developed as a quantitative measure in examining what appropriate ratio levels should be. It is our experience that from year-to-year most MCP-reported data would fall within an acceptable range conducive to matching payment with risk. However, in some instances when it is clear data quality might compromise the soundness of the rate, Mercer deems it necessary to adjust the ratio to a more normalized level. Once this process was complete, a final factor was applied across all COS so that the resulting per member per delivery cost is the same as the amount carved out of the MCP’s base data.

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 1H 2024 to CY 2026
- Program Changes
- Population Adjustments
- Cost-Based Reimbursement Clinics (CBRC) in LA County
- Maternity Supplemental Payment Rate Development

The adjustments listed above are shown within the various columns of the CRCS by rate cell and COS, or as capitation rate add-ons. The exact columns are noted within each subsection below. 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 2026 rate range development for the Mainstream managed care program, Mercer developed rating region trend rates at the COA level and for the maternity supplemental payment for each provider type or COS separately by utilization and unit cost components. Notably, Mercer selected the same trends for the SIS and UIS populations for each COA. This was done, as it is Mercer's expectation that utilization or unit cost trends will not differ materially between the two populations on a service category basis. Though Mercer did not vary trend selections between SIS and UIS, the exhibits contained in this section are created using the aggregated SIS population (without Maternity services), where the large majority of program costs are associated. For all COA group cohorts in the CY 2026 rating period, the 1H 2024 base data was trended forward 27 months from the midpoint of 1H 2024 to the midpoint of CY 2026.

Mercer reviewed and utilized multiple sources of data and information for trend development. These include recent MCP encounter data paid through June 2025,

RDT data paid through December 2024, MCP Medi-Cal-only financial statements, MCP-reported lag triangle submissions with paid data through May 2025, Medi-Cal specific hospital IP and OP payment data, Consumer Price Index, and the National Health Expenditure Projections 2024–2033 Forecast Summary[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 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.

Similar to CY 2025 rates, the CY 2026 ECM unit cost trend was assumed to be 5% based on analysis of wage inflation of the providers delivering these services. ECM utilization trends were backed into to align to the separately developed ECM PMPM for the contract period. The development of the CY 2026 ECM PMPMs is described later in this section.

Additional data was reviewed to develop the trends for CS. Mercer reviewed multiple sources of data including RDT data submissions in which MCPs were required to report CS experience, publicly available quarterly CS utilization reports, and CS encounter data. All available data suggests CS utilization will continue to increase. Based on this data, Mercer developed utilization trend factors for the CS COS. Additionally, as these CS services are offered in lieu of traditional services, Mercer assumed unit costs for CS would trend similarly to those of the related categories of service. Utilization and unit cost trends vary by COA and region.

Nearly all service categories experienced growth in annual claim cost trends to reflect the more recent trend experience. However, the COS' in the table below experienced the most growth. In these instances, the annual PMPM trend factors aggregated to a statewide level by COS changed by more than 1.50%. These large changes from the prior year are a result of reviewing newer and emerging information (as described

[1] https://www.cms.gov/files/document/nhe-projections-forecast-summary.pdf

above) to appropriately align prospective payment levels. Please see the table below for a summary of material changes in the Mercer estimate trend assumptions by COS, aggregated to a statewide level.

Table 1

Annual Aggregate PMPM Trend Factors — All SIS			
COS	**CY 2025**	**CY 2026**	**Change**
ER	4.26%	6.34%	2.08%
FQHC	5.39%	7.12%	1.73%
Non-Physician Professional	4.96%	6.50%	1.54%
MHOP	8.75%	12.89%	4.14%
Laboratory and Radiology	4.01%	7.13%	3.12%
Transportation	6.62%	11.44%	4.83%
CBAS	3.72%	11.72%	8.00%
Hospice	0.00%	1.79%	1.79%
CS	14.31%	24.93%	10.62%
ECM	79.60%	45.50%	-34.10%
Other HCBS	5.05%	6.77%	1.71%
All Other	5.05%	6.80%	1.75%

In addition to the annual FQHC trend updates, the FQHC trends now include considerations for CBRCs in LA County. In prior years, the base data was adjusted to include CBRC experience. Starting with CY 2026 rates, the CBRC expenses are included in the base data as reported by the MCPs. Additional data provided by LA County Health Services was used to inform the unit cost trends for CBRCs and therefore the FQHC unit cost trend was adjusted to account for CBRCs within the SPD-LTC COA for LA County.

Trends for the LTC provider type are displayed as 0.0% for unit cost. Due to the relatively high level of legislatively mandated changes surrounding LTC, Mercer has handled LTC unit cost trends through the program changes section of the methodology. Similarly, most Hospice unit cost trends are handled through a program change.

Effective October 1, 2024, California Senate Bill (SB) 525 introduced a tiered minimum wage schedule for covered healthcare employees, requiring many employers to pay $25.00 per hour by June 2026. This new schedule builds on the previous minimum wage of $15.00 per hour and aims to ensure fair compensation for

healthcare workers while addressing industry-specific needs. Mercer analyzed Bureau of Labor Statistics wage data, focusing on occupations within the Medi-Cal benefit package, and assessed the broader impact of wage increases on total labor costs. Additionally, Mercer gathered survey data from MCPs regarding expected changes in contracted rates due to SB 525, anticipating that increased wage pressures will lead to higher reimbursement demands from providers. The SB 525 adjustment is incorporated into the prospective unit cost trend assumption, varying by service category to reflect the specific workforce composition.

After the Mercer 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. In aggregate, the annualized Mercer estimate claim cost trends for the SIS population, across all regions, all COA groups, and all COS, average 4.1% for utilization and 2.7% for unit cost, or 6.9% PMPM. This represents an increase of 1.7% over the aggregate trend figures at the Mercer estimate from those developed for the CY 2025 capitation rates.

The specific trend levels by utilization and unit cost for each COS are displayed in columns (D) and (E) of the CRCS, respectively, for each rate cell 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 midpoint of the base period to the midpoint of the rating period.

Program Changes

Program change adjustments recognize the impact of benefit or eligibility changes that took place during or after the base data period. The program changes incorporated in the development of the rates were based on information provided by DHCS staff as of October 1, 2025. 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 2026 capitation rates. A summary showing the managed care impact by rate cell can be found within the program change charts provided within the Excel file titled *CY 2026 Medi-Cal Rate Summaries 2025 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, unit cost 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. In addition, these services are subject to a State directed payment fee schedule at the State Plan rate under 42

CFR § 438.6(c). It was deemed reasonable and appropriate to use the FFS rate increases in the managed care rate setting process.

Beginning in CY 2024, rate increases for all LTC facilities occur on January 1 of each year. The LTC rate increase factors are developed by rate cell. To calculate the adjustment factors for each rate cell, the distribution of LTC days by the different LTC facility types alongside the fee schedule changes by facility type between the beginning of the base period and the end of the rating period, inclusive of SB 525 considerations, are analyzed by rate cell.

Hospice Rate Increase

Similar to the LTC COS, most 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 October 1 of each year, and the rate increases for Hospice room and board that occur on January 1 of each year. Note that the room and board increases were historically updated on August 1 of each year; however, starting January 1, 2024, these increases are now effective January 1 of each year. To calculate the adjustment factor applied in the capitation rates, the rate increases for Hospice services are weighted with the rate increases for Hospice room and board. In addition, SB 525 was considered in the development of the adjustment. Two adjustment factors are developed at a statewide level across Non-Dual and Dual populations.

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, 21-0017, 22-0040, 23-0020, and 24-0025, and anticipated future continuances, DHCS makes add-on payments to Ground Emergency Medical Transportation (GEMT) providers in the State's FFS program who meet specified requirements using proceeds from a GEMT provider quality assurance fee (QAF). Both State law (Welfare & Institutions Code § 14129.3[b]) and the approved SPAs establish the combination of the State's FFS base and add-on payments constitute the Rogers rates MCPs must pay to non-contracted GEMT providers serving managed care enrollees for those fiscal years in which the GEMT add-on is effective. Similar to prior years, the certified capitation rates have included a program change adjustment to account for this MCP obligation. To develop the program change adjustment, applicable codes were queried in the encounter data, and a per trip add-on of $220.80 was assumed for each applicable trip. In instances where Medicare is anticipated to cover costs for GEMT trips for Full-Dual/Part B eligible members, the total Medi-Cal paid amount was compared to the Medicare fee schedule, and smaller add-on amounts were assumed for these trips based on these differences. Further, this add-on only applies

to non-contracted trips and non-public GEMT providers. All trips were assumed to be non-contracted in the development of this adjustment since historical reporting by the MCPs on contracts for GEMT services has shown very minimal levels of contracting in the program. Further, DHCS provided a list of public GEMT providers, and the trips within this adjustment were only based on providers not in this public provider list.

Ground Emergency Medical Transportation Rate Increase Assembly Bill 1705

Effective January 1, 2023, AB 1705 established the Public Provider GEMT program, increasing the per-trip rate for GEMT public service providers. Based on the data, assumptions, and methodology used in the previous subsection pertaining to the GEMT QAF add-on, a separate rate increase of $1,518.61 was applied to the assumed public GEMT provider trips. Specific to the dual population, this per-trip add-on puts all GEMT trips for the applicable codes above the Medicare fee schedule. As such, all Full-Dual/Part B only public provider GEMT trips have been adjusted to only reflect Medi-Cal's liability of the total GEMT payment, rate inclusive of the AB 1705 add-on. Further, this add-on only applies to non-contracted trips. All trips were assumed to be non-contracted in the development of this adjustment since historical reporting by the MCPs on contracts for GEMT services has shown very minimal levels of contracting in the program.

An assumed add-on increase of $1,518.61 is applied in the CY 2026 rates versus the prior approved add-on rate of $1,049.98. SPA 25-0030 was submitted to CMS on September 30, 2025, for the proposed add-on increase and is currently under review by CMS.

Foster Care Mandatory Transition

Certain Medi-Cal populations within the FFS delivery system transitioned to managed care including the following, effective January 1, 2024 and January 1, 2025:

- Foster Care Mandatory Transition for new COHS regions (San Benito, Rural Upper Central, and Mariposa County, which is a subset of the Central California region)
- Foster Care Mandatory Transition in Single-Plan regions (Alameda, Contra Costa, and Imperial)

For this population, both expected membership volume and costs were considered in the calculation of the program change adjustment. Foster Care members and their associated claims, in new COHS and Single-Plan model counties as of January 1, 2024, were identified in both the 1H 2024 FFS data and emerging managed care encounter data to the extent it was available. For the FFS data, once the appropriate members and claims were identified, the following adjustments were made to make FFS claims more appropriate for these analyses:

- Repriced FQHC FFS units to managed care costs, which do not reflect wrap-around payments made by DHCS.

- Excluded claims for services that would not be covered by MCPs.
- Excluded abortion and delivery claims for the Child, Adult, ACA Expansion, and WCM COAs.
- Impacts for these program change adjustments can be found in the attached Excel rate documentation.

Transitional Care Services

Effective January 1, 2023, Transitional Care Services (TCS) were required for the following populations: IP discharges as a result of pregnancy, discharges for Children with Special Health Care Needs, and discharges for members in the Specialty MH and Drug Medi-Cal programs. These members were all considered high-risk for purposes of TCS.

Effective January 1, 2024, all other discharges from facilities not already covered became subject to the TCS requirements. These other populations/discharges are considered low risk for purposes of TCS.

For the CY 2026 rating period, PMPM adjustments were made at a region level for all TCS services with the final year of program ramp up. CY 2023 and CY 2024 managed care encounter data was averaged to develop estimated totals for CY 2026 TCS population groups. An average of 3.5 service hours per discharge was assumed for high-risk members and an average of 1.07 hours for low-risk members. The staffing model produced for ECM was leveraged for TCS services, and a weighted staffing cost was developed assuming 15% licensed and 85% unlicensed staff for low-risk members, and 70% licensed and 30% unlicensed staff for high-risk members.

Children and Youth Behavioral Health Initiative

Effective January 1, 2024, CYBHI is a policy change and State directed payment for school-linked behavioral health services that implements a minimum fee schedule, incorporated within the Targeted Provider Rate Increase (TRI) fee schedule, which is associated with SPA 24-007 and SPA 24-0035. Local Education Agencies (LEAs) and Institutes of Higher Education (IHEs) participating in the program collaborate with providers to offer school and community-based BH services to students aged 5–25. The providers then bill MCPs through the LEAs according to a minimum fee schedule.

LEA participation in the program is occurring in cohorts, with Cohort 1 LEAs beginning January 1, 2024, Cohort 2 LEAs and IHEs beginning July 1, 2024, Cohort 3 LEAs and IHEs beginning January 1, 2025, Cohort 4 LEAs and IHEs beginning July 1, 2025, and Cohort 5 LEAs and IHEs beginning January 1, 2026.

To determine the impact of this program change, various data sets were analyzed. First, data from SFY 2023–24 was used to determine the percentage of Medi-Cal members in each cohort and archetype (Low Needs, Moderate Needs, High Needs) per region. Members were evaluated based on specific criteria (i.e., homelessness,

foster care status, ACEs screening, etc.), to place them into an archetype. This data identified members aged 5–25 who reside in zip codes covered by LEAs in Cohorts 1 through 4. Cohort 5 LEA and IHE participants were not finalized at the time of rate development, so Cohort 5 utilization was assumed only for regions with an LEA or IHE who applied to be part of Cohort 5. The percentages of members in Cohort 5 for each of these regions were assumed to be half of the remaining population not already covered by Cohorts 1–4, and the percentages of members in each archetype in Cohort 5 were assumed to be the same as the percentages in Cohort 2.

Service utilization assumptions were developed by archetype: Low Needs members were assumed to utilize two services per year, Moderate Needs members five services per year, and High Needs members 20 services per year. Unit cost assumptions, which remain unchanged since CY 2025 rates, were developed by analyzing the CYBHI fee schedule and considering the mix of services likely to be used by each archetype. Additionally, ramp-up assumptions were refined compared to CY 2025 rates based on the utilization trajectory observed through encounter reporting across cohorts that have already begun.

Finally, the regional CYBHI rates for CY 2026 were developed by determining the projected member count in each cohort and using the utilization and unit cost assumptions to calculate the projected dollars. Ramp-up assumptions, varying by cohort, were then applied to the projected dollars. Additionally, since CYBHI procedure codes are existing service codes, SFY 2023–24 claims experience for these codes was carved out of the projected amounts in order to identify the dollars that are a result of the increased utilization from this program change.

Wellness Coach Benefit

Effective January 1, 2025, Wellness Coach is a policy change that implements a Certified Wellness Coach (CWC) to provide Wellness Coach Services. These are preventive services to support non-clinical BH needs of children/youth aged 0–25 but is available to all Medi-Cal members. Services offered include wellness promotion and education, screening, care coordination, individual and group support, and crisis referral. These services must be recommended by a licensed practitioner in order to be offered to a member.

There are two tiers of CWCs based on different educational and workforce pathways. The rate for CWC 2 is assumed to be higher than the rate for CWC 1, as CWC 2 requirements include higher levels of education and more existing experience in the field.

To determine the impact of this program change at a statewide level, a detailed review of utilization data from the first quarter of CY 2025 was performed, which combined insights drawn from prior experience with program ramp-up phases for similar initiatives, recent expenditure trends, and historical ramp-up patterns. It was assumed that each utilizer will receive an average of four CWC services each month, from which we determined the projected hours provided per month by COA. It was then assumed that 99% of these hours were performed in a Managed Care setting.

Final program dollars were then calculated with the assumption that 70% of services will be performed by CWC 1's and 30% performed by CWC 2's. After reviewing current program utilization, projected dollar amount for CY 2026 rates is unchanged from CY 2025 rate development. The program is expected to ramp up to full implementation over a five-year period starting from the implementation date. The projected dollars were then allocated among COAs according to their projected utilization. Please note that this adjustment only applies to the SIS population, since any impacts to the UIS population are considered to be state-only.

Medicare Part A Buy-in

Effective January 1, 2025, DHCS began paying the Medicare Part A premium for certain eligible Medi-Cal members. Effective January 1, 2026, DHCS will expand the scope of eligible Medi-Cal members for the buy-in. Member eligibility for this buy-in program is identified using a combination of both aid codes and Medicare Part A and B indicators available within the Medi-Cal eligibility data. The material impact to member classification is that qualified partial dual members with only Medicare Part B formerly within the SPD-LTC COA would now receive Medicare Part A benefits and will therefore be moved to the SPD-LTC/Full-Dual COA group. This adjustment accounts for the movement of members from SPD-LTC to SPD-LTC/Full-Dual, as well as the reduction in costs associated with these members that will be covered by Medicare Part A during the rating period.

