MERCER

AIDS HealthCare Foundation

Capitation Rate Development and Certification

January 1, 2021–December 31, 2021

State of California
Department of Health Care Services
Capitated Rates Development Division
January 28, 2021

Mercer Government
Ready for next. Together.

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January 28, 2021

Subject: AIDS Healthcare Foundation (AHF) — Rate Range Development and Certification for January 1, 2021 through December 31, 2021.

Dear Mr. Davtian:

The State of California Department of Health Care Services (DHCS) contracted with Mercer Government Human Services Consulting (Mercer), as part of Mercer Health & Benefits LLC, to develop an actuarially sound Medicaid capitation rate range for members who are at least 21 years old and who have ever had a Diagnosis of Stage 3 HIV infection and who voluntarily enroll in the program for use during the calendar year 2021 (CY 2021). CY 2021 encompasses the time period of January 1, 2021 through December 31, 2021. This letter presents an overview of the analyses and methodology used in Mercer's managed care rate range development for the purpose of satisfying the requirements of the Centers for Medicare & Medicaid Services (CMS).

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.

(Note: Please see page 2 of the Actuarial Standard of Practice No. 49: Medicaid Managed Care Capitation Rate Development and Certification, from the Actuarial Standards Board, http://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049_179.pdf).

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Executive Summary

DHCS contracted with Mercer to develop actuarially sound internal capitation rate ranges, and to certify to final contracted capitation rates for the AHF for rating period of January 1, 2021 through December 31, 2021 (CY 2021). This will be the first rating period since DHCS' decision to shift rate development from state fiscal year (SFY) rating periods (July through June) to calendar year rating periods; mainly to enable DHCS and Mercer to evaluate, plan and adjust for legislative changes affecting managed care that have historically occurred with minimal time prior to the start of the SFY rating periods.

This document describes the rate development process and provides the certification of actuarial soundness required by 42 CFR §438.4. This document was developed to provide the requisite rate documentation to DHCS and to support the CMS rate review process. This report follows the general outline of CMS July 2020 through June 2021 Medicaid Managed Care Rate Development Guide, which is the applicable version of the guide for CY 2021. The rate development process included the historical practice of developing rate ranges. However, the actuary is certifying to a final rate within the developed rate ranges as federally required.

Multiple attachments are included as part of this rate certification package. These attachments include summaries of the CY 2021 capitation rates (including the final and certified capitation rates) and capitation rate calculation sheet (CRCS) exhibits. These attachments are referenced throughout the body of this letter. The final capitation rates can be found in the attached file titled *CY 2021 AIDS Healthcare Foundation Rates 2021 01 28.xlsx.*

With projected member months of 7,705 for CY 2021, the lower bound capitation rates (including Ground Emergency Medical Transportation add-on, Proposition 56 (Prop 56) funding and Hospital Quality Assurance Fee [HQAF] and Martin Luther King, Jr Hospital [MLK] pass-through payments) generate approximately $12.0 million in projected capitation revenue.

Mercer has not trended forward the previous year's rates, but has done a comprehensive exercise of rebasing using more recent program experience. The rebasing means that 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.

One significant change for the CY 2021 rating period is the decision to carve pharmacy out of managed care. This decision was originally made to be effective January 1, 2021, but a three-month delay was announced, which resulted in the need to develop a managed care capitation rate for pharmacy for the January 1, 2021–March 31, 2021 period. The development of this pharmacy rate is consistent with other base data and rate development for the CY 2021 period.

Proposition 56 add-ons are contingent on appropriations of funds being provided by the California Legislature. Absent continued appropriations, some elements of Proposition 56 add-ons will sunset on June 30, 2021. To account for this uncertainty while setting prospective rates, Mercer developed these add-ons to be reasonable and appropriate for both 6-month and 12-month effective period and Mercer actuaries certify these add-ons as actuarially sound regardless of the budget outcome and the subsequent effective dates of the add-ons.

As such, there will be either two or three different sets of capitation rates applicable for CY 2021, dependent upon the Proposition 56 budget appropriations.

- If the budget appropriations are not met and programs sunset effective June 30, 2021, there are three different sets of capitation rates:
  - One set of rates applicable for the three-month period of January 2021 to March 2021
  - One set of rates applicable for the three-month period of April 2021 to June 2021
  - One set of rates applicable for the final six-month period of July 2021 to December 2021
- If the budget appropriations are met and the programs continue through the end of CY 2021, there are two different sets of capitation rates:
  - One set of rates applicable for the three-month period of January 2021 to March 2021
  - One set of rates applicable for the final nine-month period of April 2021 to December 2021

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

- Proposition 56 Physician – dependent on budget appropriations, either January 2021 to June 2021 or January 2021 to December 2021
- Proposition 56 Trauma Screening – dependent on budget appropriations, either January 2021 to June 2021 or January 2021 to December 2021
- Proposition 56 Family Planning – January 2021 to December 2021
- Proposition 56 Value-Based Payment (VBP) – dependent on budget appropriations, either January 2021 to June 2021 or January 2021 to December 2021
- Pass Through Hospital Quality Assurance Fee (HQAF) – January 2021 to December 2021
- Pharmacy – January 2021 to March 2021
- Other Add-ons (pass through MLK) – January 2021 to December 2021

The development of all of these add-ons are detailed in the respective sections below.

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

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General Information

This section provides a brief overview of California's AHF managed care program and an overview of the rate-setting process.

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

Program Overview

AHF contracts with DHCS to provide covered health care services for its eligible members who are at least 21 years old and who have ever had a Diagnosis of Stage 3 Human Immunodeficiency Virus (HIV) infection. AHF receives a capitation payment from DHCS for the services provided.

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

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

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

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

Covered Services

Generally, services covered through the contract with AHF are consistent with those covered under the underlying Two-Plan model, along with all approved AIDS prescription drugs. These covered services include the following:

- IP Facility
- Outpatient (OP) Facility
- Emergency Room (ER) Facility

- Long-Term Care (LTC)
- Primary Care Physician
- Specialty Physician
- Federally Qualified Health Center (FQHC)
- Other Medical Professional Services
- Mental Health (MH) – OP
- Pharmacy
- Laboratory and Radiology
- Transportation
- Community-Based Adult Services (CBAS)
- Hospice
- Home- and Community-Based Services (HCBS) – Other (HCBS Other)
- All Other

Multipurpose Senior Services Program (MSSP) are covered services for Coordinated Care Initiative (CCI) plans only. As AHF is not a CCI plan, these services are not covered.

Additionally, certain MH services for members with mild to moderate MH conditions are covered. Notable additional services carved out of the managed care program include the following:

- Specialty MH services (including IP and OP behavioral health services, with exceptions noted below).
- Alcohol and substance use disorder treatment services.
- HCBS (with certain exceptions).
- Dental services, except medically necessary Federally Required Adult Dental Services and fluoride varnish dental services that may be performed by a medical professional.
- Certain pharmaceutical products, including blood factor drugs and psychotherapeutic drugs.
- Effective April 1, 2021, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim: covered outpatient drugs, including physician administered drugs, medical supplies and enteral nutritional products.

Covered Populations

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

Rate Structure

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

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

Federal Medical Assistance Percentage

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

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

In particular, populations that receive a higher FMAP than the regular FMAP include the Breast and Cervical Cancer Treatment Program (BCCTP) population (now a subset of the SPD population) who meet federal standards, and the ACA Expansion population. For CY 2021, the BCCTP population receives 65% FMAP, while the ACA Expansion population receives 90% FMAP.

DHCS uses aid codes in its capitation payment system to identify qualifying recipients for higher FMAP. With certain exceptions, such as individuals who do not have satisfactory immigration status for whom federal financial participation is available for emergency and pregnancy-related services only, the full capitation rate for these recipients receives the higher 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 implementation of the Families First Coronavirus Response Act (H.R. 6021) provides a temporary 6.2 percentage point increase for certain populations effective beginning January 1, 2020, and extending through the last day of the calendar quarter in which the public health emergency, declared by the Secretary of Health and Human Services for Coronavirus 2019 (COVID-19), including any extensions, terminates. The increased FMAP percentage applies to the standard 50% FMAP, and smaller increases apply to the BCCTP population FMAPs.

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

In addition to the populations that receive enhanced FMAP, there are two services for which the State receives a different FMAP than the regular FMAP that applies on a population basis. Those services are 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 the State prepare separate memoranda that describe and document the process for estimating the proportion of the capitation rate subject to these different FMAPs.