Eligibility and encounter data from the CY 2024 time period was used to develop both enrollment impacts of members moving from SPD-LTC to SPD-LTC/Full-Dual, and cost relativities of the eligible SPD-LTC Part A buy-in members as compared to the larger SPD-LTC COA (inclusive of Part A buy-in eligible members). Both enrollment impacts and cost relativities were used to calculate the PMPM impacts of removing these members from the SPD-LTC rate cells and adding the same members to the respective SPD-LTC/Full-Dual rate cells, while applying reductions to Medicare Part A covered services consistent with the new benefit coverage these members will have.

This adjustment was only applied for the SIS population given the significantly low volume of members within the UIS population. Further, other rate development items were adjusted to account for the impact of the Medicare Part A buy-in, including but not limited to enrollment projections and risk adjustment.

Enhanced Care Management

The ECM program became effective January 1, 2022, and is an important component of the CalAIM initiative developed by DHCS. The ECM benefit replaced elements of the Health Homes Program (HHP), and the care management services provided by the Whole Person Care (WPC) pilots (services provided 2021 and earlier), and ensures the state's most vulnerable, high-need Medi-Cal members can receive WPC services that address both clinical and non-clinical needs through intensive and comprehensive care management support.

The CY 2026 ECM component of the capitation rates is developed by blending the clinical rate development model with the actual ECM emerging experience. Historically, the clinical rate development approach had been utilized exclusively given the lack of credible emerging ECM experience. The clinical model uses statewide clinical assumptions with region-specific adjustments, combined with ECM enrollment projections, to derive MCP and region-specific ECM PMPMs. For CY 2026, actual ECM experience from 1H 2024 is also utilized to develop region-specific ECM PMPMs. The use of emerging experience reflects the planned transition to experience-based rate development in future rating periods as ECM emerging experience becomes more stable and credible.

The final CY 2026 ECM PMPM from both approaches have a 50% blend at a region level, apart from Contra Costa, San Benito, and Central California regions, which are blended at 75% clinical and 25% RDT. Different blending percentages were given to these regions due to the lack of credible experience in the RDT reporting. The clinically developed PMPMs are further adjusted to reflect member acuity based on projected ECM enrollment. It assumes that as enrollment increases in a region, average member acuity and service use decrease.

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, unless otherwise noted. 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 risk-adjusted county average rate process described later in this report.

Health Plan of San Mateo Dental

Effective January 1, 2022, dental services are covered by HPSM in San Mateo County through a dental pilot program. Dental add-ons are applicable only to HPSM and only to the SIS population. The add-ons for the UIS population are considered state-only. Data for the additional dental benefit was excluded from the main RDT submission and submitted through a separate RDT specific to the dental pilot program. The base data utilized was CY 2024 Medi-Cal Dental RDT data reported by HPSM. Expenditures related to the Prop 56 Dental State directed payment under 42 CFR § 438.6(c) were separated out and projected separately. The Prop 56 add-on is applicable only for 1H 2026 (January 1, 2026–June 30, 2026), reflecting the termination of the Prop 56 Dental State directed payment after June 30, 2026. The Prop 56 and the non-Prop 56 components were then adjusted for the following items:

1. The base data was adjusted for the following:
    A. Supplemental to the RDT data submission, HPSM was required to report costs for services that were not a part of the State Plan benefit package during the CY 2024 base period. The reported costs and utilization for these value-added services were removed from the base data.

   B. Through a review of encounter data, Mercer identified abnormal utilization for a particular service at a specific provider in the base period data. In discussion with HPSM, they confirmed they were actively investigating the matter for potential fraud, waste, and abuse. The utilization for the service in question was not indicative of future utilization; therefore, claims were identified and excluded from the base data.

2. Annualized trend factors were applied from the midpoint of the base period to the midpoint of the respective rating period:

   A. For the non-Prop 56 component, the trends are applied from the midpoint of the CY 2024 base period (July 1, 2024) to the midpoint of the CY 2026 rating period (July 1, 2026) for a total of 24 months. Annualized utilization trends ranged from 1.0% to 7.0% by COA, and unit cost trends of 5.0% were applied to all COAs.

   B. For the Prop 56 component, the trends are applied from the midpoint of the CY 2024 base period (July 1, 2024) to the midpoint of the 1H 2026 rating period (April 1, 2026) for a total of 21 months. Annualized PMPM trends ranged from 3.0% to 9.0% by COA.

3. The base data collected in the RDT defined the Child COA as inclusive of all SPD members aged 0–20. In the rating period, SPD members aged 0–20 will be excluded from the Child COA and included in the SPD-LTC COA. In addition, members subject to the State's Medicare Part A buy-in program were reported in the SPD-LTC COA in the RDT base data but will be part of the SPD-LTC/Full-Dual COA in the rating period. As Medicare does not cover this dental benefit, the cost profile for these services is not expected to change with the Part A buy-in. Adjustments were applied to the Child, SPD-LTC, SPD-LTC/Full-Dual COAs to reflect the shift of members from the base reported COA to the rating period COA.

4. A population acuity adjustment was applied, consistent with the adjustment applied in the broader (non-dental) rate development, adjusted to reflect the underlying CY 2024 base period used for the dental add-on, as the non-dental base rate leverages a 1H 2024 base period, as well as for the 1H 2026 rating period for the Prop 56 component.

5. Lower bound administration and underwriting gain loads consistent with the broader rate development were utilized in the development of the PMPM add-on.

The development of the dental add-ons and each adjustment described above is detailed within the Excel file titled *CY 2026 Medi-Cal San Mateo Dental Add-on CRCS 2025 12.xlsx*.

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 2026 capitation rates but ultimately determined these to have no rate impact.

Reinstatement of Asset Thresholds

Effective January 1, 2026 for the SPD-LTC and SPD-LTC/Full-Dual COAs, asset limit qualifications will be reinstated at $130,000 per member (with each additional household member adding $65,000 to the asset limit). Asset limit qualifications were eliminated for Medi-Cal members effective July 1, 2024.

After reviewing information provided by DHCS on the impacted population, it was determined that an adjustment to the rates due to disenrollments resulting from reinstated asset thresholds was not warranted.

Expanded Biomarker and Pharmacogenomic Testing

Effective July 1, 2024, this program change would expand availability of Biomarker and Pharmacogenomic tests not previously covered by SB 535 Biomarker testing. The expansion would require prior authorization, and the new tests would not be a widely available benefit. Predicted utilization of the new expanded benefits is low and it was determined that there was no impact to the rates.

Population Adjustments

For CY 2026, additional adjustments were applied to the managed care data. The adjustments are applied within columns (K) and (L) of the CRCS in the Excel files *titled CY 2026 Medi-Cal Detail CRCS Package LB Rate Smry 2025 12.xlsx and CY 2026 Medi-Cal Detail CRCS Package UB Rate Smry 2025 12.xlsx*. More detail on each adjustment is provided below.

Population Acuity Adjustment

Since the beginning of the PHE beginning March 1, 2020, Medi-Cal ceased disenrolling members with certain exceptions such as members who moved out of state, passed away, or voluntarily requested to be disenrolled. As a result, managed care enrollment numbers began increasing significantly; a reversal of the slightly declining trend observed prior to March 1, 2020. Beginning April 1, 2023, the Maintenance of Effort ended, which included a 90-day processing period, and eligibility disenrollments restarted July 1, 2023. At this point members were subject to be disenrolled if they no longer met eligibility requirements, and the disenrollment of these surplus members was required to occur over a 12-month period, to June 30, 2024 (i.e., the unwinding). As such, the 1H 2024 base data period is the second-half of the unwinding period.

During the unwinding period, DHCS adopted flexibilities offered by CMS to help increase administrative efficiencies in the Medi-Cal renewal process. Most of these

flexibilities expired June 30, 2025, subsequently increasing the number of disenrollments through annual redeterminations.

Separately, starting January 1, 2026, California will implement a Medi-Cal enrollment freeze for certain UIS members aged 19 and older, meaning they will no longer be able to enroll in new, full-scope Medi-Cal coverage. However, those already enrolled can maintain their coverage by completing annual renewals. Children aged 18 and under, and pregnant individuals, can still enroll.

Given the above enrollment changes, the CY 2026 population acuity adjustment is comprised of the following two components:

- An adjustment to account for any acuity impacts (not already included in the base data) related to the unwind to the 1H 2024 base data, and
- An adjustment to account for acuity impacts related to enrollment changes between the base data period and through the CY 2026 contract period.

Unwind Impact to Base Data

The adjustment component for the unwind impact is driven by the identification of member months and services corresponding to members that were ultimately disenrolled through the unwind and present in the 1H 2024 base data. These members were identified using the overlap of four criteria: enrolled as of May 2023, having at least 12 months of enrollment as of May 2023, disenrolled by September 2024 (to allow for the 90-day cure period), and not disenrolled due to death of the member. The adjustment was calculated by removing the member months and services for these members from the base data.

The adjustment component for the unwind impacts was only applied to the SIS population for the Child, Adult, and ACA Expansion COAs. In addition, this component of the adjustment varied by rating region. The UIS population was not adjusted for this component as the 1H 2024 UIS base data was dominated by the expansion of age 26 to 49 members into managed care effective January 1, 2024.

Prospective Acuity Impacts

There are two main items being accounted for within the adjustment component specific to enrollment changes between the base data period and through the CY 2026 contract period. This includes the expiration of the enrollment flexibilities that expired on June 30, 2025, and the enrollment freeze specific to the UIS population aged 19 and older. The adjustment component for the acuity impacts related to enrollment changes between the base data period and through the CY 2026 contract period was done using sensitivity testing of two factors: the acuity of members expected to leave the program and the projected enrollment changes.

The assumption for the acuity of the members expected to leave was based on multiple data sources, including encounter data paid through March 2025 as well as risk score information for members who left the program from July 2025 to August 2025. Within the encounter data, leavers were identified by finding members that left

the Medi-Cal managed care program and did not return within six months. Members that left the program due to death are not labelled as 'leavers' for the purpose of the relativity development. Mercer flagged the last six months of data prior to termination and summarized the member months and services, creating leaver PMPMs. Leaver PMPMs were then compared to the total population PMPM to calculate leaver PMPM relativities. Additionally, CDPS+Rx risk score information was reviewed for the population who was enrolled in Medi-Cal in July 2025 but was not enrolled in August 2025. The risk scores for those that left were compared to risk scores for members who did not leave. July 2025 to August 2025 disenrollments were reviewed since these were the first months which significant enrollment declines were observed as part of the expiring waiver flexibilities. Both data sources indicated that members who leave the program exhibited lower acuity than members who stay enrolled. The estimated enrollment changes were tested using various scenarios of the level of members who will ultimately disenroll.

Due to uncertainty around the magnitude of enrollment changes related to the sunsetting of the temporary eligibility flexibilities and the UIS enrollment freeze (among other influences) as well as the actual acuity levels of the members who will disenroll, Mercer selected an adjustment at the statewide level that represents Mercer's best estimate based on scenario testing. Mercer evaluated multiple scenarios by manipulating both the leaver acuity and the enrollment changes over time, at the statewide level, separated by immigration status and COA. The SIS population was adjusted for Child, Adult, and ACA Expansion COAs, while the UIS population was adjusted for Child, Adult, ACA Expansion, and SPD-LTC COAs.

This adjustment is applied within column (K) of the CRCS in the Excel files titled *CY 2026 Medi-Cal Detail CRCS Package LB Rate Smry 2025 12.xlsx* and *CY 2026 Medi-Cal Detail CRCS Package UB Rate Smry 2025 12.xlsx*. In aggregate, the impact of this adjustment was as follows in Table 2.

Table 2

COA	CY 2025	CY 2026	Change
Child — SIS	4.9%	3.8%	-1.1%
Adult — SIS	5.8%	7.3%	1.5%
ACA Expansion — SIS	6.2%	8.8%	2.6%
Child — UIS	2.3%	1.9%	-0.4%
Adult — UIS	0.0%	5.4%	5.4%
ACA Expansion — UIS	0.0%	5.4%	5.4%

SPD-LTC — UIS	0.0%	1.0%	1.0%

Cost-Based Reimbursement Clinics in Los Angeles County

Full CBRC experience was included in the base data in the development of the CY 2026 rates. This experience was trended to the midpoint of the CY 2026 rating period, as previously described under the Trend subsection. Like prior rate cycles, due to higher costs associated with CBRCs and the disproportionate distribution of CBRC services across the MCPs within LA County for the SPD-LTC COA, further refinement was necessary. The CBRC cost was divided into two components; an arm's length transaction amount reflective of cost levels in line with typical professional services, which includes administrative and underwriting gain loads and is subject to risk adjustment, and a "not subject to risk adjustment" carve out amount, which includes only medical costs and is not subject to risk adjustment.

Within column (S) of the CRCS, the carve-out amounts not subject to risk adjustment are removed from the region-specific rate calculation. These region-specific rates then flow through the risk-adjustment process, which is described later in this certification report. Once the risk-adjusted region average rates are calculated, the medical component of the "not subject to risk adjustment" carve-out amount is added back into the capitation rates for both LA Care and Health Net. For the SIS rates, the medical component carve-out amounts added back into the capitation rates are $95.49 and $58.05 for LA Care and Health Net, respectively, at the lower bound, and $97.53 and $59.29 at the upper bound. Similarly, $7.42 PMPM and $7.16 PMPM was added to the federal component of the UIS rates for SPD-LTC members in LA Care and Health Net, respectively ($7.57 and $7.30 at the upper bound). As Kaiser does not contract with LA DHS and does not utilize CBRCs, this "not subject to risk adjustment" add-on does not apply to Kaiser.

Reclassification of 0–20 Year Olds in Disabled Aid Codes

The base data collected in the RDT defined the Child COA as inclusive of all SPD members aged 0–20. In the rating period, SPD members aged 0–20 will be excluded from the Child COA and included in the SPD-LTC COA. An adjustment was applied to shift any members aged 0–20 in disabled aid codes, and their associated costs, from Child rate cells to the respective SPD-LTC rate cells. The statewide impact of this transition consisted of shifting a total of 1.6 million member months and removes approximately $15.6 billion from Child rate cells and increases SPD-LTC rate cells by approximately $15.6 billion. This adjustment is only applied to the SIS population, since the count of disabled children aged 0–20 was deemed immaterial for the UIS population.

It should be noted that this adjustment is budget neutral in aggregate but is not budget neutral to the capitation PMPMs as an additional $2.3 million was added to the SPD-LTC rate cells to account for maternity supplement payment costs that are not paid out for this COA. Specifically, since there is no maternity supplemental payment for members in SPD-LTC rate cells (and any maternity costs associated

with these members was carved out of the base since they were originally in Child rate cells), assumed costs associated with the maternity supplemental payments were added to the expected disabled child costs when adding the assumed dollars into the SPD-LTC rate cells.

Hospice Adjustment

In review of hospice cost and utilization experience over the past several years, anomalous experience was noted in the LA, Inland Empire, and San Diego rating regions. From this review, it was noted that PMPM experience in these regions was significantly higher than other regions within the managed care program. As a result of these noted anomalies, further analysis was conducted. Specifically, base (1H 2024) hospice experience from encounter data was analyzed by separating hospice experience for members who died versus members who did not die, based on death information through February 2025. Based on this analysis, it was observed that hospice PMPM costs in these regions were similar to other regions for members who had died, but significant outliers compared to other regions for members who had not yet died. Additionally, effective July 1, 2026, DHCS will allow MCPs to implement prior authorization requirements for hospice services.

Due to the anomalous data noted in addition to the policy change for prior authorization of hospice services, a downward adjustment was applied to the Hospice COS line in the LA, Inland Empire, and San Diego regions for the Adult, ACA Expansion, and SPD-LTC rate cells (only impacting the SPD-LTC rate cell in San Diego County). In developing the adjustment, actuarial judgement was utilized, focusing on a reduction to PMPM costs associated with members who had not yet died within the analysis. The adjustment brings hospice PMPM spend in these regions more in line with observed hospice PMPM spend in other regions.

Maternity Supplemental Payment Development

In the development of the maternity supplemental payment, the base data (as described in Section 3) was projected into CY 2026. The steps below describe the process utilized in the development of the CY 2026 maternity supplemental payment rates applicable to the Child, Adult, ACA Expansion, and WCM COA groups.

- Trend base costs forward to the midpoint of the rating period.
  - The trend development process is described in a previous subsection.
- Adjust for applicable program changes.
- Add load for administration and underwriting gain:
  - The development of non-benefit load assumptions is described in Section 5 of this certification report. For the maternity supplemental payment, the assumed administrative expense load leveraged the process described in Section 5 for the standard CY 2026 capitation rates, with a focus on the variable component that typically represents approximately half of the total administrative loading.

This is a supplemental payment and is consistent with the historical approach where only the variable portion of the administrative load is applied since the fixed portion is included in the member's monthly capitation payment. Section 5 provides a summary of the detailed administrative loading percentages specific to supplemental payments including maternity. The underwriting gain load for this payment rate is consistent with those applied for the standard CY 2026 capitation rates (2% at the lower bound, 3% at the Mercer estimate, and 4% at the upper bound).

- SIS and UIS Payment Rates
  - As noted in Section 3, the maternity supplemental payment base data is the same for the UIS and SIS populations. Since no differences are assumed in trend and program change factors by COS, the resulting supplemental payment rates are the same for the UIS and SIS populations by region. The maternity payment specific for the UIS population is considered 100% federal.

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.

Mercer initially reviewed potential encounter data information for making an appropriate adjustment. Unfortunately, the required information (a present on admission indicator, for example) is not consistently part of the encounter data. This is an ongoing process without any consistent information available for a rate adjustment. Other studies and other state experience have shown limited needed adjustments related to these types of conditions. Further, MCPs are assumed not to pay for HACs as part of contractual requirements. No adjustments have been included within these rates.

Graduate Medical Education

Regarding Graduate Medical Education (GMED) 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

MCP contracts regarding GMED. The MCPs do not pay specific rates containing GMED or other GMED-related provisions. As MCP data serves as the base data for the rate ranges, GMED expenses are not part of the capitation rate development process.

Third-Party Liability

The MCP 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

MCPs in the Mainstream managed care program are not required to cover retrospective eligibility periods for their enrollees. These periods are covered in the Medi-Cal FFS program. Since MCP data predominantly serves as the base data for the rate ranges, retrospective eligibility periods are not part of the capitation rate development process. No further adjustments are necessary.

Mental Health Parity and Addiction Equity Act

Regarding the MH Parity and Addiction Equity Act, DHCS staff has confirmed there are no provisions in the MCP contracts in violation of MH Parity and Addiction Equity Act.

Provider Overpayments

The RDT and encounter data used for rate setting are net of provider overpayments. The MCPs are 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).

In Lieu of Services Documentation

For requirements outlined in CMS' communication on In Lieu of Services (ILOS) with the State Medicaid Directors Letter #23-001 (also see 42 C.F.R. § 438.16 and 42 C.F.R. § 438.3(e)(2)), please refer to the following sources included in the certification package for CMS' convenience. The state of California calls ILOS 'Community Supports':

- The *DHCS Community Supports Policy Guide, Volume 1*[2] contains service definitions, target populations, and the State Plan services crosswalk on pages 9, 48, and 73, respectively.
- The *DHCS Community Supports Policy Guide, Volume 2*[3] contains service definitions, target populations, and the State Plan services crosswalk on pages 24, 81, and 108, respectively.
- For the projected ILOS Cost Percentage, please refer to the file named *CY 2026 Prospective ILOS Cost Percentage 2025 12.pdf*.
- For a review on cost-effectiveness, please refer to the files titled *CA ILOS Literature Review 2025 12.pdf* and the *DHCS CY 2024 Community Supports Annual Report*[4].

[2] https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf
[3] https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide-Volume-2.pdf
[4] https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-1915b-Annual-Report-on-ILOS-STC-B20-2025.pdf

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:

- Administration
- Underwriting gain
- MCO Tax

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

Administration

Below is a table detailing the aggregate Mercer estimate administrative percentages assumed within the rate development for CY 2026. The range for the regular administrative loading is +/- 0.7% at the upper/lower bound from the Mercer estimate value for all regions.

Table 3

Region	CY 2025 Administrative Load	CY 2026 Administrative Load	CY 2026 Administrative Load For Supplemental Payments and Add-Ons
Alameda	7.50%	6.65%	3.325%
Contra Costa	7.50%	6.20%	3.100%
Tri-County	7.50%	6.65%	3.325%
Kern	7.50%	6.50%	3.250%
Los Angeles	7.50%	6.90%	3.450%
Inland Empire	7.50%	6.60%	3.300%
San Francisco	7.50%	7.20%	3.600%
San Joaquin Valley	7.50%	6.50%	3.250%
Santa Clara	7.50%	6.25%	3.125%

Region	CY 2025 Administrative Load	CY 2026 Administrative Load	CY 2026 Administrative Load For Supplemental Payments and Add-Ons
Tulare	7.50%	7.25%	3.625%
Sacramento	7.50%	6.85%	3.425%
San Diego	7.50%	6.65%	3.325%
Imperial	7.50%	6.90%	3.450%
Rural South	7.50%	6.30%	3.150%
Rural Central	7.50%	6.50%	3.250%
San Benito	7.50%	7.15%	3.575%
Rural Upper Central	5.20%	6.45%	3.225%
Central California	7.50%	7.10%	3.550%
Central Coast	6.95%	7.00%	3.500%
Orange	6.30%	7.25%	3.625%
San Mateo	6.85%	7.10%	3.550%
Ventura	7.80%	8.20%	4.100%
North Bay	5.20%	6.20%	3.100%
Rural North	5.20%	6.20%	3.100%
Statewide	7.17%	6.73%	3.365%

Similar to prior years, the administrative load assumption for the Medi-Cal Managed Care program is developed in aggregate across rate cells. In prior rating periods, the administrative load was developed using region-specific experience for COHS regions only and in aggregate for all non-COHS regions. For CY 2026, the administrative load factors were developed using a blend of region-specific and statewide experience resulting in the region-specific factors shown above. This approach of region-specific factors was to better reflect administrative costs of the population mix which can vary by region, especially in the case of LTC members, since this population has now transitioned into Medi-Cal Managed Care statewide.

As can be anticipated with a program the size and scope of Medi-Cal, a massive amount of historical and current data and information, from a wide variety of sources, is gathered and analyzed for each capitation rate setting component, with the administration load component being no exception. These sources include data and

information collected from the RDTs used for rate setting as well as quarterly and annual Medi-Cal-specific financial reports submitted by the MCPs to DHCS.

The Mercer estimate percentage was developed in large part from a review of the MCPs' historically-reported administrative expenses. The administrative costs are reviewed to ensure they are appropriate for the approved State Plan services and Medicaid eligible members. Mercer also utilized its experience and actuarial judgment in determining the Mercer estimate and lower/upper bound percentages to be reasonable. A review of the most recent Medi-Cal specific administrative cost data and information indicates an overall decrease of administration percentage from multiple data sources including the most recent quarterly financial data through the second quarter of CY 2025. In addition, with the sunset of enrollment waiver flexibilities, CY 2026 enrollment is expected to be lower than what was experienced in CY 2025. The maintenance of fixed administrative expenses from year-to-year is therefore expected to spread across less membership and revenue. With these considerations, Mercer developed the assumed administration percentage level for CY 2026 rates. As in prior years, the administration load factor is expressed as a percentage of the capitation rate (i.e., percent of premium).

It should also be noted that the aggregate percentages developed are across the entire program, which includes the SIS population as well as both the federal and state-only components for the UIS population. While the percentages are the overall targeted aggregate administrative percentages, the administrative expense associated with each rate cell and UIS/SIS distinction varies from the overall percentage. The administrative component can be viewed in two pieces, a fixed cost component and a variable cost component. The fixed cost component represents items such as accounting, salaries, rent, and information systems, while the variable cost component represents items such as claims processing and medical management per eligible.

While allocating the administrative costs as a uniform percentage of capitation rate for each of the rate cells is an appropriate method, it does not consider the differences in fixed versus variable administrative costs for each. This can be exacerbated especially in cases where a significantly more expensive rate cell may not necessarily incur proportionally as much administrative expense as a uniform percentage may suggest. As the fixed cost component is likely less variable between rate cells, this component was viewed on a PMPM basis, and as such, allowed to vary in percentage across rate cells. The variable cost component is then allocated to each rate cell based on projected claim cost distributions. This concept has been applied in a budget neutral fashion (no administrative dollars have been gained or lost) to the capitation rates, whereby the administrative percentage will be greater for less expensive rate cells than the aggregate administrative percentage over the entire population. Similarly, the administrative percentage for the more expensive rate cells will be less than the aggregate administrative percentage over the entire population.

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

Underwriting Gain

The Mercer estimate underwriting gain remained consistent with the prior rating period at 3% for the CY 2026 rating period across all MCPs. The range for the underwriting gain component is +/- 1.0% at the upper/lower bounds from the Mercer estimate value for all models. Mercer has implicitly and broadly considered the cost of capital within our rating assumptions.

Mercer's conclusion is, these assumptions surrounding underwriting gain, as well as the income an MCP generates from investments, are sufficient to cover at least minimum cost of capital needs for the typical MCP.

Managed Care Organization Tax

An MCO Tax, for which CMS approved waivers of the broad-based and uniformity requirements in December 2023, is in effect during the rating period. To calculate the total tax liability for each MCP, DHCS utilized enrollment from CY 2022. Based on this enrollment period, each MCP's member months were taxed at specific per member rates, categorized by tiers, which also varied depending on the member's type of coverage (Medicaid versus non-Medicaid). Included below is a table that summarizes the approved tax structure for the CY 2026 rating period.

Table 4 — CY 2026 MCO Tax Structure

Medicaid		Non-Medicaid	
Member Range	**Tax per member**	**Member Range**	**Tax per member**
0–1,250,000	$0.00	0–1,250,000	$0.00
1,250,001–4,000,000	$274.00	1,250,001–4,000,000	$2.25
Over 4,000,000	$0.00	Over 4,000,000	$0.00

For the CY 2026 calculations currently included in the accompanying exhibits, Mercer used projections that were informed by enrollment through August 2025 to calculate the add-on PMPMs. CMS issued a "Dear Colleague letter" on November 14, 2025, that provided guidance applicable to the MCO Tax for CY 2026. DHCS anticipates and is currently awaiting further CMS guidance on the MCO Tax model in the form of a final rule. Any necessary changes or adjustments to the appropriate funding levels for or duration of the tax will be re-evaluated and incorporated in a future rate amendment.

Section 6
Risk Adjustment

Risk adjustment was applied to the region average capitation rates for certain rate cells and services with 100% credibility. Within the risk-adjustment process used for the CY 2026 capitation rates, certain services are separated within the region average rates and specific risk-adjustment mechanisms are used to create MCP-specific rates, separate for these services. Within the development of the risk-adjustment factors, the following services were separated out and risk adjusted using different methodologies.

- BHT
- CBAS
- LTC long-term stays
- ECM
- All remaining services

This was done since the traditional model used to risk adjust capitation payments does not necessarily explain MCP risk for certain services like BHT, CBAS, LTC long-term stays, and ECM. For the “all remaining services” item (which represents the majority of costs within the capitation rates), the CDPS+Rx health-based payment model, Version 7.2, was used. For the remaining services (BHT, CBAS, LTC long-term stays, and ECM), separate methodologies were used to risk adjust those components of the capitation rates.

There will be two sets of risk-adjustment factors applicable to the capitation rates for the CY 2026 contract period. The first set of factors will be applicable to capitation rates effective January 1, 2026 through June 30, 2026 (1H 2026) and the second set of factors will be applicable to capitation rates effective July 1, 2026 through December 31, 2026 (2H 2026). This section describes the methodology used to risk adjust each component of the capitation rates for 1H 2026, with anticipated details on the factors for 2H 2026 also described. All of the processes described below are done for both the UIS and SIS populations separately, with credibility considerations described later.

All Remaining Services

The process described in this subsection details the traditional risk-adjustment process for “all remaining services”, which is all services within the capitation rates excluding BHT, CBAS, LTC long-term stays, and ECM.

Mainstream capitation rates are risk adjusted using the CDPS+Rx health-based payment model, Version 7.2, developed by researchers from the University of

California (UC), San Diego. This risk-adjustment process applies to both the SIS and UIS populations, but to the Child, Adult, ACA Expansion, and SPD-LTC COAs only. In addition, since a separate maternity payment rate has been developed, maternity costs were excluded from the risk-adjustment process for the Child, Adult, and ACA Expansion COAs.

Since risk adjustment is applied to distribute funds to MCPs within a region and some regions only have one MCP, capitation rates for MCPs in these regions are not risk adjusted. Further, the WCM rates are not risk adjusted since no readily available model exists for this very specific population. SPD-LTC/Full-Dual rate cells are also not risk adjusted using the CDPS+Rx model as the majority of a dual member's expenses are Medicare's liability, leaving limited experience and costs within the Medi-Cal program for which the CDPS+Rx model is not appropriately calibrated.

The individual acuity factors and final MCP factors in effect for 1H 2026 were based on claims and encounter data with dates of service November 1, 2023 through October 31, 2024 (referred to as the study period), using encounter data submitted by the MCPs to DHCS by April 30, 2025. After individual acuity factors are calculated using the above study period, these acuity factors are aggregated by MCP and rate cell using each MCP's enrollment snapshot as of August 2025.

To ensure the risk-adjustment process does not increase or decrease the total amount of capitation payments, the MCPs' risk factors are adjusted for budget neutrality. The intent of this adjustment is to recalibrate all the MCP risk-adjustment factors to yield a region average of 1.0. Each MCP's own risk-adjustment factors is then applied to the region average base capitation rates (less BHT, CBAS, LTC long-term stays, and ECM components) to arrive at each MCP's risk-adjusted rate.

The risk-adjustment process only includes experience data for individuals who have at least six months of total Medi-Cal eligibility within the 12-month study period. Individuals who do not meet the 6-month eligibility criterion are assigned an assumed risk score, which is typically the respective MCP's average risk factor associated with that individual's rate cell. The exception to this is the Adult and ACA Expansion rate cells for the UIS population, where unscored members in the same region received the region average risk score for a given rate cell to recognize that there is still a ramp up occurring for the UIS age 26–49 expansion population that became eligible for full-scope services in January 2024.

For additional details of the CDPS+Rx risk-adjustment methodology, please see the separate document *CY 2026 CA Final RAR Methodology Document 2025 12.pdf*.

The risk-adjustment factors will be updated for capitation rates for 2H 2026. Updated scores will follow the same general methodology. It is anticipated that a study period of June 1, 2024 through May 31, 2025 will be used in conjunction with an enrollment snapshot month of March 2026 for the 2H 2026 update.

Behavioral Health Treatment Services

The BHT risk-adjustment process is only applicable for the Child and SPD-LTC rate cells, due to immaterial amounts of this service provided to members in other rate cells. To calculate the risk-adjustment factors specific to BHT services, 1H 2024 BHT PMPM experience from the RDT was utilized. Since RDT data for disabled children age less than 21 was reported in Child rate cells, it was necessary to split out RDT-reported BHT costs for disabled children versus non-disabled children to align with the rate cell structure within the CY 2026 rates. To do this, encounter data from 1H 2024 was utilized. Once PMPM costs were split out for the Child and SPD-LTC rate cells, the 1H 2024 PMPMs were used as the basis for the risk-adjustment process. The 1H 2024 BHT PMPMs by MCP were aggregated to a region average level using projected CY 2026 enrollment, and the MCP-specific PMPMs were divided by the region average PMPMs to arrive at the risk-adjustment factor used for BHT services. This process was done for each MCP, region, and applicable rate cell.

Further, only MCPs and regions that met certain credibility criteria were risk adjusted. In order for factors to be calculated for an MCP by rate cell, a minimum of 3,000 base 1H 2024 member months and at least 2% market share was required. If the entire rate cell had less than $100,000 in BHT spend, no factors were calculated. When no factors were calculated, MCPs were defaulted to a 1.0 factor and received the region average BHT PMPM.

Additionally, it should also be noted that the BHT risk-adjustment factors will be updated for capitation rates for 2H 2026. A similar process will be utilized in this update, but RDT-reported data from a more recently submitted RDT will be utilized.

Finally, it should be noted that PMPM experience was utilized for the CY 2026 risk adjustment, and this process will be subject to change in future years. Mercer is currently developing new processes to risk adjust BHT services, which will likely be either diagnosis or utilizer-based (not PMPM based). This process was not complete in time for CY 2026 rates but is intended to be for future rating periods.

Community-Based Adult Services

To calculate the risk-adjustment factors specific to CBAS services, CBAS utilizer prevalence was measured using encounter data from January 2024 through December 2024 (CY 2024) and the State's eligibility data. The encounter data was reviewed at a monthly level and checked for reasonableness against prior experience volume, specific to CBAS services.

The first step in this process was to limit members in the enrollment snapshot month of August 2025. Medi-Cal managed care and FFS enrollment for these members was then reviewed for the CY 2024 time period, and if a member had six or more months of Medi-Cal managed care enrollment within the CY 2024 data period, the member was deemed scored; otherwise, the member was deemed unscored. Any member who had at least 25 days of CBAS utilization in the study period was deemed a CBAS utilizer. Based on this information, CBAS utilizer statistics were generated

based on the snapshot month. This process was done on scored recipients only. Unscored members were assumed to have the same utilizer mix as scored members, separate for each MCP and rate cell.

To derive the MCP factors applicable to the CBAS portion of the capitation rates, each MCP's plan-specific CBAS utilizer percentage was divided by the region average.