Rate Methodology Overview

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

For rate range development for the AHF population, Mercer utilized various data elements: CY 2018 and CY 2019 AHF-reported encounter data, CY 2018 and CY 2019 Rate Development Template (RDT) data, and other ad hoc claims data reported by DHCS and AHF. The most recently available Medi-Cal specific financial reports submitted to the California Department of Managed Health Care (DMHC) at the time the rate ranges were determined were also considered in the rate range development process.

The RDT data used in the development of the rate ranges is data collected from AHF. The data requested from AHF is completed at the level of detail needed for rate setting purposes, which includes AHF membership, medical utilization and medical cost data for the two most recent base data years (CY 2018 and CY 2019 for the CY 2021 rate ranges) by COA group and by category of service (COS).

Adjustments were made to the selected base data to match the covered population risk and the State Plan approved benefit package for CY 2021. Additional adjustments were then applied to the selected base data to incorporate:

- Prospective and historic (retrospective) program changes not reflected (or not fully reflected) in the base data.
- The addition of any fee-for-service (FFS) claims for IP, related hospital facility services, and AIDS drugs that are the contractual responsibility of AHF beginning July 1, 2019.
- An adjustment to pharmacy claims reported by AHF to reflect 340B pricing for the first three months of the rating period.
- Trend factors to project the expenditures and utilization to the rating period.
- Administration and underwriting gain loading.

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

- Application of a Hepatitis C supplemental payment for first three months of the rating period.
- Application of a Maternity supplemental payment.

The above approach has been utilized in the development of the rate range for CY 2021 AHF program to be consistent, where applicable, with rate setting under other Medi-Cal program models. DHCS will offer the final certified rate within the actuarially sound rate range as developed by the actuary. AHF has the opportunity and responsibility to independently review the rates offered by DHCS and to determine whether the rates are acceptable based on their individual financial requirements.

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

Medical Loss Ratio

Mercer confirms that the capitation rate development process and resulting rates, as outlined in this certification and supporting documentation, are reasonable, appropriate and attainable and that AHF is assumed to reasonably achieve a Medical Loss Ratio (MLR) greater than 85%.

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

Rate Ranges

To assist DHCS during its rate discussions with AHF, Mercer provides DHCS with rate ranges that were developed using an actuarially sound process. The rate ranges were developed using appropriate actuarial considerations to arrive at both a lower and upper bound rate. To the extent the final contracted rates fall within the bounds of the Mercer rate ranges, the contracted rates will be

determined actuarially sound and certified as such. Mercer is certifying the contracted rates and not the rate ranges.

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

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Data

Base Data

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

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

- IP Facility
- OP Facility
- ER
- LTC
- Primary Care Physician
- Specialty Physician
- FQHC
- Other Medical Professional
- MH – OP
- Pharmacy
- Laboratory and Radiology
- Transportation
- CBAS
- Hospice
- HCBS Other
- All Other

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

CY 2018 and CY 2019 served as the 24-month base data period. All selected base data was adjusted (as appropriate) to reflect the impact of historical program changes within this period. This is discussed further in the program changes section.

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

A requirement of 42 CFR 438.3(c)(ii) is that all payment rates under the contract are based only upon services covered under the State Plan to Medicaid-eligible individuals. As described above, the RDT served as the starting base data for rate setting. The RDT data submission was thoroughly reviewed, vetted and discussed with AHF during the rate-setting process. Base period COA eligibility (described below) data was pulled consistent with service code mappings from DHCS. Mercer has relied on data and other information provided by AHF and DHCS in the development of these rate ranges. Mercer has reviewed the data and information for reasonableness and Mercer believes the data and information utilized in the rate development to be free of material error and suitable for rate range development purposes for the populations and services covered under the contract. Mercer did not audit the data or information, and if the data or information is materially incomplete or inaccurate, Mercer's conclusions may require revision. However, Mercer did perform alternative procedures and analyses that provide a reasonable assurance as to the data's appropriateness for use in capitation rate development under the State Plan.

The Excel rate range spreadsheets contain detailed CRCS for the AHF rate development. Base data are presented by COS as annual utilization per 1,000 members, average unit cost and the resulting per member per month (PMPM) calculations and are reflected in columns (A), (B) and (C) of the CRCS, respectively.

In Lieu of Services

As part of the CY 2018 and 2019 RDT data submissions, AHF was required to report costs for services that were not a part of the State Plan benefit package during the base data years, but were provided as an in lieu of service. AHF did not report amounts for in lieu of services in the base costs used for rate development.

Hepatitis C Supplemental Payment

To enhance the measured matching of payment to risk, DHCS will utilize a Hepatitis C supplemental payment for the first quarter of 2021. This aligns with the pharmacy benefit in managed care continuing for an additional quarter. It should be noted that Hepatitis C pharmaceutical therapy costs were removed from the CY 2018 base experience as a program change to allow the supplemental payment to cover the anticipated pharmaceutical therapy costs associated with Hepatitis C. Please see the following attachment *Q1 CY 2021 Hepatitis C Supplemental Payment Methodology 2020 12 17.pdf* for further details on the Hepatitis C supplemental payment methodology and subsequent rate development. Additionally, exhibits showing the final capitation rates can be found in the Excel file titled *CY 2021 Medi-Cal Hep C Supp Rate Exhibits 2021 01 28.xlsx.*

Maternity Supplemental Payment

The measured matching of payment to risk, DHCS utilizes a maternity supplemental payment for all counties in CY 2021. Separate maternity supplemental payments enhance matching payment to risk in large part because they mitigate potential adverse selection effects.

Costs for pregnant women are substantially higher than the average medical cost of care for men and non-pregnant women with similar demographic characteristics. To mitigate the maternity risk impact within the rates, DHCS includes a maternity supplemental payment, which represents costs for the delivery event. (Pre-natal and post-partum care costs are not part of the supplemental payment, but remain within the capitation rates at their respective COA level.) AHF would receive the lump sum maternity supplemental payment if or when one of its current member's gives birth and DHCS is appropriately notified that a birth event has occurred. Note that non-live birth expense data and non-live birth outcomes are excluded from the maternity supplemental payment analysis and the corresponding development of the CY 2021 maternity supplemental payments. This results in non-live, birth expenses being included in the base capitation rates rather than in the supplemental payment.

For the CY 2018 and CY 2019 base data period, AHF did not experience any maternity events for its members and did not incur any maternity related costs. The process described below is applicable to the maternity supplemental payment development for the Two-Plan MCOs operating in Los Angeles County. The final maternity supplemental payment for AHF is based on the Los Angeles County rate, with some appropriate modifications described below.

Maternity Supplemental – Design

- Payment made on delivery event that generates a State vital record.
- One supplemental payment per delivery regardless of number of births.
- One blended supplemental payment combining caesarean and vaginal deliveries.
- Supplemental payment reflects cost of delivery event only (mother and baby, excluding pre-natal and post-partum care).

- Supplemental payment is for all of CY 2021.
- Same supplemental payment is utilized for AIDS Non-Dual and AIDS Full-Dual COA groups.
- If costs had existed in the base period for AHF then those costs would have been carved out of the base data. However, AHF had no such maternity experience; therefore, a carve out was not necessary.

Maternity Supplemental – Modifications for AIDS Healthcare Foundation

As mentioned above, the maternity supplemental rate for the MCOs in Los Angeles was leveraged for AHF. Additionally, clinical guidance indicates that members diagnosed with AIDS are automatically considered to have high-risk pregnancies and therefore have a significantly higher prevalence of caesarean deliveries. A 100% caesarean delivery assumption was utilized to create the maternity supplemental payment applicable to AHF. Exhibits showing the final capitation rate and CRCS can be found in the Excel file titled *CY 2021 AIDS Healthcare Foundation Maternity Rates 2021 01 28.xlsx.*

Category of Aid (Aid Code) Groupings

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

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

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Projected Benefit Costs and Trends

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

- Trend from the midpoint of the 24 month base of CY 2018 and CY 2019 (January 1, 2019) to the midpoint of CY 2021 (July 1, 2021)
- Program changes
- 340B Adjustment (Pharmacy)
- Other items

The adjustments listed above are shown within the various columns of the CRCS by COS. The exact columns are noted within each subsection below.

Trend

Trend is an estimate of the change in the overall cost of medical services over a finite period of time. Trend factors are necessary to estimate the expenses of providing health care services in a future period. As part of the CY 2021 rate range development for the AHF program, Mercer developed trend rates for each provider type or COS separately by utilization and unit cost components.