Since the vast majority of CBAS costs occur within the SPD-LTC and SPD-LTC/Full-Dual COA groups, this process only applies to these two COA groups. All other populations did not contain enough CBAS service volume to warrant an application of risk adjustment, and the CBAS portion of the rate is not subject to the CBAS risk-adjustment process in these cases.

The risk-adjustment factors will be updated for capitation rates for 2H 2026. Updated scores will follow the same general methodology. It is anticipated that a study period of July 1, 2024 through June 30, 2025 will be used in conjunction with an enrollment snapshot month of March 2026 for the 2H 2026 update.

Long-Term Care Long-Term Stays Services

Budget neutral risk-adjustment factors were created for the portion of the LTC COS attributable to long-term stays (i.e., 90 consecutive days or more). To calculate the risk-adjustment factors specific to LTC long-term stay services, LTC utilizer prevalence by certain facility types was measured using encounter data from April 2024 through December 2024 and the state's eligibility data.

The first step in this process was to limit to members in the enrollment snapshot month of August 2025. Managed care and FFS enrollment for these members was then reviewed for the April 2024 through December 2024 time period, and if a member had three or more months of managed care enrollment within this data period, the member was deemed scored; otherwise, the member was deemed unscored. Any scored member who had at least 90 consecutive days in an LTC facility in the study period was deemed an LTC utilizer. These members were then further classified into three different risk groups hierarchically, as follows: members residing in Distinct Part Skilled Nursing Facilities (DP-NF) facilities, members residing in ICF-DD facilities, and members residing in any other facility (such as a SNF-B facility). In order to be classified in the DP-NF or ICF-DD groups, the member had to have at least 30 days at one of those facilities. Each member was assigned the highest-level risk group that they were classified into within the study period. LTC utilizers classified as DP-NF or ICF-DD received a cost weight value that varied by facility type and region, and all other LTC utilizers received a cost weight value of 1.00. This was done to recognize different average cost levels based on the Medi-Cal fee schedule associated with the different facility types. Members who are not LTC utilizers received a cost weight value of 0.00. Each MCP's unadjusted LTC risk score was calculated as the average cost weight value of all scored recipients and can be viewed as a "cost-weighted LTC utilizer prevalence". Unscored members were

assumed to have the same LTC risk score as scored members, separate for each MCP and rate cell.

To derive the MCP factors applicable to the LTC long-term stays portion of the capitation rates, each MCPs plan-specific average LTC risk score (as described above) was divided by the region average.

This process applies to all COA groups with the exception of Child and WCM, since these two COAs did not contain enough LTC service volume to warrant an application of risk adjustment. In these instances, the LTC long-term stay portion of the rate is not subject to the LTC risk-adjustment process.

The risk-adjustment factors will be updated for capitation rates for 2H 2026. Updated scores will follow the same general methodology. It is anticipated that a study period of October 1, 2024 through June 30, 2025 will be used in conjunction with an enrollment snapshot month of March 2026 for the 2H 2026 update.

Enhanced Care Management

Budget neutral risk-adjustment factors were created by evaluating the relative proportion of members enrolled in ECM to the overall population, or ECM prevalence (i.e., the ratio of ECM member months to total member months). To account for ECM service intensity differences across MCPs and regions, Mercer adjusted membership counts based on reported base period per enrollee per month (PEPM) relativities. ECM enrollment rosters submitted by the MCPs in quarterly reporting for June 2025, adjusted by PEPM relativity, served as the numerator. Total MCP enrollment from the State's eligibility data for the same month was used as the denominator.

To derive the MCP factors applicable to the ECM benefit portion of the capitation rates, each MCP's plan-specific average ECM prevalence was divided by the regional average and then adjusted to recognize the program is still ramping up from the program's inception in January 2022.

The ECM risk-adjustment process only applies to the Child, Adult, ACA Expansion, SPD-LTC, and SPD-LTC/Full Dual COA groups.

The risk-adjustment factors will be updated for capitation rates for 2H 2026. Updated scores will follow the same general methodology. It is anticipated that the quarterly reporting through December 2025 will be used for the 2H 2026 update.

Credibility Considerations

Within all risk-adjustment processes (excluding BHT which is noted in the BHT subsection above), there were credibility requirements for an MCP to be risk adjusted. In order for an MCP to be credible in a certain rate cell, the following criteria needed to be met:

- Scored recipients needed to be at least 500 in the enrollment snapshot month.
- Market share needed to be at least 2.0% in the enrollment snapshot month.

In the event an MCP in a certain rate cell did not meet the credibility criteria noted above, its score was defaulted to a 1.0 factor and final budget neutral factors for all credible MCPs in that rate cell were recalculated excluding the non-credible MCP.

Further, at the rate cell level for the CBAS, LTC, and ECM processes only, a minimum number of utilizers needed to be present in the enrollment snapshot in order for any MCP to be risk adjusted in that rate cell. If the number of utilizers was less than 30 across an entire rate cell, all MCPs within that region and rate cell were defaulted to a 1.0 factor.

All of the risk-adjustment processes apply to both the UIS and SIS populations. However, there are many instances where credibility criteria are not met, in particular for the UIS population. As noted, final risk-adjustment scores are defaulted to a 1.0 in these cases.

Per Members Per Months Not Subject to Risk Adjustment

Noting, while risk adjustment is applied after the inclusion of administrative and underwriting gain loads, it is before the addition of several add-on PMPM amounts, which include the following:

- The LA County CBRC medical component “not subject to risk adjustment” carve-out PMPM amount (described in a prior section).
- Amounts not included within the CRCS sheets but applied as add-on PMPMs — these rating components are not included in the CRCS sheets but applied as pure capitation rate PMPM add-on amounts, similar to prior rating years.
  - Prop 56 Family Planning PMPMs (described in Section 7).
  - ACEs and Developmental Screening PMPMs (described in Section 7).
  - Pass-Through Payment PMPMs (described in Section 7).
  - MCO Tax PMPMs (described in Section 5).
  - FQHC Alternative Payment Methodology (APM) PMPMs (described in Section 7).

The risk-adjustment process described in this section is budget neutral and is not intended to increase or decrease the total statewide capitation payments made by DHCS. As noted above, with the two sets of risk-adjustment factors applicable to CY 2026 capitation rates, two separate sets of rates will be paid in the CY 2026 contract period, separate for 1H 2026 and 2H 2026, differentiated by the two sets of risk-adjustment factors.

Section 7

Special Contract Provisions Related to Payment

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

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

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).

Quality Withhold and Incentive Program — Quality Incentive

The state implemented the Quality Withhold and Incentive (QWI) program beginning in CY 2024. The QWI program is designed to incentivize MCPs to improve the care quality received by Medi-Cal managed care members and reduce racial and ethnic disparities for specified quality measures.

Under the QWI program, a quality incentive is implemented alongside a quality withhold. Any withhold dollars not earned back by MCPs under the quality withhold will be paid out through the quality incentive. Documentation of the quality withhold is included in the Withhold Arrangements section of this certification.

- All MCPs are in the program for CY 2026.
- The QWI incentive has no effect on the development of capitation rates.

Further details of the quality incentive are described in the accompanying methodology letter titled *CY 2026 CA Quality Withhold and Incentive Methodology 2025 12.pdf.*

Withhold Arrangements

Quality Withhold and Incentive Program — Quality Withhold

The quality withhold is implemented alongside the quality incentive under the QWI program, as described in the previous section on Incentive Arrangements. Any withhold dollars not earned back by MCPs under the quality withhold will be paid out through the quality incentive.

MCPs will be scored for achievement based on their performance during the contract period and scored on improvement in performance using a specified set of quality measures. MCPs scoring below a predefined threshold will not earn back the full withhold amount.

The QWI program will withhold 0.76% from the final certified rates across all MCPs for CY 2026. The withhold will apply to both SIS and UIS rates across all rate cells.

All MCPs will participate in the program for CY 2026. The enrollees covered by the QWI program include all Medi-Cal populations covered under the MCPs that are expected to participate in the program for CY 2026.

The QWI withhold has no effect on the development of capitation rates.

Of the total withheld amount, 0% is not reasonably achievable under the QWI program. Further details on the achievability and reasonableness of the quality withhold are described in the accompanying methodology letter titled *CY 2026 CA Quality Withhold and Incentive Methodology 2025 12.pdf.*

Risk-Sharing Mechanisms

Proposition 56 Family Planning Directed Payments

The State is continuing a two-sided, risk corridor associated with the Prop 56 Family Planning directed payment initiative which had such a mechanism in the prior rating period (CY 2025). This is a financial monitoring mechanism to ensure the State directed payment is distributed in accordance with the State's contractual terms and terms of the CMS-approved preprints and is not subject to 42 CFR § 438.6(b)(1). The arrangement is further discussed in the Delivery System and Provider Payment Initiative subsection of this report.

Rationale for the Use of the Risk-Sharing Arrangement

The Proposition 56 Family Planning risk corridor supports DHCS' policy interest in mitigating potential perverse financial incentives for MCPs, thereby lessening the risk of inappropriate utilization of services subject to this directed payment by limiting gains and losses associated with the initiative to a pre-determined threshold. Further, the use of a risk corridor helps promote accurate encounter submissions from providers and MCPs.

Description of How the Risk-Sharing Arrangement is Implemented

A two-sided risk corridor shall be in effect for Prop 56 Family Planning Directed Payments capitation payments to MCPs. The risk corridor 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 COAs and rating regions where the MCP operates for dates of service within the program year. DHCS will perform the risk corridor calculations no sooner than 12 months after the end of the rating period.

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 Family Planning Directed Payments add-on amount, multiplied by the applicable directed payment add-on amount for each encounter. The resulting amounts will be considered the "actual amount" of Prop 56 Family Planning Directed Payments expenditures issued by the MCP to its eligible providers in accordance with this preprint for dates of service within the rating period. 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 Family Planning Directed Payments capitation payment revenues for the rating period, 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 Family Planning 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 Family Planning 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 Family Planning 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 Family Planning Directed Payments.

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

There is no impact on the CY 2026 capitation rates for the provision of the risk corridor. The CY 2026 capitation rates, outlined in the rate certification, reflect Mercer's best estimate of the anticipated costs associated with the Prop 56 Family Planning Directed Payment.

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

Mercer confirms the CY 2026 Prop 56 Family Planning Directed Payment add-on risk-sharing mechanisms were developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medi-Cal covered populations and services under the MCP contract.

Enhanced Care Management

DHCS will continue to use a symmetrical, two-sided risk corridor which was originally implemented during CY 2022 for the ECM benefit in CY 2026.

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 MCP and region depending on the effectiveness of their roll out of the ECM program. MCP-submitted encounters and MCP-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 MCPs. Therefore, the use of this risk corridor helps to better match the payments to the overall risk.

Description of How the Risk-Sharing Arrangement is Implemented

The risk-sharing arrangement will be a two-sided risk corridor utilizing actual ECM expenditures experienced by the MCPs relative to ECM costs funded within the capitation rates. The risk corridor shall be based on a calculated MEP achieved by each MCP. The MEP shall be calculated in aggregate across all applicable rate cells where the MCP 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 an MCP's-submitted encounters that have been accepted by the state in accordance with its policies and MCP-reported supplemental data reported in a DHCS created template, for either of the following allowable medical expenses:

- Approved ECM services for members enrolled in ECM
- Outreach efforts performed by an ECM provider on members 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 MCP'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 MCP will remit to the state within 90 days of notice the difference between 95% of the medical portion of the MCP's applicable ECM add-on capitation payment revenues and the aggregate amount of the MCP's MEP numerator.
- If the aggregate MEP is greater than or equal to 95%, but less than or equal to 105%, the MCP will retain all gains or losses, with no reconciliation payments from the state to the MCP, or vice versa.
- If the aggregate MEP is greater than 105%, the state will remit to the MCP the difference between 105% of the medical portion of the MCP's applicable ECM add-on capitation payment revenues and the aggregate amount of the MCP's MEP numerator.

Once an MEP is calculated, the percentage may be increased by an appropriate credibility adjustment for MCPs with low member months. 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 CS services), expenses for members who do not meet ECM population or phase-in criteria.
- Unreasonable outlier medical expense levels for which the MCP does not provide satisfactory justification based on member mix, utilizer acuity, unique network considerations, and/or other factors.
- Related party expense levels in excess of unrelated party expense levels.
- Separate and distinct payments 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.
- An assumed non-medical component of global subcapitation payments made by MCPs to global subcontractors that aligns with assumptions used in the CY 2026 rate development. Reductions will be applied in a manner that ensures alignment between allowable medical expenses and medical costs considered in the rate development process.

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

Allowable medical expenses will include appropriate expenses for ECM services delivered by the MCP, subject to DHCS having previously authorized the MCP'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 2026 capitation rates for the provision of a risk corridor. The CY 2026 capitation rates, outlined in this rate certification, reflect 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 2026 ECM 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 MCP contract.

Federally Qualified Health Centers Alternative Payment Model

Continuing for the CY 2026 rating period, DHCS will implement a symmetrical, two-sided risk corridor for the FQHC APM program. This risk mitigation mechanism will be applicable to all MCPs having members participating in the FQHC APM.

Rationale for the Use of the Risk-Sharing Arrangement

The potential variability associated with the implementation and ramp up of the FQHC APM supports the benefits of utilizing a two-sided risk corridor. Member enrollment and FQHC participation could vary significantly by rate cell and MCP. MCPs do not have much autonomy in the process; the PMPM is mandated, the MCPs do not select the FQHCs who participate, and it is difficult to change member assignment with FQHCs. MCP-submitted encounters and MCP-reported supplemental data submitted in a DHCS template will be utilized in the risk corridor calculations. The use of a risk corridor helps promote accurate encounter and membership roster submissions from providers and MCPs. Therefore, the use of this risk corridor is an appropriate approach to better match the payments to the overall risk and will improve the completeness and accuracy of data submissions.

Description of How the Risk-Sharing Arrangement is Implemented

The risk-sharing arrangement will be a two-sided risk corridor that utilizes actual FQHC APM PMPM expenditures experienced by the MCPs relative to FQHC APM PMPM costs funded within the capitation rates. The risk corridor shall be based on a

calculated MEP achieved by each MCP. The MEP shall be calculated in aggregate across all applicable rate cells where the MCP 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 MCP-submitted FQHC APM PMPM payments that have been accepted by the state in accordance with its policies and MCP-reported supplemental data reported in a template provided by DHCS.

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 MCP's FQHC APM PMPM add-on capitation payment revenues and the projected medical portion of the APM PMPM already included in the MCP's base capitation rate, for the rating period. The risk corridor will consist of the following bands:

- If the aggregate MEP is less than 99.25%, the MCP will remit to the state within 90 days of notice the difference between 99.25% of the medical portion of the MCP's applicable FQHC APM PMPM add-on capitation payment revenues and the aggregate amount of the MCP's MEP numerator.
- If the aggregate MEP is greater than or equal to 99.25%, but less than or equal to 100.75%, the MCP will retain all gains or losses, with no reconciliation payments from the state to the MCP, or vice versa.
- If the aggregate MEP is greater than 100.75%, the state will remit to the MCP the difference between 100.75% of the medical portion of the MCP's applicable FQHC APM PMPM add-on capitation payment revenues and the aggregate amount of the MCP's MEP numerator.

Once an MEP is calculated, the percentage may be increased by an appropriate credibility adjustment for MCPs with low member months. 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.

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

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

There is no impact on the development of the CY 2026 capitation rates related to the risk corridor provision. The CY 2026 capitation rates, outlined in this rate certification, reflect Mercer's best estimate of the anticipated costs associated with FQHC APM PMPM.

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

Mercer confirms the CY 2026 FQHC APM PMPM 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 MCP contract.

Medical Loss Ratio Remittance

DHCS will continue to impose an 85% minimum MLR remittance for CY 2026. The formula for calculating the Contractor's MLR is a/b, where a is the total covered benefit and service costs of the MCP, including IBNR claim completion in accordance with 42 CFR 438.8(e), and b is the total capitation payments received by the MCP, including any withhold payments minus taxes, licensing, and regulatory fees, in accordance with 42 CFR 438.8(f). Remittance takes place when the Contractor's MLR is below the 85% minimum requirement and is the difference (excess) between the two percentages. Further details of the MLR can be found in the MCP contracts.

Although capitation rates are not directly affected by the minimum MLR requirement, the rates were developed in such a way that the MCPs are reasonably expected to achieve an MLR of at least 85% for CY 2026. This risk mitigation mechanism has been developed in accordance with generally accepted actuarial principles and practices.

State Directed Payments

There are several State directed payments applicable to the Mainstream managed care program CY 2026 capitation rates. All applicable directed payments are summarized in the table below. The following subsections provide more detail around each initiative.

Table 5

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 Dental	Uniform dollar and percentage increases	Uniform percentage and dollar increases for	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?
		specific dental services	
ACEs Screening (no preprint required)	Minimum fee schedule using State Plan approved rates	Minimum fee schedule for specific ACEs Screening services	Rate adjustment
Control Name TBD — Developmental Screenings	Uniform dollar increase	Uniform dollar increase for specific Developmental Screening services	Rate adjustment
Control Name TBD — MOT	Delivery system reform	FFS-equivalent payment requirement for network and non-network providers for newly transitioning organ and bone marrow 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 — Children's Hospital Supplemental Payment (CHSP)	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 increases to capitation	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?
		payments and uniform dollar increases for FFS services limited to predetermined pool amounts by Designated Public Hospital (DPH) class and IP/non-IP service sub-pools	
Control Name TBD — District and Municipal Public Hospital Directed Payment (DHDP)	Uniform dollar increase	Uniform dollar increases for services limited to predetermined pool amounts for IP/non-IP service sub-pools	Separate payment term
Control Name TBD — DPH Quality Incentive Program (QIP)	Quality/performance payments	Payments based on performance on designated measures with specified maximum allowable payments for each DPH	Separate payment term
Control Name TBD — District and Municipal Public Hospital (DMPH) QIP	Quality/performance payments	Payments based on performance on designated measures with specified maximum allowable payments for each DMPH	Separate payment term
Control Name TBD — LTC FFS Equivalent	Delivery system reform	FFS-equivalent payment requirement for network providers for qualifying LTC services in	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?
		transitioning counties; at-least FFS-equivalent requirement for network providers for qualifying LTC services in non-transitioning counties	
TRI (no preprint required)	Minimum fee schedule using State Plan approved rates	Minimum fee schedule for professional, obstetric, and non-specialty MH services	Rate adjustment
CA_Fee_PC_New_20240101-20261231 — Equity and Practice Transformation	Value-based payment	Payments based on performance on designated measures	Separate payment term
CalAIM Dental Preventive Services (no preprint required)	Minimum fee schedule using State Plan approved rates	Minimum fee schedule for specified preventive service codes at the equivalent of 75% above the State's Schedule of Maximum Allowances	Rate adjustment
FQHC APM (no preprint required)	Minimum fee schedule using State Plan approved rates	Minimum fee schedule for participating FQHCs	Rate adjustment
Control Name TBD — Community	Performance-adjusted uniform dollar increase	Uniform, fixed-dollar add-on payments for	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?
Clinics Directed Payment (CCDP)		qualifying contracted visits based on the utilization. Payments will be in the form of a uniform per-unique daily visit increase for qualifying services that is adjusted based on facility-specific performance on the designated quality metric.	

There are no additional directed payments in the program for CY 2026 unaddressed in this rate certification. Any additional directed payments subsequently submitted by the State, not captured herein, shall be addressed in an amendment. There are no requirements regarding the reimbursement rates the MCPs 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.

Federally Qualified Health Centers Alternative Payment Model

Effective July 1, 2024, an APM which provides reimbursement to participating FQHCs on a capitated basis was implemented. For the CY 2026 rating period, two FQHCs have opted into the APM program.

FQHCs are currently reimbursed their PPS rate for each eligible service provided to a Medi-Cal managed care member. This takes the form of MCPs paying an encounter or market rate for each PPS eligible visit that their members make to the FQHC. The State makes a wrap payment to the FQHC representing the difference between the PPS rate to which the FQHC is entitled to and the market rate which the MCP initially reimbursed the FQHC.

The APM pays FQHCs a monthly capitated payment for each Medi-Cal managed member assigned to the FQHC. This monthly capitation is developed using actuarial methods by projecting historical member FQHC utilization into the contract period and applying the PPS rate to the utilization to develop this PMPM. Acknowledging some FQHC utilization naturally comes from unassigned/walk-in members, the utilization assumed in the APM capitation includes unassigned members, subject to

reasonable limitations. If a member is assigned to a clinic, but visits another, different APM participating clinic, no payment for this visit is made to the rendering clinic as that member would be considered unassigned to the other clinic. In situations where there is no assignment between an MCP and an APM participating clinic, and therefore no APM capitation paid, if a member from the MCP visits said clinic the MCP will reimburse the full PPS rate.

In order to evaluate the impact of this program change for affected MCPs, Mercer projected the expected expense the specific MCP will experience based on historical data. These expenses and utilization were projected for the potential payment scenarios the MCP could experience and compared to the historical base expenditures at this clinic, projected to the contract period, to develop the add-on PMPM paid to the MCP. A 4% administrative load, representing the increase in variable administrative expense, and a 3% margin/underwriting gain was applied to this add-on PMPM.

The APM includes safeguards to ensure that participating FQHCs receive their full PPS entitlement and will be linked to specific quality metrics that must be satisfied as a condition of continued participation. The APM does not cover dual eligible members or dental services. These populations and services were excluded from this evaluation.

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

Table 6

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
FQHC APM	Child, Adult, ACA Expansion, SPD-LTC	See "Sum – Add-Ons Details" tabs in the file titled *CY 2026 Medi-Cal Rate Summaries 2025 12.xlsx*	Described above	No preprint required (minimum fee schedule)	Not applicable

Proposition 56/General Fund Directed Payments

Consistent with 42 CFR § 438.6(c), DHCS is utilizing the following provider directed payment initiatives. Two of these share the same designation of "Prop 56" as these payment initiatives are or previously were 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 two are funded using State General Funds and are listed as follows:

- Prop 56 Family Planning
- Prop 56 Dental
- ACE Screening
- Developmental Screening

Prop 56 add-ons are contingent on appropriations of funds being approved by the California Legislature. Currently, all components (with the exception of Prop 56 Dental) are effective for the entire CY 2026 period (January 1, 2026 through December 31, 2026). To the extent the California Legislature does not appropriate funds for the State share for one or more of these payment initiatives for any portion of the CY 2026 period, the state will discontinue the program(s) as of that date (and submit a rate certification amendment). The ACE Screening and Developmental Screening initiatives, listed above with no reference of "Prop 56", will be funded by State General Fund for the State share in CY 2026.

To facilitate CMS rate review for each of the Prop 56/General Fund payment initiatives, the table below summarizes the Prop 56/General Fund 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.

Table 7

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
CalAIM Dental Preventive Services	HPSM only — All COAs	Directed payment is reflected in the CY 2024 base data	Minimum fee schedule for specified preventive service codes at the equivalent of	No preprint required (minimum fee schedule).	Not applicable

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
			75% above the State's Schedule of maximum Allowances.		
Control Name TBD — Prop 56 Family Planning	All except SPD-LTC/Full-Dual	See "Sum – Add-Ons Details" tabs in the file titled *CY 2026 Medi-Cal Rate Summaries 2025 12.xlsx*	Adjustment is applied as a PMPM add on to the rates. A description of the data, assumptions and methodology is provided in the narrative below.	Confirmed. The preprint will be submitted to CMS in December 2025.	Not applicable
Control Name TBD — Prop 56 Dental	HPSM only — All COAs	See exhibit referenced above	Adjustment is applied as a PMPM add on to the rates. A description of the data, assumptions and methodology is provided in the narrative below.	Confirmed. The preprint will be submitted to CMS in December 2025.	Not applicable
ACE Screening	All except SPD-LTC/Full-Dual	See exhibit referenced above	Adjustment is applied as a PMPM add on to the rates. A description of	No preprint required (minimum fee schedule).	Not applicable

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
			the data, assumptions and methodology is provided in the narrative below.		
Control Name TBD — Developmental Screenings	All except SPD-LTC/Full-Dual	See exhibit referenced above	Adjustment is applied as a PMPM add on to the rates. A description of the data, assumptions and methodology is provided in the narrative below.	Confirmed. The preprint will be submitted to CMS in December 2025.	Not applicable

Dental Preventive Services

Consistent with 42 CFR §438.6(c)(1)(iii)(A), DHCS implemented a directed payment initiative that imposes a minimum fee schedule for network providers that provide certain dental services under the contract using State Plan approved rates. The minimum fee schedule for these dental procedure codes applies to all eligible providers who perform these services. These payments are included in the CY 2024 dental base data described previously.

Prop 56 Family Planning

The Prop 56 Family Planning directed payment is a payment arrangement, which directs MCPs to pay a uniform and fixed dollar amount add-on payment for specific family planning services to eligible network and non-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 prior rating periods and the renewal version applicable to the current rating period will be

submitted to CMS for approval in December 2025, with no changes to major terms and conditions.

The following provides a brief description of this payment initiative:

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

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 add-on. The following describes the data, assumption, and methodology used to develop these add-on rates.

There were relatively complete and credible claims experience data available in the base period for both SIS and UIS populations, 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 SFY 2023–24 base period encounter data of the listed 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 childbearing 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. Additionally, payments to American Indian Health Services providers and CBRCs are also excluded. In addition, because the network provider mix varies substantially across individual MCPs and individual rating regions, Mercer further adjusted the statewide claims PMPM using rating region-specific and MCP-specific FQHC/RHC provider exclusion factors to develop the final claims PMPM, which vary

by MCP, rating region, and member immigration status. This benefit cost PMPM is developed separately for SIS and UIS populations. Note, 0% of the Family Planning services were found to meet the criteria as a pregnancy-related or emergency service. As a result, no portion of the UIS rates specific to this directed payment are part of this certification. Lastly, the PMPM amount of each rate component was adjusted to include half of the region-specific administrative load, which provides for the variable component of the administrative costs of the program 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 MCP-specific amounts are provided in the accompanying rate development exhibits in Excel format.

See the table below for detailed impacts for CY 2026.

Table 8

Family Planning (January 2026–December 2026)					
Population	**COA**	**Projected Member Months**	**Prop 56 Add-on Projected Units**	**Total PMPM**	**Total Dollars**
SIS	Child	50,742,585	192,138	$0.73	$36,957,137
SIS	Adult	16,603,898	644,139	$9.47	$157,220,341
SIS	ACA Expansion	41,454,689	632,745	$2.83	$117,159,227
SIS	SPD-LTC	6,968,202	43,646	$0.96	$6,681,372
SIS	WCM	361,833	1,403	$0.75	$270,167
SIS	**All COAs**	**116,131,207**	**1,514,071**	**$2.74**	**$318,288,244**

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 and as described earlier in this certification, the add-on rate payment for this payment initiative will be subject to a two-sided risk corridor specific to Prop 56 Family Planning.

Prop 56 Dental

Consistent with 42 CFR § 438.6(c), DHCS implemented a directed payment initiative that provides payment increases varying from 20% to 60% of the Schedule of Maximum Allowances, or a fixed dollar amount, for certain dental services. The payment increases for these dental procedure codes will be made to all eligible network providers who perform these services for HPSM Dental pilot enrollees. The supplemental payments are included as a PMPM add-on to HPSM's capitation rates. The effective end date for this State directed payment is June 30, 2026. See the Program Changes subsection within Section 4 above regarding HPSM Dental for more details.

Adverse Childhood Experiences Screening

The Adverse Childhood Experiences (ACEs) Screening directed payment is a payment arrangement, which directs MCPs to pay no less than a minimum fee schedule payment for specific ACE 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.
- MCPs are required to pay the eligible providers for the applicable incurred period using a minimum fee schedule for qualifying covered services provided to eligible managed care enrollees up through age 64.

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

The service was added in CY 2021, and Mercer was able to rely on encounter data available in the SFY 2023–24 base period to help inform the take-up assumptions for the CY 2026 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, which is consistent with the actual observed utilization of this service within the base encounter data by COA. Note, enrollees above age 65 or with Medicare Part B coverage are not eligible for this service. The benefit cost PMPM is developed at a statewide level separately for the SIS and UIS populations. Note, 0% of ACE Screening services were found to meet the criteria as a pregnancy-related or emergency service. As a result, no portion of the UIS rates specific to this directed payment is part of this certification. Lastly, the PMPM amount of each add-on rate component was adjusted to include half of the region-specific administrative load, which provides for the variable component of the administrative costs of the program 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 MCP-specific amounts are provided in the accompanying rate development exhibits in Excel format.

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

Table 9

ACEs Screening (January 2026–December 2026)					
Population	**COA**	**Projected Member Months**	**Prop 56 Add-on Projected Units**	**Total PMPM**	**Total Dollars**
SIS	Child	50,742,585	1,215,178	$0.73	$37,052,213
SIS	Adult	16,603,898	95,503	$0.18	$2,988,702
SIS	ACA Expansion	41,454,689	183,996	$0.14	$5,803,656
SIS	SPD-LTC	6,968,202	25,025	$0.11	$766,502
SIS	WCM	361,833	8,039	$0.68	$246,046
SIS	**All COAs**	**116,131,207**	**1,527,740**	**$0.40**	**$46,857,120**

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.

Developmental Screening

The Developmental Screening directed payment is a payment arrangement, which directs MCPs to pay a uniform and fixed dollar amount add-on payment for specific developmental screening 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 prior rating periods and the renewal version applicable to the current rating period will be submitted to CMS for approval no later than December 31, 2025, 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.
- MCPs are required to pay the eligible providers for the applicable incurred period using a uniform dollar increase schedule for qualifying covered services provided to eligible managed care enrollees up through age 20.

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 add-on. The following describes the data, assumption, and methodology used to develop these add-on rates.

Mercer was able to rely on experience data available in the SFY 2023–24 base period to help inform the take-up assumptions for the CY 2026 contract period. Note,

only children under age 21 and without Medicare Part B coverage are eligible for this service. In conjunction with prior take-up assumptions used for historical rating periods, Mercer also relied on actual experience data for the Developmental Screening code within the SFY 2023–24 base period to inform the take-up assumptions used for the CY 2026 contract period. This service is primarily intended for younger children under age three, though older children ages three through 20 are also eligible to receive this service if deemed medically necessary. Given the assumed utilization of this service for each group, the underlying utilization within the encounter data for the SFY 2023–24 base period, and the known additional unit cost (uniform dollar increase), Mercer then calculated the expected claims PMPM as the benefit cost component of the add-on rate. This benefit cost PMPM is developed separately for the SIS and UIS populations. Note, 0% of Developmental Screening services were found to meet the criteria as a pregnancy-related or emergency service. As a result, no portion of the UIS rates specific to this directed payment is part of this certification. Lastly, the PMPM amount of each rate component was adjusted to include half of the region-specific administrative load, which provides for the variable component of the administrative costs of the program 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 MCP-specific amounts are provided in the accompanying rate development exhibits in Excel format.

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

Table 10

Developmental Screening (January 2026–December 2026)					
Population	**COA**	**Projected Member Months**	**Prop 56 Add-on Projected Units**	**Total PMPM**	**Total Dollars**
SIS	Child	50,742,585	865,641	$1.08	$54,692,300
SIS	Adult	16,603,898	6,185	$0.02	$332,078
SIS	ACA Expansion	41,454,689	4,338	$0.01	$414,547
SIS	SPD-LTC	6,968,202	402	$0.00	$0
SIS	WCM	361,833	7,140	$1.25	$450,916
SIS	**All COAs**	**116,131,207**	**883,706**	**$0.48**	**$55,889,841**

Hospital Directed Payments

The following directed payments outlined below are paid as separate payment terms, apart from MOT, 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.

Table 11

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	$13,187.26 million	The actuary certifies the incorporation of the separate payment term	See pink labeled columns in file titled *CY 2026 Medi-Cal Hospital Directed Payment Summary 2025 12.xlsx* for the PMPM estimates	The preprint will be submitted to CMS no later than December 31, 2025.	Confirmed
Control Name TBD — CHSP	$230.00 million	The actuary certifies the incorporation of the separate payment term	See exhibit referenced above	The preprint will be submitted to CMS no later than December 31, 2025.	Confirmed
Control Name TBD — EPP	$3,865.00 million	The actuary certifies the incorporation of the separate payment term	See exhibit referenced above	The preprint will be submitted to CMS no later than December 31, 2025.	Confirmed

Control Name TBD — DHDP	$842.39 million	The actuary certifies the incorporation of the separate payment term	See exhibit referenced above	The preprint will be submitted to CMS no later than December 31, 2025.	Confirmed
Control Name TBD — DPH QIP	$3,463.69 million	The actuary certifies the incorporation of the separate payment term	See exhibit referenced above	The preprint will be submitted to CMS no later than December 31, 2025.	Confirmed
Control Name TBD — DMPH QIP	$178.52 million	The actuary certifies the incorporation of the separate payment term	See exhibit referenced above	The preprint will be submitted to CMS no later than December 31, 2025.	Confirmed

Information included in the attached spreadsheet *(CY 2026 Medi-Cal Hospital Directed Payment Summary 2025 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 MCP on historical utilization and expenditures by COS and provider class as well as the contracted share of those expenditures (payments associated with the MCP 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 will be submitted to CMS for approval no later than December 31, 2025. The PHDP is a uniform dollar add-on payment for services provided by three classes of network private hospitals, Children's hospitals, Critical Access Hospitals (CAHs), and All Other private hospitals. The three classes of network private hospitals are limited to pre-determined pool amounts, with the following splits designated to IP services and to OP services: 51% to IP and 49% to OP for Children's class, 35% to IP and 65% to OP for CAH class, and 57% to IP and 43% to OP for All Other class. The PHDP is a separate payment term; the actual

uniform dollar increase will be calculated after the end of each half of the CY 2026 period based on actual contracted IP and OP/ER services utilized within each 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 each class were applied to the GME PMPM component of the capitation rate by rate cell for each impacted COS (IP and OP/ER). These calculations produced estimated contracted days (for IP) or visits (for non-IP) by class, by rate cell and in total, which formed the basis for creating estimated uniform dollar add-on payment for each COS that would total the intended directed payment target.