Mercer reviewed and utilized multiple sources of data and information for trend development. These include most recent MCO encounter and RDT data, MCO Medi-Cal only financial statements, Medi-Cal-specific hospital IP and OP payment data, Consumer Price Index and National Health Expenditures updates and multiple industry trend reports including the CMS Medicaid actuarial report. Each of these data and information sources has strengths and challenges, and those strengths and challenges may change over time. Hence, no one, or combination of, data and information source(s), was utilized within a prescribed formula. Rather, each was reviewed for its potential applicability and utilized collectively with other data and information via actuarial judgement in order to inform the final trends. The claim cost trend assumptions being used are consistent with the CY 2021 Two-Plan/ Geographic Managed Care (GMC) assumptions, with the exception of pharmacy. Upon analysis, the pharmacy trend was further informed and refined for the AHF population that reflect different utilization of therapeutic classes relative to a non-AHF population. Mercer modeled an annual pharmacy PMPM trend of approximately 7.51% at the lower bound. The components associated with this PMPM trend

are a utilization trend 0.4% and a cost per script of 7.1%. The cost per script trend is mainly driven by brand cost inflation and high cost drugs associated with the AHF eligible conditions.

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 that 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.

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Note that any low or negative utilization trends would be a by-product of the above process and are viewed by Mercer as reasonable and appropriate. In particular, the negative utilization trends for inpatient were informed by the consistent negative utilization trends as projected by CMS actuaries for Medicaid population(s) nationwide for the roughly corresponding trend periods. Such trends are documented in the 2018 CMS Medicaid actuarial report.[1] The report provides the following examples:

Persons with Disabilities			
COS	**2019 (over 2018)**	**2020 (over 2019)**	**2021 (over 2020)**
IP Hospital	-9.3%	-8.1%	-7.0%

Child Enrollees			
COS	**2019 (over 2018)**	**2020 (over 2019)**	**2021 (over 2020)**
IP Hospital	-5.1%	-3.1%	-3.1%

Mercer did not use negative utilization trend factors as aggressive as these since there clearly were/are many, many sources (some of it conflicting/contradictory) of inpatient experience and projections. However, in our opinion these annual CMS Medicaid actuarial reports provide excellent independent data and information around trends and their directionality.

For the CY 2021 rating period, the midpoint of the 24 month base period of CY 2018 and CY 2019 (January 1, 2019) was trended forward 30 months to the mid-point of CY 2021 (July 1, 2021). The pharmacy benefit was only trended 25.5 months from the mid-point of CY 2018 and CY 2019 to the mid-point of the first quarter of 2021 to align with limited three-month continuation of this benefit in managed care.

Note that trends for the LTC provider type are displayed as 0.0% for both utilization and unit cost. Due to the relatively high-level of legislatively-mandated changes surrounding LTC, Mercer has handled LTC trends through the program changes section of the methodology. Similarly, unit cost trends for the Hospice COS are displayed as 0.0% for similar reasons.

After the mid-point/best estimate trends were determined, a trend range was created by adding 0.25% to each of the utilization and unit cost components as the upper bound or subtracting 0.25% as lower bound with the exception that no range was created for individual COS like LTC where the best estimate trends were determined to be zero. Annual lower bound claim cost trends, across all COS, for AIDS Non-Dual are 0.1% for utilization and 2.6% for unit cost or 2.7% PMPM and for AIDS Full-Dual are -0.1% (downward) utilization and 2.2% for unit cost or 2.1% PMPM.

[1] https://www.cms.gov/files/document/2018-report.pdf, pages 48–49.

The specific lower bound trend levels by utilization and unit cost for each COS are displayed in columns (D) and (E) of the CRCS, respectively, for each COA group. These annual trend figures are applied for the number of months represented in the time periods section in the upper right hand corner of the CRCS. The number of trend months is determined by comparing the mid-point of the base period to the mid-point of the rating period.

Program Changes

Program change adjustments recognize the impact of benefit or eligibility changes that took place during or after the base data period. The program changes incorporated in the development of the rate ranges were based on information provided by DHCS staff. 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 that were accounted for within the CY 2021 capitation rates. A summary showing the managed care impact can be found within the program change charts that are provided within the Excel file titled *CY 2021 AIDS Healthcare Foundation Rates 2021 01 28.xlsx.* Additionally, the program change adjustments identified below are applied in columns (F) and (G) of the CRCS, unless otherwise indicated.

Long-Term Care Rate Changes

As noted in the Trend subsection, trend factors were not developed for the LTC COS. In lieu of a trend adjustment, rate increases for LTC services are handled through a program change adjustment and are based on legislatively mandated annual FFS rate increases. In general, managed care payment levels have aligned closely with FFS payment levels for these services and it was deemed reasonable and appropriate to use the FFS rate increases in the managed care rate setting process. Historically, rate increases for all LTC facilities typically occurred August 1 of each year. Beginning in CY 2021, rate increases for AB 1629 LTC facilities occur January 1 of each year, while rate increases for non-AB 1629 LTC facilities will continue to occur on August 1 of each year. The LTC rate increase factors are developed separately for each county (or rating region) within the Two-Plan, GMC, Regional and COHS model programs. To calculate the adjustment factors for each county, costs and rate increases by the different LTC facility types are analyzed by county/region and the final adjustment factor is developed using this information.

In addition, DHCS implemented a 10% fee increase for LTC facilities effective for the duration of the public health emergency, declared by the Secretary of Health and Human Services for COVID-19, beginning March 1, 2020. The underlying assumption is that this increase will be applicable for six months of the CY 2021 rating period.

Hospice Rate Increase

Similar to the LTC COS, unit cost trend factors were not developed for the Hospice COS. Instead, Hospice price increases are handled through a program change adjustment and are based on

legislatively mandated annual FFS rate increases. In general, managed care payment levels have aligned closely with FFS payment levels for these services and it was deemed reasonable and appropriate to use the FFS rate increases in the managed care rate-setting process. There are two components to the Hospice rate increase: the rate increases for Hospice services that occur on August 1 of each year, and the rate increases for Hospice room and board that occur on October 1 of each year. To calculate the adjustment factor applied in the capitation rates, the rate increases for Hospice services are weighted with the rate increases for Hospice room and board. One adjustment factor is developed at a statewide level across all populations.

Ground Emergency Medical Transportation Fee Increase

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

To derive the PMPM adjustment factors for this program change, both encounter data and supplemental transportation data provided by AHF were utilized. From this data, utilization per 1,000 statistics were developed and the applicable GEMT add-on was assumed for each applicable trip. This adjustment was developed by COA.

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

1. Non-dual members and dual members only eligible for Medicare Part A.

2. Members fully eligible for Medicare and members eligible for Part B only.

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

For the non-dual/Part A subpopulation, two data sources were utilized (CY 2018 and CY 2019 dates of service were compiled for both data sources):

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

2. Health plans-submitted encounter data limited to the ground emergency transportation codes affected by the fee increase (A0225, A0427, A0429, A0433, and A0434).

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

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

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

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

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

Adult Optional Benefits

Effective January 1, 2020, DHCS restored coverage for optional benefits for all adults age 21 or older in all settings. The optional benefits that were restored include vision (optometric and optician services, except that lens fabrication will not be covered under managed care), audiology, speech therapy, podiatry and incontinence creams and washes. DHCS already provides these services under the Early and Periodic Screening, Diagnostic, and Treatment benefit for individuals under 21 years of age, pregnant women and beneficiaries receiving LTC in a nursing facility. This benefit change is accounted for as a PMPM adjustment to the All Other COS for all applicable COAs.

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

1. Medi-Cal FFS data specific to each service for members age 21 or older from when the benefits were previously covered in Medi-Cal. The FFS data included dates of service from July 1, 2007 through June 30, 2009.

2. Separately provided data from certain MCOs in the Medi-Cal program that already cover these benefits on their own. Note that these services were not part of the State Plan benefit package and were not reported within the MCOs' RDT experience. This data included dates of service in CY 2017.

To derive the PMPM adjustments, both of these data sources were trended to CY 2021 (the time period in which the benefits are effective) using trends in line with historical trend factors for the Other Medical Professional and All Other COS lines. Then, a blend of each data source was utilized for each service and applied consistently for each COA. The blending factors utilized were based on actuarial adjustment; no specific formulas were used to develop them. The PMPMs were developed at a statewide level, with no variation across counties, since recent data was not available to make reliable PMPM assumptions by county/region.