The total impact of the PHDP directed payment across the classes is targeted to be approximately $13,187.26 million. The attached exhibit (*Exhibit I CY 2026 Directed Payments PHDP 2025 12.pdf*) contains the full detail of these calculations for each class and COS. The resulting estimates on a PMPM basis by rate cell are provided in the attached spreadsheet (*CY 2026 Medi-Cal Hospital Directed Payment Summary 2025 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 42 CFR § 438.6(c) preprint.

Children's Hospital Supplemental Payment

The CHSP preprint will be submitted to CMS for approval no later than December 31, 2025. The CHSP is a uniform dollar add-on payment for services provided by three classes of network private children's hospitals, limited to pre-determined pool amounts. Within Class 1, 30% is designated to IP services and 70% to OP/ER services; within Class 2 and Class 3, 70% is designated to IP services and 30% to OP/ER services. The CHSP is a separate payment term; the actual uniform dollar increase will be calculated after the end of each half of the CY 2026 period based on actual contracted IP and OP/ER services utilized within each class.

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

The total impact of the CHSP directed payment across the classes is targeted to be approximately $230.00 million. The attached exhibit (*Exhibit VI CY 2026 Directed Payments CHSP 2025 12.pdf*) contains the full detail of these calculations for each class and COS. The resulting estimates on a PMPM basis by rate cell are provided in the attached spreadsheet (*CY 2026 Medi-Cal Hospital Directed Payment Summary 2025 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 42 CFR § 438.6(c) preprint.

Enhanced Payment Program

The EPP directed payment preprint will be submitted to CMS for approval no later than December 31, 2025. The EPP consists of two parts; first, uniform dollar add-on payment for services provided by the four classes of DPHs and second, 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 FFS 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 2026 period based on actual contracted services utilized or members assigned, respectively, within the applicable provider classes and COS.

Classes A through D are outlined below:

- Class A is comprised of non-UC DPHs in Santa Clara County
- Class B is comprised of non-UC DPHs in LA County
- Class C is comprised of non-UC DPHs in Alameda, San Bernardino, San Francisco, 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 42 CFR § 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 MCP 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 member months 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 42 CFR § 438.6(c) preprint.

The total impact of the EPP directed payment across the classes is targeted to be approximately $3,865.00 million. The attached exhibits (*Exhibit II CY 2026 Directed Payments EPP 2025 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 2026 Medi-Cal Hospital Directed Payment Summary 2025 12.xlsx*).

District and Municipal Public Hospital Directed Payment Uniform Dollar Increase

The DHDP preprint will be submitted to CMS for approval no later than December 31, 2025. The DHDP is a uniform dollar add-on payment for services provided by the class of network DMPHs, limited to a predetermined pool amount, with 55% designated to IP (IP/LTC) services and 45% to non-IP (OP/ER) services. The DHDP is a separate payment term; the actual uniform dollar increase will be calculated after the end of each half of the CY 2026 period based on actual contracted IP and non-IP services utilized within the class.

The approach for developing the estimated DHDP uniform dollar increases and PMPM impacts is similar to prior years. The estimated contracted share of revenue and unit cost differentials for the DMPH class were applied to the GME PMPM component of the capitation rate by rate cell for each impacted COS (IP, LTC, and OP/ER). These calculations produced estimated DMPH 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 total impact of the DHDP directed payment across the classes is targeted to be approximately $842.39 million. The attached exhibit (*Exhibit III CY 2026 Directed Payments DHDP 2025 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 2026 Medi-Cal Hospital Directed Payment Summary 2025 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 42 CFR § 438.6(c) preprint.

Designated Public Hospital Quality Incentive Pool

The DPH QIP directed payment preprint will be submitted to CMS for approval no later than December 31, 2025. The DPH QIP directed payment provides value-based payments to DPHs for meeting specified performance measures linked to the utilization and delivery of services under the MCP 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 DPH QIP directed payment estimates are calculated as a uniform percentage increase to anticipated DPH expenditures in CY 2026 by rate cell; the uniform percentage estimate is modeled on a region-specific basis for the counties with non-UC DPHs and a statewide basis for the UC facilities. Each 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 region and for the UC facilities.

The total impact of the DPH QIP directed payment is targeted to be approximately $3,463.69 million. The attached exhibits (*Exhibit IV CY 2026 Directed Payments DPH QIP 2025 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 2026 Medi-Cal Hospital Directed Payment Summary 2025 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 42 CFR § 438.6(c) preprint.

District and Municipal Public Hospital Quality Incentive Pool

The DMPH QIP directed payment preprint will be submitted to CMS for approval no later than December 31, 2025. The DMPH QIP directed payment provides value-based payments to DMPHs for meeting specified performance measures linked to the utilization and delivery of services under the MCP contracts. Each region 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 DPH QIP estimates. The DMPH QIP directed payment estimates are calculated as a uniform percentage increase to anticipated DMPH expenditures in CY 2026 by rate cell; the uniform percentage estimate is

modeled on a region-specific basis for the regions with DMPHs. Each 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 region, which formed the basis for creating uniform percentage increases that would total the intended directed payment maximum allowable payment target for each DMPH region.

The total impact of the DMPH QIP directed payment is targeted to be approximately $178.52 million. The attached exhibits (*Exhibit V CY 2026 Directed Payments DMPH QIP 2025 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 2026 Medi-Cal Hospital Directed Payment Summary 2025 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 42 CFR § 438.6(c) preprint.

Major Organ Transplant Hospital Directed Payment

The MOT directed payment preprint will be submitted to CMS for approval no later than December 31, 2025. This directed payment is specific to hospital stays incorporating the MOT event and only applies to transplants that were historically covered under FFS prior to January 1, 2022. This directed payment directs MCPs to pay hospitals at levels that would be paid in the Medi-Cal FFS delivery system.

Table 12

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	Child, Adult, ACA Expansion, SPD-LTC, SPD-LTC/Full-Dual	$0	Described above.	Confirmed.	Not applicable

Long-Term Care Directed Payment

DHCS implemented a delivery system reform directed payment under 42 CFR § 438.6(c) for the facility per diem reimbursement of LTC services as follows:

- Effective January 1, 2023, MCPs operating in non-COHS and non-CCI regions are required to reimburse network LTC providers at, and those providers are

required to accept, the payment rate that would otherwise have been paid in the FFS delivery system (i.e., Medi-Cal FFS per diem rate). This requirement applies to all LTC services (including ICF-DD and SA services which transitioned to managed care January 1, 2024), both for services transitioning from FFS and all LTC services previously covered by MCPs in these regions.

- Effective January 1, 2023, MCPs operating in COHS and CCI counties are required to reimburse network LTC providers at no less than the payment rate that would otherwise have been paid in the FFS delivery system (i.e., Medi-Cal FFS per diem rate).

This directed payment is incorporated into the capitation rates. As the directed payment was in effect during the base period, no additional rating adjustments were required.

Table 13

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
TBD — LTC Directed Payment	All	$0	The State directed payment is reflected in the base data	Confirmed.	See description above.

Equity and Practice Transformation Directed Payment

The Equity and Practice Transformation (EPT) directed payment requires MCPs to reimburse selected network providers with a uniform dollar add-on payment, modified based on performance on designated measures. The add-on payment is based on 48 provider classes defined by ranges of assigned lives. The directed payment preprint was approved to be categorized as a multi-year value-based payment. The total CY 2026 impact for the EPT Directed Payment is targeted to be approximately $46.7 million.

Table 14

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
CA_VBP_PC_New_20240101 – 20261231 — EPT	All except SPD-LTC/Full-Dual	See the file titled *CY 2026 Medi-Cal EPT Directed Payment Summary 2025 12.xlsx*	Described above.	Confirmed.	Not Applicable.

Targeted Provider Rate Increase

The Targeted Provide Rate Increase directed payment is a payment arrangement, which directs MCPs to pay no less than a minimum fee schedule payment for specific 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 pre-print submitted per 42 CFR § 438.6(c)(2)(ii).

To facilitate CMS rate review for TRI, the table below summarizes the directed payment, since it is incorporated into the capitation rates as part of the base data.

Table 15

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
TRI	All	$0	The State directed payment is reflected in the base data	Not Applicable.	Not Applicable.

Community Clinics Directed Payments

The Community Clinics Directed Payment (CCDP) as outlined below are paid as separate payment terms, apart from other separate payment term directed payments. The actual payments associated with this directed payment will be paid in the future and will be adjusted based on clinic-specific performance on the designated quality metric. A summary of the separate payment term directed payment is provided in the table below.

Table 16

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 — CCDP	$205 Million	The actuary certifies the incorporation of the separate payment term	See *CY 2026 Medi-Cal CCDP Directed Payment Summary 2025 12.xlsx* for the PMPM estimates	The preprint will be submitted to CMS no later than December 31, 2025.	Confirmed

The CCDP preprint will be submitted to CMS for approval no later than December 31, 2025. The CCDP is a performance-adjusted uniform per visit dollar add-on payment for services provided by eligible community clinics when a visit occurs with at least one procedure code contained on the eligible procedure code list. The actual uniform dollar increase will be calculated after the end of the rate period based on actual eligible visits that occurred adjusted for performance measures. The total impact of the PHDP directed payment across the classes is targeted to be approximately $205 million.

The approach for developing the estimated CCDP uniform dollar increases and PMPM impacts is described below. Encounter data is gathered for the applicable providers and procedure codes that occurred during the base period. This utilization is projected by rate cell and region to CY 2026. The uniform dollar add-on is calculated by dividing the targeted program amount ($205 million) by the projected number of qualifying visits. The PMPM impacts are calculated by applying the add-ons to the expected qualifying visits in CY 2026 and dividing by the projected

member months in the analogous rate cell. The resulting estimates on a PMPM basis by rate cell are provided in the attached spreadsheet *CY 2026 Medi-Cal CCDP Directed Payment Summary 2025 12.xlsx*.

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 42 CFR § 438.6(c) preprint.

Pass-Through Payments

Pass-through payments, as described below, are applied in the Mainstream CY 2026 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 MCP 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

Historical adjustments associated with the private hospital quality assurance fee (HQAF) are continuing for CY 2026. The approach for making these adjustments within the capitation rates is being addressed through two paths; first, pass-through payments as defined by 42 CFR § 438.6(d), and second, 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 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 was applied to the capitation GME PMPM by rate cell for each impacted COS (IP and OP/ER). These calculations produced estimated private PMPMs, by rate cell and in total. It should be noted the GME amounts utilized to produce the baseline amounts are inclusive of projected 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 components of the capitation rates were increased by a uniform percentage increase to the IP component and a uniform percentage increase to the OP/ER component. The total target impact of $900 million is projected across all regions and programs. The development of the 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.

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

Included attachments labeled *Exhibit A CY 2026 Private Hospital IP HQAF Pass-Through 2025 12.pdf* and *Exhibit B CY 2026 Private Hospital OP ER HQAF Pass-Through 2025 12.pdf* contain the detailed components behind these calculations. The resulting PMPM add-on rates by rate cell are provided in the "Sum – Region Add-Ons" tabs within the attached spreadsheet *CY 2026 Medi-Cal Rate Summaries 2025 12.xlsx*.

These pass-through payments are paid to private hospitals.

For the private hospital HQAF, the non-federal share of this payment arrangement will consist of the State's HQAF revenue. There are no intergovernmental transfers (IGTs) related to this payment arrangement. As the final payments will be based upon actual member months realized by MCPs, the total amount of the HQAF revenue ultimately necessary for the payments will not be known until after the rating period has ended. 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.

Martin Luther King Jr. Community Hospital in Los Angeles Region

Historical program change adjustments for the Martin Luther King Jr. Community Hospital (MLK) IP component of the LA Region SPD-LTC 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 SB 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 are inclusive of projected 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 includes a 3.10% administrative load, which aligns with administrative costs assigned to the maternity supplemental payment as well as the administrative load included with the Prop 56 directed payment add-on payments. An underwriting gain of 2.00%, 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 $68.73 million across CY 2026 based upon enrollment projections.

Included attachment labeled *Exhibit C CY 2026 MLK IP Pass-Through 2025 12.pdf* contains the detailed components behind these calculations. The resulting PMPM add-on rates by rate cell are provided in the "Sum – Region Add-Ons" tabs within the attached spreadsheet *CY 2026 Medi-Cal Rate Summaries 2025 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. There are no IGTs related to this payment arrangement. As the non-federal share of the final payments will be based upon actual member months realized by MCPs, 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.

Benioff Children's Hospital Oakland in Alameda Region

Historical base data adjustments for Benioff Children's Hospital Oakland (BCHO) in the Alameda region for the Child and SPD-LTC rate cells are being presented as pass-through payments based upon the definition of a pass-through payment within 42 CFR § 438.6(d). As described in prior certifications, the payment levels incorporated within the base data utilized for rate development did not reflect the costs the hospital was incurring to serve the Medi-Cal population. Based upon a review of the cost information provided from the MCPs and the hospital, adjustments have been introduced to produce add-on PMPM amounts reflecting the difference between costs included in the base capitation rates and the actual costs.

The estimated share of revenue for BCHO was applied to the capitation GME PMPM by rate cell and applicable COS. These calculations produced estimated BCHO PMPMs by rate cell and in total. It should be noted the GME amounts utilized to produce the baseline amounts are inclusive of projected 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 across all applicable COS was established to reflect the needed adjustments to reflect total costs. The development of these adjustments also includes a 2.98% administrative load that aligns with administrative costs assigned to the maternity supplemental payment as well as the administrative load included with the Prop 56 directed payment add-on payments. An underwriting gain of 2.00%, 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 $24.26 million across CY 2026 based upon enrollment projections.

The detailed build-up of these adjustments is included in the attachment labeled *Exhibit D CY 2026 BCHO Pass-Through 2025 12.pdf*. The resulting PMPM add-on rates by rate cell are provided in the "Sum – Region Add-Ons" tabs within the attached spreadsheet *CY 2026 Medi-Cal Rate Summaries 2025 12.xlsx*.

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

The non-federal share of this payment arrangement will consist of voluntary IGTs from eligible public entities. For this payment, the entity transferring funds is UC, San Francisco, a state entity that does not have general taxing authority. The IGT for the non-federal share of the payments is voluntary, and the State solicits a letter of intent from UC, San Francisco that will identify the approximate amount of IGTs they plan to provide. As the non-federal share of the final payments will be based upon actual member months realized by MCPs, 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 entity has not received State appropriations specific to this program at this time. As stated above, the non-federal share of this payment will consist of a voluntary IGT for which the transferring entity will certify the transferred funds qualify for federal financial participation. The State has yet to enter into any written agreement with the funding entity relating to the non-federal share of this payment arrangement. The State is not aware of any additional written agreements currently existing 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 a separate agreement with the transferring entity regarding the provision of IGTs for this purpose, including a mechanism whereby the transferring entity certifies that the funds transferred are public funds and eligible for federal financial participation pursuant to applicable federal regulations.

Hospital Pass-Through Payments Base Amount Calculation

For the CY 2026 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 42 CFR § 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, 42 CFR § 438.6(d)(3)(ii)

The amount of historical pass-through payments to hospitals identified in the MCP contract(s) and rate certification(s) in accordance with 42 CFR § 438.6(d)(1)(i) is $2,405,046,774. This amount is unchanged from prior rating periods.

Phased-Down Base Amount, 42 CFR § 438.6(d)(3)(i)

General Methodology

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

1. Twenty (20) percent of the base amount defined at 42 CFR § 438.6(d)(2) applicable to the period of January 1, 2026 through June 30, 2026.
2. Ten (10) percent of the base amount defined at 42 CFR § 438.6(d)(2) applicable to the period of July 1, 2026 through December 31, 2026.

The aggregate amount resulting from this calculation is $993,588,479 as displayed in the exhibit *CY 2026 Base Amount Calculation 2025 12.pdf*.

The 42 CFR § 438.6(d)(2)(i) component of the base amount is equal to the aggregate difference between the amounts calculated in accordance with 42 CFR § 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 MCP contracts for the 12-month period immediately two years prior to the CY 2026 rating period, which corresponds to CY 2024.