For vision services, the PMPM adjustment was developed by estimating the price for frames and lens dispensing fees, as well as developing an assumed utilization of the benefit. To estimate the price for frames and lens dispensing fees, encounter data from CY 2017 to CY 2019 was utilized, as this benefit is already covered in Medi-Cal for children under age 21, pregnant women and beneficiaries residing in a nursing facility. From this data, a price per eyeglasses was developed for CY 2021, which includes frames and lens dispensing fees only, as lens fabrication provided by Prison Industry Authority (PIA) is not covered in managed care. To develop the utilization assumption, historical figures budgeted by DHCS along with data estimates from the California Optometric Association estimate were reviewed. The California Optometric Association estimated that approximately two million Medi-Cal beneficiaries aged 21–64 need eyeglasses.[2] Using this estimate as a benchmark, an assumption was then made on the number of those who need eyeglasses would actually get them in

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

CY 2021 (the time period in which the benefit is effective). The ramp up assumption used was 50%, and was based on actuarial judgement.

Psychiatric Collaborative Care Management Services

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

- The proportion of the population with behavioral health conditions, which was estimated based on pharmacy records submitted for risk adjustment analyses.
- The proportion of the eligible population that would utilize the Psych CoCM services during CY 2021, which was based primarily on review of another State's Medicaid experience, consultation with clinical resources, and actuarial judgement.
- FFS reimbursement rate for each CPT code provided by DHCS.

340B Adjustment

AHF is enrolled in the 340B Drug Pricing Program and shall dispense drugs priced at the appropriate 340B level when possible. However, AHF-reported pharmacy claims prior to any 340B discount in the CY 2018 and CY 2019 RDTs. Based on the current 340B penetration, as well as the information provided to DHCS and Mercer by AHF concerning the AHF pharmacy network, an adjustment of 62% (38% decrease) was made to the pharmacy claims reported on the RDT. Mercer utilized the expertise of its pharmacy benefit practice and industry knowledge to arrive at the factor of 62%. This recognizes that not all drugs are eligible for 340B pricing, as well as the fact that not all eligible 340B drugs will be filled utilizing 340B pricing. Based on available data it was assumed that approximately 75%–80% of pharmacy costs are eligible for 340B pricing. Mercer also estimated that 10% of 340B eligible drugs are not filled using 340B pricing because these drugs were filled at non-340B pharmacies.

Mercer repriced past claims for CY 2016 and CY 2017 for AHF members using 340B prices based on available market information. This analysis combined with the assumptions above resulted in the adjustment factor of 62%.

Other Items

Health Care-Acquired Conditions

Section 2702 of the ACA of 2010 required CMS to establish regulations prohibiting federal Medicaid payments to states for amounts expended for Health Care-Acquired Conditions (HACs). On June 30, 2011, CMS published the final rule implementing the requirements set forth in Section 2702 of the ACA, but delayed compliance action until July 1, 2012.

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

As such, Mercer initially reviewed potential encounter data information for making an appropriate adjustment (though because AHF went full risk on July 1 2019, encounter data is very limited). Unfortunately, the required information (a present on admission indicator, for example) is not currently part of the encounter data. This is an ongoing process without any current information available for a rate adjustment. Other studies and other state experience have shown limited needed adjustments related to these types of conditions. This issue will continue to be reviewed. No adjustments have been included within these rates. It should be noted that reductions related to potentially preventable IP admissions have been included as part of Mercer's efficiency adjustments related to the base managed care data, as noted previously.

Retrospective Eligibility Periods

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

Mental Health Parity and Addiction Equity Act

With regard to the Mental Health Parity and Addiction Equity Act (MHPAEA), DHCS staff has confirmed that there are no provisions in the AHF managed care contract in violation of MHPAEA.

Indian Health Care Providers

AHF model contract Exhibit A, Attachment 8, Provider Compensation Arrangements, details the Indian Health Care Providers (IHCP) reimbursement required, as it does for FQHCs and RHCs. Applicable base data has been captured per contractual requirements. This certification does not include development or certification of an Indian Health capitation rate.

Member Cost Sharing

There are no member copayments, coinsurance or deductibles. Hence, no data adjustment for any of these items was necessary.

Third-Party Liability

Medicaid is the payer of last resort. RDT and independent financial statement data were net of any Third-Party Liability data, and so no base data adjustment was necessary.

Graduate Medical Education

With regard to Graduate Medical Education (GME) 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 that there are no provisions in the AHF contract regarding GME. AHF does not pay specific rates that contain GME or other GME-related provisions. As RDT data serves as the base data for the rate ranges, GME expenses are not part of the capitation rate development process.

Institution for Mental Diseases

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

Provider Overpayments

The RDT and encounter data used for rate setting are net of provider overpayments. AHF was instructed to report medical expenditures net of provider overpayments within the RDT submissions, and have policies and procedures for these types of payments per 42 CFR § 438.608(d).

Pharmacy Add-On

One significant change for the CY 2021 rating period is the decision to carve pharmacy out of managed care. This decision was originally made to be effective January 1, 2021, but a three month delay was announced which resulted in the need to develop a managed care capitation rate for pharmacy for the January 1, 2021–March 31, 2021 period. The development of this pharmacy rate is previously described and consistent with other base data and rate development for the CY 2021 period. A 2% administration and 1.5% underwriting gain were assumed for the pharmacy add-on as informed by Mercer pharmacy sector's experience and industry knowledge.

COVID-19

CY 2021 capitation rates include PMPM add-ons to reflect the impact of the COVID-19 pandemic. Significant national uncertainty exists regarding the impact of COVID-19 during CY 2021 due to the ever-changing situation with regionalized infection rates, responses driven by local governments and new treatment protocols, to name a few factors. Utilization and cost assumptions considered many elements, including infection rate and severity mix of cases, the impact of social distancing, the Federal Government's involvement in COVID-19-related funding (e.g., HHS and FEMA) and the availability of a vaccine. Given the limited experience resulting from the COVID-19 pandemic, Mercer

used several data sources to develop the COVID-19 impacts to CY 2021 capitation rates, including Mercer and Oliver Wyman internal modeling, and national and state data sources.

Given the uncertainty surrounding COVID-19, Mercer separated assumptions into the following categories.

Testing

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

Treatment

Treatment costs considered the estimated cost of treatment based on case severity. Scenarios were considered that ranged from in-home care for mild cases to hospitalization, including ICU, for more severe cases. Average treatment costs were developed based on projected treatment protocols, including average days in the hospital. The treatment costs were then weighted based on an assumed distribution of incidence rate and severity of cases, which varied by rate cell. For example, AHF members are assumed to be at higher risk for more severe infection, requiring more costly treatment, than younger members. Results were calibrated based on rate cell demographic information.

Deferred Care

Given the nature of the AHF member population, it was assumed no care would be deferred into the future.

Mental Health Outpatient Services Acuity

Acuity changes may occur as new needs develop and treatment becomes warranted. Based on national evidence that the pandemic is having a material impact on mental health needs, Mercer is forecasting an uptick in BH-related services, including the mild to moderate MH conditions covered by managed care. The COVID-19 add-on includes additional costs for this increase, modeled as a 10% increase in the projected MH outpatient services.

Administration and Underwriting Gain

The COVID-19 add-on is loaded for administration and underwriting gain consistent with the base capitation rate as described in Section *Projected Non-Benefit Costs*.

Considered but Not Adjusted

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

- Coverage of Vaccines: Given the uncertainty surrounding the availability and uptake of a vaccine, DHCS carved both the vaccine and vaccine administration out of managed care. In addition, per the CMS vaccine toolkit, there is no assumed Medicaid liability for the cost of the vaccine itself in CY 2021. Consequently, no explicit adjustment was made for these costs.
- Long-Term Impact of COVID-19: Given uncertainty around long-term implications of COVID-19, Mercer did not make an explicit assumption specific to this potential impact for CY 2021.

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Projected Non-Benefit Costs

The projected costs as described in Section 3 and 4 represent the benefit costs. This section describes the components of the rate that are not directly related to benefit costs, which include the following:

- Administration
- Underwriting gain
- MCO tax
- Health Insurance Providers Fee (HIPF)

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

Administration

The administration loading for AHF was developed from a review of AHF's historical reported administrative expenses, which are submitted as part of their attested RDTs on an annual basis. The administrative costs are reviewed to ensure that they are appropriate for the approved State Plan services and Medicaid eligible members. Mercer utilized its experience and professional judgement in determining the mid-point and lower/upper bound percentages for the AHF population that are reasonable and appropriate within the context of this certification, taking into account the size and specialized nature of the AHF population. The administration load for the lower bound, mid-point and upper bound are all 13.5%.

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

Underwriting Gain

The underwriting gain component at the lower bound, mid-point, and upper bound are all established at 1.5%. Mercer has implicitly and broadly considered the cost of capital within Mercer's rating assumptions. Mercer's conclusion is that Mercer's assumptions surrounding underwriting gain, as well as the income an MCO generates from investments, are sufficient to cover at least the minimum cost of capital needs for the typical MCO.

Managed Care Organization Tax

The MCO tax does not apply to AHF.

Health Insurance Providers Fee

HIPF is no longer applicable due to the discontinuation after the CY 2019 premium year.

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Special Contract Provisions Related to Payment

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

- Withhold arrangements
- Risk-sharing mechanisms
- Pass-through payments
- Delivery system and provider payment initiatives

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

Withhold Arrangements

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

Risk Sharing Mechanisms

The state is continuing two-sided risk corridors associated with the five Proposition 56 directed payment initiatives. These arrangements are further discussed in the Delivery System and Provider Payment Initiative subsection of this report.

Pass-Through Payments

Pass-through payments, as described below, are applied in the AHF CY 2021 capitation rates.

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

Historical adjustments associated with the private hospital HQAF and District and Municipal Public Hospitals (DMPHs) (formerly known as Non-Designated Public Hospitals) are continuing for CY 2021. The approach for making these adjustments within the capitation rates are being addressed through two paths: 1) Pass-through Payments as defined by 42 CFR 438.6(d) and 2) Directed Payments as defined by 42 CFR 438.6(c). The directed payment approach is described later within this certification

report and with the exception of the Proposition 56 directed payments, does not currently impact the certified rates. The pass-through components of the HQAF/DMPH adjustments are being included within the certified rates and have been developed in a fashion similar to historical approaches. The approach takes into consideration the private hospital (IP and OP/ER services) and DMPH (IP services only) components of the capitation rates. The private hospital/DMPH components of the capitation rates are being increased based upon a uniform percent increase to IP rates (14.75%) and a uniform percent increase to OP/ER rates (15.82%), such that the targeted total impact of $1,797.4 million is produced across all of the California managed care models (Two-Plan, GMC, COHS, and Regional models) for the 12-month rating period. The DMPH targeted expenditure accounts for approximately 7.57% of the total IP + DMPH combined targeted expenditure; the DMPH targeted expenditure is approximately $97.4 million across the 12-month period. The DMPH total is a subset of the IP factor and the DMPH targeted expenditure of $97.4 million is part of the $1,797.4 million total impact. We would note that the prior year certification was for the 18-month bridge period and the prior year certification reflected a total targeted impact of $2,846.1 million for the entire 18-month period, which equated to ~$1,897.4 targeted spend for a 12-month equivalent.

The aforementioned IP and OP/ER percentages were applied to the private/DMPH components of the capitation rates to produce PMPM adjustments that are added to the post risk adjustment rate ranges. The PMPM adjustments were developed based upon the MCO specific upper bound GME, as well as MCO information submitted through a SDR. The SDR included CY 2018 summarized payment information by hospital type (private, public, University of California (UC), and DMPH). This data included information by COS and payment arrangement (capitation and whether FFS payments were contracted or not). This information was leveraged to produce percentages of private hospital (including DMPH for IP) expenditures that could be applied to the base rate PMPM to produce a total projected spend equivalent to the aforementioned totals. For purposes of calculating the HQAF percent add-on to the base rates, the upper bound PMPM from the base rates were selected. It should be noted that the GME amounts utilized to produce the baseline amounts were prior to the removal of maternity costs. This approach was taken so that these adjustments did not impact the maternity supplemental payments (this is consistent with historical practice). Sacramento and San Diego counties had two new MCOs join during the SFY 17–18 rating period. Because these plans did not have credible information to submit within the SDR, county averages have been utilized to supplement the needed factors for this adjustment.

Included attachments labeled *Exhibit A CY 2021 Private Hospital DMPH IP HQAF Pass-through 2021 01 28.pdf* and *Exhibit B CY 2021 Private Hospital OP ER HQAF Pass-through 2021 01 28.pdf*; these attachments contain the detailed components behind these calculations. The IP chart below, which is an excerpt of the “Exhibit A” file, displays the elements involved:

- {H} is the upper bound base rate PMPM from the rates
- {I} is the estimated percent that private and DMPH hospitals compose of the total base rate, based on the payment information from the SDR
- {J} = {H} * {I} is the product of the first two elements

- {K} is the IP factor that produces approximately 70% of the targeted spend amounts mentioned above; there is also a corresponding OP/ER factor computation that achieves the remaining 30% spend of the targeted spend amounts, which when combined with IP, produces 100% of the targeted spend amounts

- {L} = {J} * {K} produces the final add-on PMPM amounts included in the final certified rates

	{H}	{I}	{J} = {H} * {I}	{K}	{L} = {J} * {K}
COA	**Rate PMPM**	**Private/DMPH Share (PMPM)**	**Private/DMPH PMPM**	**Add-on %**	**Add-on PMPM**
Child	$10.41	85.9%	$8.94	14.75%	$1.32
Adult	$108.67	85.7%	$93.08	14.75%	$13.73
ACA OE	$103.21	82.5%	$85.13	14.75%	$12.56
SPD	$311.21	82.6%	$256.96	14.75%	$37.91
LTC	$1,571.94	85.4%	$1,341.99	14.75%	$197.96
OBRA	$163.17	0.0%	-	14.75%	-
AIDS Non-Duals	$462.40	88.8%	$410.43	14.75%	$60.54
WCM	$821.82	86.7%	$712.24	14.75%	$105.06
All COAs	**$82.61**	**83.5%**	**$69.00**	**14.75%**	**$10.18**

A similar process was applied to the OP/ER components; 15.82% is being applied to the private OP/ER PMPM. These calculations are included in "Exhibit B". As noted above, the actuary has continued the historical practice of developing rate ranges; however, there was no variation of the developed add-on PMPMs across the rate ranges. The development of these add-on amounts did not impact the underlying data or assumptions associated with the regular development of the capitation rates. Consistent with historical approaches, no additional administrative load or underwriting gain is included within these add-on amounts for HQAF/DMPH.

HQAF is paid to hospital providers.

The non-federal share of the pass-through payment is financed utilizing quality assurance fees provided by hospitals and voluntary intergovernmental transfers (IGTs) provided by local government entities.

Martin Luther King Jr. Community Hospital in Los Angeles County

Historical program change adjustments for the MLK IP component of the LA County SPD and ACA Expansion rate cells are being presented as pass-through payments based upon our and DHCS' interpretation of the definition of a pass-through within 42 CFR 438.6(d). The detailed build-up of the adjustments associated with the MLK pass-through payment are included in the attached "Exhibit C" (*Exhibit C CY 2021 MLK IP Pass-through 2021 01 28.pdf*). In alignment with the prior program change

adjustment, additional costs not included within the base data are added to the IP COS to meet the requirements of Senate Bill 857 that establishes IP payment levels for MLK. A uniform percentage for the IP COS was established to provide the needed adjustments to reflect the required costs. The development of these adjustments also include a 3.875% administrative load, which aligns with administrative costs assigned to supplemental payments such as the maternity payment as well as the administrative load included with the Proposition 56 physician directed payment add-on payments discussed below. An underwriting gain of 1.5%, 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 $25.8 million across CY 2021 based upon enrollment projections that utilize actual experience through October 2020.

MLK is a hospital provider.

The non-federal share of the pass-through payment is financed utilizing State General Funds.

Pass-Through Payments Base Amount Calculation

For the CY 2021 rating period, DHCS has confirmed that the projected aggregate amount of pass-through payments to hospitals does not exceed either of:

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

2. The amount specified by § 438.6(d)(3)(ii).

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

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

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

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

General Methodology

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

1. Seventy percent of the base amount defined at § 438.6(d)(2) applicable to the period of January 1, 2021 through June 30, 2021.

2. Sixty percent of the base amount defined at § 438.6(d)(2) applicable to the period of July 1, 2021 through December 31, 2021.

The aggregate amount resulting from this calculation is $2,207,183,907, as displayed in the exhibit *CY 2021 Base Amount Calculation 01.29.21.pdf*.

The § 438.6(d)(2)(i) component of the base amount is equal to the aggregate difference between the amounts calculated in accordance with §§ 438.6(d)(2)(i)(A) and (d)(2)(i)(B). This amount is the differential between the amount paid under Medicaid managed care and the amount Medicare FFS would have paid for inpatient and outpatient hospital services provided to eligible populations under the Medicaid managed care contracts for the 12-month period immediately two years prior to the CY 2021 rating period, which corresponds to CY 2019.