The 42 CFR § 438.6(d)(2)(i)(A) calculation includes two elements; unit cost and utilization. All state-only services were excluded in the cost and utilization data for this part of the calculation. Unit costs were based on Department of Health Care Access and Information, statewide data for Medicare FFS beneficiaries. CY 2023 data was leveraged to arrive at estimated CY 2024 average unit costs for IP and OP hospital services. To maintain consistency with the approach used for the 42 CFR § 438.6(d)(2)(i)(B) component, unit cost trend was applied to the CY 2023 data in order to determine a reasonable estimate of CY 2024 unit costs. The trend applied was based on the Consumer Price Index for All Urban Consumers for hospital-related services over the previous three SFYs (SFY 2022–23 through SFY 2024–25). The resulting estimated IP and OP unit costs are 4.79% higher year-over-year compared to the CY 2023 unit costs.

Utilization was calculated based on January 2024 to June 2024 base data used in Medi-Cal managed care rate development that was trended forward to CY 2024. Distinct trends were applied for IP and OP hospital services based on the base data utilization change from SFY 2021–22 through January 2024 to June 2024, annualized. 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 amounts were then summed to determine the total amount for the 42 CFR § 438.6(d)(2)(i)(A) component of the calculation.

The 42 CFR § 438.6(d)(2)(i)(B) calculation includes three elements: unit cost, utilization, and directed payments. January 2024 to June 2024 data was trended to arrive at estimated CY 2024 average unit costs for IP and OP hospital services. The same trend used for the 42 CFR § 438.6(d)(2)(i)(A) component of the calculation was utilized here. Utilization is identical to that used for the 42 CFR § 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 2024 base period to arrive at the total amount for 42 CFR § 438.6(d)(2)(i)(B). The applicable directed payments were made as part of the DPH EPP, PHDP, and DHDP.

Aggregate Difference

The aggregate difference between the total amounts of 42 CFR § 438.6(d)(2)(i)(A) and (d)(2)(i)(B) is $6,623,923,196. This amount was multiplied by a factor of 0.15 to account for the 20% and 10% phase-down levels associated with the ninth and tenth fiscal years, respectively, occurring after July 1, 2017.

Trend Adjustments

At the time of this calculation, January 2024 to June 2024 cost and utilization data specific to Medi-Cal managed care was available for use in this calculation and trended forward to determine the reasonable estimates in calculating the Base Amount for the CY 2026 rating period. Both unit cost and utilization trends were applied in the calculation of the amount specified by 42 CFR § 438.6(d)(2)(i). Trends were applied consistently for both 42 CFR § 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 year-over-year growth from July 1, 2022 through July 1, 2024 was used to determine an annual trend percentage of 4.79%. 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 year-over-year growth from SFY 2021–22 through January 2024 to June 2024, annualized, 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 = $993,588,479

Unit Cost Trend Removed = $769,090,499

Utilization Trend Removed = $951,021,302

Unit Cost Trend and Utilization Trend Removed = $730,372,047

DHCS believes both the unit cost and utilization trends applied in this calculation are reasonable and appropriate.

The 42 CFR § 438.6(d)(2)(ii) component of the base amount is assumed to be equal to $0 at this time, 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 2025 rating period that have subsequently shifted to the Medicaid managed care delivery system. There were material shifts of IP and OP hospital services, and of eligible populations, from Medicaid FFS to Medicaid managed care for the applicable time periods. However, given the 42 CFR § 438.6(d)(2)(i) component on its own exceeds the projected aggregate amount of pass-through payments for the CY 2025 rating period, DHCS has opted to keep this component of the calculation $0 at the

current 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 8

Certification and Final Rates

This certification assumes items in the Medicaid State Plan or Waiver, as well as the MCP 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 MCPs, and its vendors. DHCS, its MCPs, 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 Mainstream capitation rates, for CY 2026, January 1, 2026 through December 31, 2026, 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 MCP 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, and collectively do certify to the actuarial soundness, of these Medicaid Medi-Cal 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 MCP 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.

MCPs 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 MCPs for any purpose. Mercer recommends that any MCP 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 Rodney Armstrong at rodney.armstrong@mercer.com, Katharina Katterman at katharina.katterman@mercer.com, Jim Meulemans at james.meulemans@mercer.com, Robert O'Brien at robert.j.o'brien@mercer.com, Ethel Tan at ethel.tan@mercer.com, or Timothy Washkowiak at timothy.washkowiak@mercer.com.

Sincerely,

[redacted]

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Appendix A

Pregnancy-related and Emergency Service Identification Logic

This appendix details the logic and codes that were used in the identification of pregnancy-related and emergency services, which make up the federally eligible capitation rates for the UIS population. The process utilized contained logic and codes developed both by DHCS and Mercer. In this process, each encounter for the UIS population was flagged (yes or no) into different types of categorizations identified as either pregnancy-related or emergency services. After each encounter was categorized into these flags, a hierarchy was used to ensure each encounter only flagged into one category. Finally, based on the final category for each encounter, each encounter was then classified as pregnancy-related, emergency, or neither. Encounters identified as pregnancy-related, or emergency were the basis of the development of the pregnancy-related and emergency percentages and the federally eligible capitation rates for the UIS population.

Below is a list of the different types of emergency and pregnancy-related categories. Additionally, an indication as to whether the categorization is emergency or pregnancy-related is also shown. Detailed codes and logic for each category are listed later in this Appendix. Note, the Rx claims are not present within the logic below since Rx services were carved out of the MCP contracts effective January 1, 2022. Additionally, the order of the categorizations below corresponds to the hierarchy used as well.

1. Labor and Delivery (Emergency) — Labor and delivery is separated out from other maternity-related services since labor and delivery is considered emergency for claiming purposes.
2. Maternity DHCS (Pregnancy-related) — The State maintains an existing set of business rules or logic/criteria it uses to identify applicable maternity-related services for FFS claiming on the UIS population. This category corresponds to this logic. Mercer reviewed the State's logic to ensure agreement that the services identified by the logic would be related to a maternity-related service. Mercer's assessment was that the logic included was a reasonable basis for the identification of the maternity services.
3. Maternity Mercer (Pregnancy-related) — Mercer maintains a set of codes and coding methodology to identify maternity-related services in encounter data for capitation rate development purposes. Mercer's coding and methodology was developed by and is continually refined by Mercer's team of clinicians and coding and data specialists.

4. Pregnancy-related “Catch All” (Pregnancy-related) — This logic identified live birth or delivery events. Using that birth/delivery event date, all encounters were pulled within SFY 2022–23 for these members with dates of service 238 days prior to the delivery event (pregnancy-related services). The 238-day threshold (34 weeks) was selected because based on information from the National Center for Health Statistics, only 3% of babies are born before 34 weeks of pregnancy. That means 97% of all births are at 34 weeks of pregnancy or later. This 238-day threshold is viewed as conservative because it does not account for the first few weeks of pregnancy for most births (90% of births are at 37 weeks or later). The assumption here is that virtually every service delivered during pregnancy is ultimately for the benefit of the unborn child.
5. Emergency Medical Transportation (Emergency)
6. Emergency Facility (Emergency)
7. Emergency Other (Emergency)
8. IP Admissions that Originated Through the ER (Emergency)
9. Dialysis (Emergency)
10. Emergency DHCS (Emergency) — Similar to the Maternity DHCS categorization, the State maintains existing business rules or logic/criteria is uses to identify emergency-related services for FFS claiming on the UIS population. Mercer reviewed the State’s logic to ensure agreement that the services identified by the logic would be related to an emergency-related service. Mercer’s assessment was that the logic included was a reasonable basis for the identification of the emergency services.

Effective January 1, 2025, DHCS updated its definition of an emergency for certain IP services. As noted in the Data section within this certification, IP hospital admissions that occurred as an emergency or originated through the ED were further split into costs associated with the IP stay up to the stabilization of the patient and after the stabilization of the patient. For purposes of the federal claiming logic, emergency IP days are defined to be any IP day in which the member is in the ICU plus the first two days of each admission when a member is not in the ICU. Any other day within an IP stay that originated as an emergency is considered state-only. This logic only applies to IP days that originated through the ER or had an IP admission code indicating the admission was an emergency. All other IP days within the logic are unaffected by this change.

Detailed Codes and Logic

Note, in the logic provided below, overlap does occur. As noted previously, all encounters flagging into multiple categories were ultimately only flagged into one category due to the hierarchical logic applied.

1. **Labor and Delivery Criteria**

The following conditions must be satisfied for an encounter to be considered a Labor and Delivery encounter.

Criteria Set 1:

A. The encounter has one of the 25 diagnosis code fields populated with one of the following codes:

'O6010X0', 'O6010X1', 'O6010X2', 'O6010X3', 'O6010X4', 'O6010X5', 'O6010X9', 'O6012X0', 'O6012X1', 'O6012X2', 'O6012X3', 'O6012X4', 'O6012X5', 'O6012X9', 'O6013X0', 'O6013X1', 'O6013X2', 'O6013X3', 'O6013X4', 'O6013X5', 'O6013X9', 'O6014X0', 'O6014X1', 'O6014X2', 'O6014X3', 'O6014X4', 'O6014X5', 'O6014X9', 'O6020X0', 'O6020X1', 'O6020X2', 'O6020X3', 'O6020X4', 'O6020X5', 'O6020X9', 'O6022X0', 'O6022X1', 'O6022X2', 'O6022X3', 'O6022X4', 'O6022X5', 'O6022X9', 'O6023X0', 'O6023X1', 'O6023X2', 'O6023X3', 'O6023X4', 'O6023X5', 'O6023X9', 'O670', 'O678', 'O679', 'O68', 'O690XX0', 'O690XX1', 'O690XX2', 'O690XX3', 'O690XX4', 'O690XX5', 'O690XX9', 'O691XX0', 'O691XX1', 'O691XX2', 'O691XX3', 'O691XX4', 'O691XX5', 'O691XX9', 'O692XX0', 'O692XX1', 'O692XX2', 'O692XX3', 'O692XX4', 'O692XX5', 'O692XX9', 'O693XX0', 'O693XX1', 'O693XX2', 'O693XX3', 'O693XX4', 'O693XX5', 'O693XX9', 'O694XX0', 'O694XX1', 'O694XX2', 'O694XX3', 'O694XX4', 'O694XX5', 'O694XX9', 'O695XX0', 'O695XX1', 'O695XX2', 'O695XX3', 'O695XX4', 'O695XX5', 'O695XX9', 'O6981X0', 'O6981X1', 'O6981X2', 'O6981X3', 'O6981X4', 'O6981X5', 'O6981X9', 'O6982X0', 'O6982X1', 'O6982X2', 'O6982X3', 'O6982X4', 'O6982X5', 'O6982X9', 'O6989X0', 'O6989X1', 'O6989X2', 'O6989X3', 'O6989X4', 'O6989X5', 'O6989X9', 'O699XX0', 'O699XX1', 'O699XX2', 'O699XX3', 'O699XX4', 'O699XX5', 'O699XX9', 'O700', 'O701', 'O7020', 'O7021', 'O7022', 'O7023', 'O703', 'O704', 'O709', 'O720', 'O721', 'O722', 'O723', 'O730', 'O731', 'O740', 'O741', 'O742', 'O743', 'O744', 'O745', 'O746', 'O747', 'O748', 'O749', 'O750', 'O751', 'O752', 'O753', 'O754', 'O755', 'O7581', 'O7582', 'O7589', 'O759', 'O76', 'O770', 'O771', 'O778', 'O779', 'O80', 'O82', 'Z370', 'Z371', 'Z372', 'Z373', 'Z374', 'Z3750', 'Z3751', 'Z3752', 'Z3753', 'Z3754', 'Z3759', 'Z3760', 'Z3761', 'Z3762', 'Z3763', 'Z3764', 'Z3769', 'Z377', 'Z379’

or

A. The encounter has one of the following procedure codes:

'59400', '59409', '59410', '59510', '59514', '59515', '59610', '59612', '59614', '59618', '59620', '59622', '59899', '01960', '01961'

or

B. The encounter has one of the following surgical procedure codes:

'10D00Z0', '10D00Z1', '10D00Z2', '10D07Z3', '10D07Z4', '10D07Z5', '10D07Z6', '10D07Z7', '10D07Z8', '10D17Z9', '10D17ZZ', '10D18Z9', '10D18ZZ', '10E0XZZ'

Criteria Set 2:

Identify the IP encounter tied to the delivery event (delivery event falls between start and end dates of service, where COS equals IP). Consider all encounters within this span of time to be Labor and Delivery encounters.

2. **Maternity DHCS**

This was taken from Business Rules 001A and 006 from SDN 17041–TSD document provided by DHCS.

Any one of the following conditions (criteria set) must be satisfied:

Criteria Set 1:

A. Any of the 25 diagnosis codes are any of the ICD–10 codes mentioned in Appendix table row code set two of DHCS SDN 17041–TSD document:

   'O000' through 'O039', 'O050' through 'O069', 'O080' through 'O089', 'O0900' through 'O0993', 'O10011' through 'O16999', 'O200' through 'O2993', 'O30001' through 'O481', 'O6000' through 'O779', 'O85' through 'O9279', 'O94' through 'O9989', 'Z3400' through 'Z3493', 'Z3A00' through 'Z3A49', 'Z370' through 'Z3799', 'Z390' through 'Z392', 'A34', 'M830', 'O80', 'O82', beginning with ‘F53’, beginning with ‘Z36’, beginning with ‘O9989’, beginning with ‘Z37’

Criteria Set 2:

A. Procedure code is any of the codes mentioned in Appendix table row code set three of DHCS SDN 17041–TSD document:

   '00842', '59400', '59409', '59414', '59510', '59514', '59525', '59610', '59612', '59618', '59620', '76946', '80055', '81508', '81511', '82106', '82731', '88267', '88269', 'S0190', 'S0197', 'S0199', 'Z1030', 'Z1032', 'Z1034', 'Z1036', 'Z1038', '01958' through '01965', '01967' through '01969', '59000' through '59076', '59100' through '59160', '59300' through '59350', '59831' through '59857', '59870' through '59899', '76801' through '76828', 'Z6200' through 'Z6500'

Criteria Set 3:

A. Any of the 25 surgical procedure codes are any of the below ICD–10 surgical procedure codes mentioned in Appendix table row code set four of DHCS SDN 17041–TSD document:

   '10900ZA' through '10900ZD', '10903ZA' through '10903ZD', '10904ZA' through '10904ZD', '10907ZA' through '10907ZD', '10908ZA' through '10908ZD', '10D00Z0' through '10D00Z2', '10D07Z3' through '10D07Z8', '10Q00YE' through '10Q00YH', '10Q00YJ' through '10Q00YN', '10Q00YP' through '10Q00YT', '10Q00ZE' through ‘10Q00ZH', '10Q00ZJ' through '10Q00ZN', '10Q00ZP' through '10Q00ZT', '10Q03YE' through '10Q03YH',