The § 438.6(d)(2)(i)(A) calculation includes two elements: unit cost and utilization. Unit costs were based on Office of Statewide Health Planning and Development (OSHPD) statewide data for Medicare FFS beneficiaries. CY 2018 data was leveraged to arrive at estimated CY 2019 average unit costs for IP and OP hospital services. To maintain consistency with the approach used for the § 438.6(d)(2)(i)(B) component, unit cost trend was applied to the CY 2018 data in order to determine a reasonable estimate of CY 2019 unit costs. The trend applied was based on the average Consumer Price Index for All Urban Consumers (CPI-U) for hospital related services over the previous five state fiscal years (SFY 2015-16 through SFY 2019-20). The resulting estimated IP and OP unit costs are 3.97% higher year-over-year compared to the CY 2018 unit costs.

Utilization was calculated based on CY 2018 base data used in Medi-Cal managed care rate development that was trended forward to CY 2019. Distinct trends were applied for IP and OP hospital services based on the average base data utilization change over the previous four calendar years (CY 2015 through CY 2018). For simplicity, the base period data was not trended to the rating period; however, the state may elect to apply trend adjustments, as appropriate, in the calculation of the base amount applicable to future rating periods.

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

The§ 438.6(d)(2)(i)(B) calculation includes three elements: unit cost, utilization, and directed payments. CY 2018 data was trended to arrive at estimated CY 2019 average unit costs for IP and OP

hospital services. The same trend used for the § 438.6(d)(2)(i)(A) component of the calculation was utilized here. Utilization is identical to that used for the § 438.6(d)(2)(i)(A) component of the calculation. Unit cost was multiplied by utilization for both IP and OP hospital services, respectively. The resulting amounts were then summed and further increased by the amount of applicable directed payments for IP and OP hospital services for the CY 2019 base period. The applicable directed payments were made as part of the Designated Public Hospital Enhanced Payment Program and the Private Hospital Directed Payment Program. These directed payments were first implemented beginning on July 1, 2017.

Aggregate Difference

The aggregate difference between the total amounts of §§ 438.6(d)(2)(i)(A) and (d)(2)(i)(B) is $3,395,667,549. This amount was multiplied by a factor of 0.65 to account for the 70% and 60% phase-down levels associated with the fourth and fifth fiscal years, respectively, occurring after July 1, 2017.

Trend Adjustments

At the time of this calculation, CY 2019 cost and utilization data specific to Medi-Cal managed care was not readily available for use in this calculation. As per the standard Medi-Cal managed care rate development process, and to allow adequate time for claims completion and MCO reporting, CY 2019 base data had been only recently collected from MCOs and had not been reviewed, validated, or aggregated yet.

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

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

The utilization trend adjustment is based on the average year-over-year growth in from CY 2015 through CY 2018 of the base data used for rate development. This data source remains consistent with the utilization driving the base amount calculation beginning with the SFY 2017-18 rating period.

Fiscal Impact

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

- Phased-Down Base Amount with Trends = $2,207,183,907
- Unit Cost Trend removed = $2,025,290,069
- Utilization Trend removed = $2,135,049,377
- Unit Cost Trend and Utilization Trend removed = $1,955,910,505

DHCS believes that both the unit cost and utilization trends applied in this calculation are reasonable and appropriate. However, of note, the removal of either utilization or unit cost trend, or both, would not change the fact that the phased-down based amount exceeds the projected aggregate amount of pass-through payments for the CY 2021 rating period.

The 42 CFR 438.6(d)(2)(ii) component of the base amount is assumed to be equal to $0, consistent with the approach used for prior rating periods. The amount in accordance with 42 CFR 438.6(d)(2)(ii) is the differential between the amount paid under Medicaid FFS and the amount Medicare FFS would have paid for inpatient and outpatient hospital services provided to eligible populations through the Medicaid FFS delivery system for the 12-month period immediately two years prior to the CY 2021 rating period that have subsequently shifted to the Medicaid managed care delivery system. As there were no major shifts of inpatient and outpatient hospital services, or of eligible populations, from Medicaid FFS to Medicaid managed care for the applicable time periods, DHCS assumed that no such material payments meet this definition.

Delivery System and Provider Payment Initiatives

There are several directed payment initiatives applicable to the AHF CY 2021 capitation rates. The following subsections provide more detail around each initiative.

Proposition 56 Directed Payments

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

- Physician Proposition 56
- Trauma Screening (Adverse Childhood Experiences Screening as named in the Pre-Print) Proposition 56

- Family Planning Proposition 56
- VBP Proposition 56

Proposition 56 add-ons are contingent on appropriations of funds being approved by the California Legislature. Absent continued appropriations, some elements of Proposition 56 add-ons will sunset on June 30, 2021. To account for this uncertainty while setting prospective rates, Mercer developed these add-ons to be reasonable and appropriate for both six-month (January 1, 2021 through June 30, 2021) and 12-month (January 1, 2021 through December 31, 2021) effective periods, and Mercer actuaries certify these add-ons as actuarially sound regardless of the budget outcome and the subsequent effective dates of the add-ons. The Family Planning initiative is expected to be effective for the entire contract period.

To facilitate CMS rate review for each of the five Proposition 56 payment initiatives, the rest of this section is structured to provide documentation individually for each as required by the 2020–2021 Medicaid Managed Care RDG.

Physician Proposition 56 Add-On Per Member Per Month

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

Pre-Prints for this payment initiative have been approved for prior rating periods and the renewal version applicable to the current rating period has been submitted to CMS for approval on December 31, 2020, with no changes to major terms and conditions with the lone exception of dropping a single, minor E&M code (90863).

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

Procedure Code	Description	Uniform Dollar Amount
99201	Office/OP Visit New	$18.00
99202	Office/OP Visit New	$35.00
99203	Office/OP Visit New	$43.00
99204	Office/OP Visit New	$83.00
99205	Office/OP Visit New	$107.00
99211	Office/OP Visit Est	$10.00
99212	Office/OP Visit Est	$23.00
99213	Office/OP Visit Est	$44.00
99214	Office/OP Visit Est	$62.00

Procedure Code	Description	Uniform Dollar Amount
99215	Office/OP Visit Est	$76.00
90791	Psychiatric Diagnostic Evaluation	$35.00
90792	Psychiatric Diagnostic Evaluation With Medical Services	$35.00
99381	Preventive Visit New	$77.00
99382	Preventive Visit New	$80.00
99383	Preventive Visit New	$77.00
99384	Preventive Visit New	$83.00
99385	Preventive Visit New	$30.00
99391	Preventive Visit Est	$75.00
99392	Preventive Visit Est	$79.00
99393	Preventive Visit Est	$72.00
99394	Preventive Visit Est	$72.00
99395	Preventive Visit Est	$27.00

The application of these adjustments across all managed care models and all impacted COA groups is shown in the table below. The table highlights the components of the total amounts including the projected MMs (based upon the baseline enrollment projection that utilized actual experience through September 2020), projected impacted E&M and preventive visits, the resulting PMPMs and the total dollars. The payment adjustments for the given E&M and preventive codes are being made to all eligible contracted providers who perform these services for managed care enrollees. Services where Medicare would be the primary payer (Full-dual and Part B partial dual members) are excluded from the add-on payments. Services provided within FQHC/RHC facilities are also excluded from the add-on payments due to the wrap-around payment structure associated with these types of facilities. Additional payments to AIHS providers and CBRCs are also excluded.

Physician (January 2021–June 2021)				
COA	Projected MMs	Prop 56 Add-on Projected Units	Total PMPM	Total Dollars
Child	27,373,158	4,027,928	$8.33	$228,061,584
Adult	10,193,956	1,859,677	$9.47	$96,513,642
ACA OE	21,305,378	3,599,855	$8.94	$190,503,721
SPD	4,571,944	1,262,565	$15.41	$70,432,273
LTC	72,510	13,943	$10.96	$794,640
OBRA	852	141.835798	$8.34	$7,106

Physician (January 2021–June 2021)				
COA	**Projected MMs**	**Prop 56 Add-on Projected Units**	**Total PMPM**	**Total Dollars**
WCM	154,314	53,639	$21.15	$3,264,194
AIDS Non-Duals	2,100	622.294154	$16.30	$34,230
All COAs	**63,674,212**	**10,818,369**	**$9.26**	**$589,611,389**

The PMPM adjustments were developed based upon MCOs' encounter data as well as MCO information submitted through the RDT. These two data sources, the encounters and RDT data, were then utilized in developing a distribution and projected utilization of the impacted codes. Through a blended approach of the two data sources, similar in structure to the base data development that reviews the reasonableness of each data element, a final PMPM was developed based upon the projected utilization by code and the resulting needed add-on amount associated with each code. As described previously, certain provider types (FQHC/RHCs, AIHS providers, and CBRCs) were excluded from the analysis, as well as the exclusion of services provided where Medicaid was not the primary payer. This PMPM amount was then further adjusted to include an administrative load (representing the variable administrative costs of the program, fixed administrative costs are covered in the base capitation rates) and an underwriting gain of 1.5%. These load factors are consistent with the values utilized for the other supplemental payments as described further above. Further detail of these components, including MCO-specific amounts are included within the accompanying rate development detail provided in an Excel format.

The final add-on PMPM amounts are included in the applicable final rate ranges after the application of risk adjustment. There is no variation of the add-on PMPMs across the rate ranges. If budget appropriations are approved that allow the continuation of these add-ons for the July 2021 through December 2021 period, the following table of impacts will apply for that period.

Physician (July 2021–December 2021)				
COA	**Projected MMs**	**Prop 56 Add-on Projected Units**	**Total PMPM**	**Total Dollars**
Child	27,008,172	3,974,233	$8.33	$225,021,394
Adult	10,046,621	1,832,854	$9.47	$95,120,159
ACA OE	20,992,820	3,547,094	$8.94	$187,710,337
SPD	4,533,126	1,251,858	$15.41	$69,834,749
LTC	72,510	13,943	$10.96	$794,640
OBRA	852	141.835798	$8.34	$7,106
WCM	154,314	53,639	$21.15	$3,264,194
AIDS Non-Duals	2,100	622.294154	$16.30	$34,230

Physician (July 2021–December 2021)				
COA	Projected MMs	Prop 56 Add-on Projected Units	Total PMPM	Total Dollars
All COAs	62,810,515	10,674,385	$9.26	$581,786,808

Per the Pre-Print, the add-on rate payment for this payment initiative will be subject to a two-sided risk corridor together with the Trauma Screening Proposition 56 add-on rate payment and Developmental Screening Proposition 56 add-on rate payment. As outlined in the Pre-Print, the risk corridor will be based on the Medical Expenditure Percentage (MEP) achieved by each MCO. The MEP shall be calculated in aggregate as the percentage of the medical portion of the add-on rates paid to eligible providers for eligible services across all applicable COA and rating regions where the MCO operates. DHCS will perform the risk corridor calculation no sooner than 12 months after the end of the rating period. Further details can be found in Attachment 1 of the Pre-Print.

Trauma Screening Proposition 56

The Trauma Screening Proposition 56 directed payment is a payment arrangement, which directs MCOs to pay no less than a minimum fee schedule payment for specific Adverse Childhood Experiences Screening services to eligible network providers based on the utilization and delivery of services for eligible enrollees covered under the contract. The initial Pre-Print for this payment initiative has been approved for the prior rating period and the renewal version applicable to the current rating period has been submitted to CMS for approval on December 31, 2020, 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 minimum fee schedule payment initiative.
- MCOs are required to pay the eligible providers for the applicable incurred period using the following minimum fee schedule for qualifying covered services provided to eligible managed care enrollees up through age 64.

Procedure Code	Description	Minimum Fee Amount
96160U1	Adverse Childhood Event Screening	$29.00
96160U2	Adverse Childhood Event Screening	$29.00

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

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

As a newly added service in CY 2020, there was no credible and complete claims experience data available in the base period. Similar to the rate development approach used for the prior period, Mercer identified eligible enrollees in the most recent full year (CY 2018) of eligibility data based on their Medicare coverage status and specific age groups (age group 0–18 and age group 19–64) within each COA across all model types to calculate the percentage of members eligible for this service within each COA. Note that enrollees above age 65 or with Medicare part B coverage are not eligible for this service. Mercer worked together with the State to develop age group specific take-up assumptions around the percentages of eligible members within each age group who will receive this service within the contract period. Note that this service is primarily intended for children, but adults under 65 are also eligible to receive this service if deemed medically necessary. Therefore, the assumed take-up assumptions are much lower for adults compared to children. Given the assumed utilizations for each group, the age group mix for each COA, and the known unit cost (minimum fee schedule), Mercer then calculated the expected claims PMPM as the benefit cost component of the add-on rate for each of the two six-month periods. Lastly, this PMPM amount was adjusted to include half of the plan-specific administrative load, which provides for the variable component of the expenses while the fixed administrative costs are covered in the base capitation rates, and an underwriting gain of 1.5%. Further detail of these components, including MCO-specific amounts are included within the accompanying rate development detail provided in an Excel format.

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

Trauma Screening (January 2021–June 2021)				
COA	**Projected MMs**	**Prop 56 Add-on Projected Units**	**Total PMPM**	**Total Dollars**
Child	27,373,158	499,894	$0.56	$15,297,572
Adult	10,193,956	43,098	$0.13	$1,318,942
ACA OE	21,305,378	90,532	$0.13	$2,769,699
SPD	4,571,944	25,237	$0.17	$772,384
LTC	72,510	166	$0.07	$5,076
OBRA	852	2	$0.08	$68
WCM	154,314	2,812	$0.55	$85,454
AIDS Non-Duals	2,100	11	$0.17	$357
All COAs	**63,674,212**	**661,753**	**$0.32**	**$20,249,552**

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. If budget appropriations are approved that allow the continuation of these add-ons for the July through December 2021 period, the following table of impacts will apply for that period.

Trauma Screening (July 2021–December 2021)				
COA	**Projected MMs**	**Prop 56 Add-on Projected Units**	**Total PMPM**	**Total Dollars**
Child	27,008,172	493,229	$0.56	$15,093,610
Adult	10,046,621	42,475	$0.13	$1,299,889
ACA OE	20,992,820	89,204	$0.13	$2,729,067
SPD	4,533,126	25,022	$0.17	$765,827
LTC	72,510	166	$0.07	$5,076
OBRA	852	2	$0.08	$68
WCM	154,314	2,812	$0.55	$85,454
AIDS Non-Duals	2,100	11	$0.17	$357
All COAs	**62,810,515**	**652,922**	**$0.32**	**$19,979,347**

Per the Pre-Print, the add-on rate payment for this payment initiative will be subject to a two-sided risk corridor together with the Physician Proposition 56 add-on rate payment and the Developmental Screening Proposition 56 add-on rate payment. As outlined in the Pre-Print, the risk corridor will be based on the MEP achieved by each MCO. The MEP shall be calculated in aggregate as the percentage of the medical portion of the add-on rates paid to eligible providers for eligible services across all applicable COA and rating regions where the MCO operates. DHCS will perform the risk corridor calculation no sooner than 12 months after the end of the rating period. Further details can be found in Attachment 1 of the Pre-Print.

Family Planning Proposition 56

The Family Planning Proposition 56 directed payment is a payment arrangement, which directs MCOs to pay a uniform and fixed dollar amount add-on payment for specific family planning services to eligible network providers based on the utilization and delivery of services for eligible enrollees covered under the contract. The initial Pre-Print for this payment initiative has been approved for the prior rating period and the renewal version applicable to the current rating period has been submitted to CMS for approval on December 31, 2020, with no changes to major terms and conditions.

The following provides a brief description of this payment initiative:

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

Procedure Code[3]	Description	Uniform Dollar Amount
J7296	LEVONORGESTREL-RELEASING IU COC SYS 19.5 MG	$2,727.00
J7297	LEVONORGESTREL-RLS INTRAUTERINE COC SYS 52 MG	$2,053.00
J7298	LEVONORGESTREL-RLS INTRAUTERINE COC SYS 52 MG	$2,727.00
J7300	INTRAUTERINE COPPER CONTRACEPTIVE	$2,426.00
J7301	LEVONORGESTREL-RLS INTRAUTERINE COC SYS 13.5 MG	$2,271.00
J7307	ETONOGESTREL CNTRACPT IMPL SYS INCL IMPL & SPL	$2,671.00
J3490U8	DEPO-PROVERA	$340.00
J7303	CONTRACEPTIVE VAGINAL RING	$301.00
J7304	CONTRACEPTIVE PATCH	$110.00
J3490U5	EMERG CONTRACEPTION: ULIPRISTAL ACETATE 30 MG	$72.00
J3490U6	EMERG CONTRACEPTION: LEVONORGESTREL 0.75 MG (2) & 1.5 MG (1)	$50.00
11976	REMOVE CONTRACEPTIVE CAPSULE	$399.00
11981	INSERT DRUG IMPLANT DEVICE	$835.00
58300	INSERT INTRAUTERINE DEVICE	$673.00
58301	REMOVE INTRAUTERINE DEVICE	$195.00
81025	URINE PREGNANGY TEST	$6.00
55250	REMOVAL OF SPERM DUCT(S)	$521.00
58340	CATHETER FOR HYSTEROGRAPHY	$371.00
58555	HYSTEROSCOPY DX SEP PROC	$322.00
58565	HYSTEROSCOPY STERILIZATION	$1,476.00
58600	DIVISION OF FALLOPIAN TUBE	$1,515.00
58615	OCCLUDE FALLOPIAN TUBE(S)	$1,115.00
58661	LAPAROSCOPY REMOVE ADNEXA	$978.00