'10Q03YJ' through '10Q03YN', '10Q03YP' through '10Q03YT', '10Q03ZE' through '10Q03ZH', '10Q03ZJ' through '10Q03ZN', '10Q03ZP' through '10Q03ZT', '10Q04YE' through '10Q04YH', '10Q04YJ' through '10Q04YN', '10Q04YP' through '10Q04YT', '10Q04ZE' through '10Q04ZH', '10Q04ZJ' through '10Q04ZN', '10Q04ZP' through '10Q04ZT', '10Q07YE' through '10Q07YH', '10Q07YJ' through '10Q07YN', '10Q07YP' through '10Q07YT', '10Q07ZE' through '10Q07ZH', '10Q07ZJ' through '10Q07ZN', '10Q07ZP' through '10Q07ZT', '10Q08YE' through '10Q08YH', '10Q08YJ' through '10Q08YN', '10Q08YP' through '10Q08YT', '10Q08ZE' through '10Q08ZH', '10Q08ZJ' through '10Q08ZN', '10Q08ZP' through '10Q08ZT', '10Y03ZJ' through '10Y03ZN', '10Y03ZP' through '10Y03ZT', '10Y04ZE' through '10Y04ZH', '10Y04ZJ' through '10Y04ZN', '10Y04ZP' through '10Y04ZT', '10Y07ZE' through '10Y07ZH', '10Y07ZJ' through '10Y07ZN', '10Y07ZP' through '10Y07ZT', '0W8NXZZ', '0WQNXZZ', '10900Z9', '10900ZU', '10903Z9', '10903ZU', '10904Z9', '10904ZU', '10907Z9', '10907ZU', '10908Z9', '10908ZU', '10D17ZZ', '10D18ZZ', '10E0XZZ', '10H003Z', '10H00YZ', '10H073Z', '10H07YZ', '10J00ZZ', '10J03ZZ', '10J04ZZ', '10J07ZZ', '10J08ZZ', '10J0XZZ', '10J10ZZ', '10J13ZZ', '10J14ZZ', '10J17ZZ', '10J18ZZ', '10J1XZZ', '10J20ZZ', '10J23ZZ', '10J24ZZ', '10J27ZZ', '10J28ZZ', '10J2XZZ', '10P003Z', '10P00YZ', '10P073Z', '10P07YZ', '10Q00YV', '10Q00YY', '10Q00ZV', '10Q00ZY', '10Q03YV', '10Q03YY', '10Q03ZV', '10Q03ZY', '10Q04YV', '10Q04YY', '10Q04ZV', '10Q04ZY', '10Q07YV', '10Q07YY', '10Q07ZV', '10Q07ZY', '10Q08YV', '10Q08YY', '10Q08ZV', '10Q08ZY', '10S07ZZ', '10S0XZZ', '10T20ZZ', '10T23ZZ', '10T24ZZ', '10Y03ZE', '10Y03ZH', '10Y03ZV', '10Y03ZY', '10Y04ZV', '10Y04ZY', '10Y07ZV', '10Y07ZY', '30273H1', '30273J1', '30273K1', '30273L1', '30273M1', '30273N1', '30273P1', '30273Q1', '30273R1', '30273S1', '30273T1', '30273V1', '30273W1', '30277H1', '30277J1', '30277K1', '30277L1', '30277M1', '30277N1', '30277P1', '30277Q1', '30277R1', '30277S1', '30277T1', '30277V1', '30277W1', '3E053VJ', '3E0DXGC', '3E0E305', '3E0E33Z', '3E0E36Z', '3E0E37Z', '3E0E3BZ', '3E0E3GC', '3E0E3HZ', '3E0E3KZ', '3E0E3NZ', '3E0E3SF', '3E0E705', '3E0E73Z', '3E0E76Z', '3E0E77Z', '3E0E7BZ', '3E0E7GC', '3E0E7HZ', '3E0E7KZ', '3E0E7NZ', '3E0E7SF', '3E0E805', '3E0E83Z', '3E0E86Z', '3E0E87Z', '3E0E8BZ', '3E0E8GC', '3E0E8HZ', '3E0E8KZ', '3E0E8NZ', '3E0E8SF', '4A0H74Z', '4A0H7CZ', '4A0H7FZ', '4A0H7HZ', '4A0H84Z', '4A0H8CZ', '4A0H8FZ', '4A0H8HZ', '4A0HX4Z', '4A0HXCZ', '4A0HXFZ', '4A0HXHZ', '4A0J72Z', '4A0J74Z', '4A0J7BZ', '4A0J82Z', '4A0J84Z', '4A0J8BZ', '4A0JX2Z', '4A0JX4Z', '4A0JXBZ', '4A1H74Z', '4A1H7CZ', '4A1H7FZ', '4A1H7HZ', '4A1H84Z', '4A1H8CZ', '4A1H8FZ', '4A1H8HZ', '4A1HX4Z', '4A1HXCZ', '4A1HXFZ', '4A1HXHZ', '4A1J72Z', '4A1J74Z', '4A1J7BZ', '4A1J82Z', '4A1J84Z', '4A1J8BZ', '4A1JX2Z', '4A1JX4Z', '4A1JXBZ'

Criteria Set 4:

A. Claim type is one of the following:

ii. Claim Type 04 = OP

iii. Claim Type 05 = Medical

and

B. The provider type is not ‘009’ (Lab/Radiology)

and

C. The encounter has any one of the following CPT or CPSP (Comprehensive Perinatal Services Program) procedure codes:

‘59000’ through ‘59025’, ‘59030’ through ‘59051’, ‘59070’ through ‘59076’, ‘59100’ through ‘59151’, ‘59200’, ‘59400’, ‘59412’, ‘59300’ through ‘59325’, ‘59425’ through ‘59426’, ‘59510’, ‘59610’, ‘59618’, ‘59812’ through ‘59830’, ‘59870’ through ‘59899’, ‘S0197’, ‘Z1032’, ‘Z1034’, ‘Z1036’, ‘Z6200’ through ‘Z6204’, ‘Z6206’, ‘Z6210’, ‘Z6306’, ‘Z6300’ through ‘Z6304’, ‘Z6400’ through ‘Z6412’, ‘Z6500’

3. **Maternity Mercer**

The following codes are first checked for abortions, which will overwrite a delivery event as NULL if they fall within any of the coding ranges below:

A. Procedure codes ‘59812’, ‘59813’, ‘59814’, ‘59815’, ‘59816’, ‘59817’, ‘59818’, ‘59819’, ‘59820’, ‘59821’, ‘59822’, ‘59823’, ‘59824’, ‘59825’, ‘59826’, ‘59827’, ‘59828’, ‘59829’, ‘59830’,'59840', '59841', '59850', '59851', '59852', '59855', '59856', '59857', '59866', 'X7724', 'X7726', 'Z0336', '01964', '01966', 'S0190', 'S0191', 'S0199', 'Z2004'

or

B. Diagnosis codes beginning with ‘O040’, ‘O070’, 'O0480', 'Z332', 'Z0371', 'Z0372', 'Z0373', 'Z0374', 'Z0375', 'Z0376', 'Z0377', 'Z0378', 'Z0379'

or

C. IP claim type code with the following IP surgical codes: '10A07ZX', '10A07ZZ', '10A08ZZ', '10A00ZZ', '10A03ZZ', '10A04ZZ', '10A07Z6', '10A07ZW', '3E0E3TZ', '3E0E7TZ', '3E0E8TZ'

Any of the following conditions (criteria set) must be satisfied for an encounter to be considered a Maternity Mercer encounter (note this logic is only applied when the member’s sex is female and the member’s age is between age 12 through 55, inclusive).

Criteria Set 1:

A. The encounter has any of the 25 diagnosis codes with the codes ‘O82’, O7582’

or

B. The encounter has any procedure code with the codes ‘59510’ through ‘59515’, 59620’ through ‘59622’, 59525, 59618, 01961, 01968

Criteria Set 2:

A. The encounter has any of the 25 surgical codes with codes:

'10D07Z3', '10D07Z4', '10D07Z5', '10D07Z6', '10D07Z8', '10D07Z7', '10D00Z0', '10D00Z1', '10D00Z2', '10D17ZZ', '10D18ZZ', '10D00Z0', '10D17Z9', '10D18Z9', '10E0XZZ'

or

B. The encounter has any of the 25 diagnosis codes with the codes:

‘O80’. ‘O703’, ‘O704’, O709’

or

C. The encounter has a procedure code with the codes:

‘59400’ through ‘59410’, 59610’ through ‘59614’, 59898’ through ‘59899’, 01967’, 01960’, 57022’

Criteria Set 3:

A. The encounter has any of the 25 diagnosis codes with the codes:

'O6010X0', 'O6010X1', 'O6010X2', 'O6010X3', 'O6010X4', 'O6010X5', 'O6010X9', 'O6012X0', 'O6012X1', 'O6012X2', 'O6012X3', 'O6012X4', 'O6012X5', 'O6012X9', 'O6013X0', 'O6013X1', 'O6013X2', 'O6013X3', 'O6013X4', 'O6013X5', 'O6013X9', 'O6014X0', 'O6014X1', 'O6014X2', 'O6014X3', 'O6014X4', 'O6014X5', 'O6014X9', 'O6020X0', 'O6020X1', 'O6020X2', 'O6020X3', 'O6020X4', 'O6020X5', 'O6020X9', 'O6022X0', 'O6022X1', 'O6022X2', 'O6022X3', 'O6022X4', 'O6022X5', 'O6022X9', 'O6023X0', 'O6023X1', 'O6023X2', 'O6023X3', 'O6023X4', 'O6023X5', 'O6023X9', 'O670', 'O678', 'O679', 'O68', 'O690XX0', 'O690XX1', 'O690XX2', 'O690XX3', 'O690XX4', 'O690XX5', 'O690XX9', 'O691XX0', 'O691XX1', 'O691XX2', 'O691XX3', 'O691XX4', 'O691XX5', 'O691XX9', 'O692XX0', 'O692XX1', 'O692XX2', 'O692XX3', 'O692XX4', 'O692XX5', 'O692XX9', 'O693XX0', 'O693XX1', 'O693XX2', 'O693XX3', 'O693XX4', 'O693XX5', 'O693XX9', 'O694XX0', 'O694XX1', 'O694XX2', 'O694XX3', 'O694XX4', 'O694XX5', 'O694XX9', 'O695XX0', 'O695XX1', 'O695XX2', 'O695XX3', 'O695XX4', 'O695XX5', 'O695XX9', 'O6981X0', 'O6981X1', 'O6981X2', 'O6981X3', 'O6981X4', 'O6981X5', 'O6981X9', 'O6982X0', 'O6982X1', 'O6982X2', 'O6982X3', 'O6982X4', 'O6982X5', 'O6982X9', 'O6989X0', 'O6989X1', 'O6989X2', 'O6989X3', 'O6989X4', 'O6989X5', 'O6989X9', 'O699XX0', 'O699XX1', 'O699XX2', 'O699XX3', 'O699XX4', 'O699XX5', 'O699XX9', 'O700', 'O701', 'O7020', 'O7021', 'O7022', 'O7023', 'O740', 'O741', 'O742', 'O743', 'O744', 'O745', 'O746', 'O747', 'O748', 'O749', 'O750', 'O751',

'O752', 'O753', 'O754', 'O755', 'O7581', 'O7589', 'O759', 'Z370', 'Z372', 'Z373', 'Z3750', 'Z3751', 'Z3752', 'Z3753', 'Z3754', 'Z3759', 'Z3760', 'Z3761', 'Z3762', 'Z3763', 'Z3764', 'Z3769', 'Z379', 'O770', 'O771', 'O711', 'O713', 'O714', 'O715', 'O716', 'O717', 'O7181', 'O7182', 'O7189', 'O719', 'O8802', 'O8812', 'O8822', 'O8832', 'O8882', 'O9812', 'O9822', 'O9832', 'O9842', 'O9852', 'O9862', 'O9872', 'O9882', 'O9892', 'O9902', 'O9912', 'O99214', 'O99284', 'O99314', 'O99324', 'O99334', 'O99344', 'O99354', 'O9942', 'O9952', 'O9962', 'O9972', 'O99814', 'O99824', 'O99834', 'O99844', 'O9A12', 'O9A22', 'O9A32', 'O9A42', 'O9A52'

Criteria Set 4:

A. The encounter has a procedure code from ‘59000’ through ‘59899’.

or

B. The encounter has a revenue code of ‘720’, 0720’, 721’, 0721’, 722’, 0722’, 0724’, 0724’, 0729’, 0729’, 112’, 0112’, ‘122’, ‘0122’, ‘132’, ‘0132’, ‘142’, ‘0142’, ‘152’, ‘0152’, ‘232’, ‘0232’.

or

C. The encounter has any of the 25 diagnosis codes with the codes:

‘O720','O721','O722'

or

D. The encounter has any 25 surgical procedure codes with the codes:

'0UJD7ZZ', '0JCB0ZZ', '0JCB3ZZ', '0US90ZZ', '0US94ZZ', '0US9XZZ', '10H003Z', '10H00YZ', '10P003Z', '10P00YZ', '10P073Z', '10P07YZ', '10S07ZZ', '10900ZC', '10903ZC', '10904ZC', '10907ZC', '10908ZC', '0U7C7ZZ', '10D07Z7', '10J07ZZ', '3E053VJ', '10D17ZZ', '10D18ZZ'

Criteria Set 5:

A. The encounter has one of the following procedure codes:

'59425', '59426', 'X8170', 'Z1000', 'Z1008', 'Z1016', 'Z1018', 'Z1020', 'Z1022', 'Z1030', 'Z1032', 'Z1034', 'Z1036', 'Z2008', 'Z2502', 'Z2503', 'Z6410', 'Z6412'

Criteria Set 6:

A. The encounter has a procedure code with the codes ‘59430’, Z1004’, Z1012’, Z1026’, and Z1038’

4. **Pregnancy-related “Catch All”**

The following conditions must be satisfied for an encounter to be considered a Pregnancy-related encounter:

A. Identify deliveries for members using the following criteria:

   i. Cesarean birth: Mercer Maternity Criteria 1 (from above).

   ii. Vaginal birth: Mercer Maternity Criteria 2 (from above).

   iii. Unspecified birth: Mercer Maternity Criteria 3 (from above).

   or

   i. A member must be included in Maternity Kick Payments file provided by DHCS, which is a file that lists each member who gave birth and the birth month for each member.

All encounters 238 days prior to the delivery event are considered Pregnancy-related encounters.

5. **Emergency Medical Transportation**

The below condition must be satisfied for an encounter to be considered an Emergency Medical Transportation encounter.

A. The encounter has any one of the following procedure codes:

   'A0225','A0427','A0429','A0433','A0434'

6. **Emergency Facility**

The following conditions must be satisfied for an encounter to be considered an Emergency Facility encounter:

A. EDS claim type is 04 OP and Emergency Indicator equals YES.

and

B. FQHC National Provider Identifier is not equal to 1.

7. **Emergency Other**

Any of the following conditions must be satisfied for an encounter to be considered an Emergency Other encounter:

A. Place of service code is 0 ER.

or

B. The encounter has any one of the following procedure or revenue codes:

   ‘0450’, ‘0451’, 0452’, 0459’, 450’, 451’, 452’, 459’, 99281’ through ‘99288’.

8. **IP Admissions that Originated Through the ER**

The following condition must be satisfied for an encounter to be considered an Emergency IP encounter:

A. A member has both an ER and IP encounter (using COS) with the same date of service.

9. **Dialysis**

The following condition must be satisfied for an encounter to be considered a Dialysis encounter:

A. The encounter has any one of the following procedure codes:

i. '90935', '90937', '90940', '90945', '90947', '90951', '90952', '90953', '90954', '90955', '90956', '90957', '90958', '90959', '90960', '90961', '90962', '90963', '90964', '90965', '90966', '90967', '90968', '90969', '90970', '90999', '99512', 'G0257', '0692T', 'S9335', 'S9339'

and

B. The encounter has any one of the following diagnosis codes: ‘N170’, N171’, N172’, N178’, N179’, N185’, N186’

10. **Emergency DHCS**

This was taken from Business Rule 005 from SDN 17041 — TSD document provided by DHCS.

Any one of the below conditions must be satisfied for an encounter to have emergency service(s) for claiming FFP.

A. The provider type is not ‘009’ (Lab/Radiology)

and

B. The claim type is either 05 or 06

and

C. The emergency indicator (C54-CLM-EMERG-IND) in CP-F-54 file is ‘Y.’

or

A. The claim type is either 04 or 06 and emergency indicator (C54-CLM-EMERG-IND) in CP-F-54 file is ‘Y’

or

A. The claim type is 03 and the emergency indicator (C54-CLM-EMERG-IND) in File CP-F-54 is ‘Y’

or

A. The claim type is 03

and

B. Claim form code (C54-CLM-FORM-CODE-0273) in CP-F-54 file is SPACE

and

C. The claim admit type(C54-IN-ADMIT-TYPE) in CP-F-54 file is either 1,3, 4, 6

or

A. The claim type is 03

and

B. Claim form code (C54-CLM-FORM-CODE-0273) in CP-F-54 file is 'U'

and

C. The claim admit type (C54-IN-ADMIT-TYPE) in CP-F-54 file is 1.

or

A. The claim type is either 04, 05, 06 and the encounter procedure codes is any of the codes mentioned in Appendix table row code set 6 of DHCS SDN 17041–TSD document:

i. '15271' through '15278', '20527', '26341', '27267', '27268', '29582' through '29584', '32421', '32422', '32550', '32551', '33258', '43753', '46930', '49082' through '49084', '51100' through '51102', '51797', '59030', '59050', '59070', '59072', '59074', '59076', '59100', '59120', '59121, '59130', '59135', '59136', '59140', '59150', '59151', '59160', '59300', '59350', '59409', '59414', '59514', '59525', '59612', '59620', '59812', '59820', '59821', '59830', '59897', '60300', '62370', '64633' through '64636', '67041' through '67043', '67113', '67229', '68816', '88720', '88740', '88741', '90918' through '90990', '91100', '91105', '91110', '92071', '92072', '92950', '92953', '92970', '92971', '92975', '92977', '92978', '92979', '92980', '92981', '92982', '92984', '92987', '92990', '92995', '92996', '93651', '93652', '93998', '94002', '94003', '94656', '94657', '94728', '94729', '95885', '95887', '95938', '95939', '99281' through '99285', '99291', '99292', '99295', '96360', '96361', '96365' through '96376', '96379', '99296', '99297', '99464', '99477', 'C1830', 'C1886', 'C8929', 'C8930', 'Q4100' through 'Q4114', 'Q4122' through 'Q4130', 'S5000', 'S5001', 'Z1002', 'Z1010', 'Z1024', 'Z6000' through 'Z6042', 'Z7502', 'Z7504', 'Z7506', 'Z7508', 'Z7510', 'Z7610', 'Z7612'.

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