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

Procedure Code[3]	Description	Uniform Dollar Amount
58670	LAPAROSCOPY TUBAL CAUTERY	$843.00
58671	LAPAROSCOPY TUBAL BLOCK	$892.00
58700	REMOVAL OF FALLOPIAN TUBE	$1,216.00

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

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

There was relatively complete and credible claims experience data available in the base period though they are subject to encounter under-reporting and other data issues. Similar to the rate development approach used for the prior period, Mercer leveraged the most recent full year (CY 2018) of existing claims data using the list of procedure codes to develop the base utilization by COA for each procedure code across all model types. Mercer adjusted the base utilization for estimated encounter under-reporting and anticipated ramp-up due to the enhanced payment under this payment initiative based on literature review of expected national utilization levels of family planning services by the following major service types among child bearing age females.

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

Given the assumed utilizations for each code by COA and the known additional unit cost (uniform dollar increase schedule), Mercer then calculated the expected claims PMPM on a statewide basis as the benefit cost component of the add-on rate. Services provided within FQHC/RHC facilities are also excluded from the add-on payments due to the wrap-around payment structure associated with these types of facilities. Additional payments to AIHS providers and CBRCs are also excluded. In addition, because the network provider mix varies substantially across individual MCOs and individual rating regions, Mercer further adjusted the statewide claims PMPM using rating region specific and MCO-specific provider exclusion factors to develop the final claims PMPM, which vary by MCO and rating region. Lastly, this PMPM amount was adjusted to include half of the plan-specific administrative load, which provides for the variable component of the expenses while the fixed administrative costs are covered in the base capitation rates, and an underwriting gain of 1.5%.

Further detail of these components, including MCO-specific amounts are included within the accompanying rate development detail provided in an Excel format.

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

Family Planning (January 2021–December 2021)				
COA	**Projected MMs**	**Prop 56 Add-on Projected Units**	**Total PMPM**	**Total Dollars**
Child	54,381,330	202,836	$0.69	$37,678,297
Adult	20,240,577	894,141	$11.34	$229,528,565
ACA OE	42,298,198	716,990	$3.29	$139,187,947
SPD	9,105,070	73,909	$1.00	$9,132,702
LTC	145,020	318	$0.28	$40,855
OBRA	1,704	7	$0.03	$51
WCM	308,628	1,048	$0.63	$193,642
AIDS Non-Duals	4,200	39	$1.17	$4,914
All COAs	**126,484,727**	**1,889,287**	**$3.29**	**$415,766,974**

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 Pre-Print, the add-on rate payment for this payment initiative will be subject to a two-sided risk corridor specific to Family Planning. As outlined in the Pre-Print, the risk corridor will be based on the MEP achieved by each MCO. The MEP shall be calculated in aggregate as the percentage of the medical portion of the add-on rates paid to eligible providers for eligible services across all applicable COA and rating regions where the MCO operates. DHCS will perform the risk corridor calculation no sooner than 12 months after the end of the rating period. Further details can be found in Attachment 1 of the Pre-Print.

Value-Based Payment Proposition 56

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

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

- BH care

This arrangement directs MCOs to make additional enhanced payments for events tied to beneficiaries diagnosed with a substance use disorder, serious mental illness or who are homeless (also referenced as "At Risk Users" in the following VBP schedule). The initial Pre-Print for this payment initiative has been approved for the prior rating period and the renewal version applicable to the current rate period has been submitted to CMS for approval on December 31, 2020, 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 VBP initiative.
- MCOs are required to pay the eligible providers for the applicable incurred period using the following VBP schedule by core measure for specified services provided to eligible managed care enrollees.

Measure	Measure	Uniform Dollar Amounts for All Users	Uniform Dollar Amount for At Risk Users
1	Prenatal Pertussis ('Whooping Cough') Vaccine	$25.00	$37.50
2	Prenatal Care Visit	$70.00	$105.00
3	Postpartum Care Visit (First Visit)	$70.00	$105.00
3	Postpartum Care Visit (Second Visit)	$70.00	$105.00
4	Postpartum Birth Control	$25.00	$37.500
5	Well Child Visits in First 15 Months of Life (Six Month Visit)	$70.00	$105.00
5	Well Child Visits in First 15 Months of Life (Nine Month Visit)	$70.00	$105.00
5	Well Child Visits in First 15 Months of Life (12 Month Visit)	$70.00	$105.00
6	Well Child Visits Year Three	$70.00	$105.00
6	Well Child Visits Year Four	$70.00	$105.00
6	Well Child Visits Year Five	$70.00	$105.00
6	Well Child Visits Year Six	$70.00	$105.00
7	Childhood Vaccine — Two Year Olds (DTaP)	$25.00	$37.50
7	Childhood Vaccine — Two Year Olds (PCV)	$25.00	$37.50

Measure	Measure	Uniform Dollar Amounts for All Users	Uniform Dollar Amount for At Risk Users
7	Childhood Vaccine — Two Year Olds (IPV)	$25.00	$37.50
7	Childhood Vaccine — Two Year Olds (Hep B)	$25.00	$37.50
7	Childhood Vaccine — Two Year Olds (Rotavirus)	$25.0	$37.50
7	Childhood Vaccine — Two Year Olds (Influenza)	$25.00	$37.50
7	Childhood Vaccine — Two Year Olds (HiB)	$25.00	$37.50
8	Blood Lead Screening	$25.00	$37.50
9	Dental Fluoride Varnish	$25.00	$37.50
10	Controlling Blood Pressure	$40.00	$60.00
11	Diabetes Care	$80.00	$120.0
12	Control of Persistent Asthma	$40.00	$60.00
13	Tobacco Use Screening	$25.00	$37.50
14	Adult Influenza ('Flu') Vaccine	$25.00	$37.50
15	Screening for Clinical Depression (CDF)	$50.00	$75.00
16	Management of Depression Medication	$40.00	$60.00
17	Screening for Unhealthy Alcohol Use	$50.00	$75.00

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

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

There was limited claims experience data available in the base period to support add-on rate development. Similar to the rate development approach used for the prior period, Mercer leveraged existing eligibility data in the most recent full year (CY 2018) of eligibility data to identify the eligible group within each COA for each targeted service or event as defined under this payment initiative and then worked together with the State to develop the utilization assumption for each eligible group for each targeted service on a statewide basis. Given the assumed utilizations for each targeted service by each eligible group, eligible member mix within each COA and the known enhanced payment

(VBP schedule), Mercer calculated the expected claims PMPM on a statewide basis by COA for each core measure as the benefit cost component of the add-on rate. Services provided within FQHC/RHC facilities are also excluded from this add-on payment due to the wrap-around payment structure associated with these types of facilities. Additional payments to AIHS providers and CBRCs are also excluded. In addition, because the network provider mix varies substantially across individual MCOs and individual rating regions, Mercer further adjusted the statewide claims PMPM using rating region specific and MCO specific provider exclusion factors to develop the final claims PMPM that varies by MCO and rating region. Lastly, this PMPM amount was adjusted to include half of the plan-specific administrative load, which provides for the variable component of the expenses while the fixed administrative costs are covered in the base capitation rates, and an underwriting gain of 1.5%. Further detail of these components, including MCO-specific amounts are included within the accompanying rate development detail provided in an Excel format.

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

VBP (January 2021–June 2021)				
COA	**Projected MMs**	**Prop 56 Add-on Projected Units**	**Total PMPM**	**Total Dollars**
Child	27,373,158	1,444,582	$2.38	$65,014,846
Adult	10,193,956	864,248	$3.62	$36,907,970
ACA OE	21,305,378	1,619,353	$3.05	$64,967,080
SPD	4,571,944	359,511	$3.56	$16,291,562
LTC	72,510	5,860	$3.53	$255,736
OBRA	852	92	$4.66	$3,970
WCM	154,314	7,415	$2.15	$331,083
AIDS Non-Duals	2,100	187	$4.17	$8,757
All COAs	**63,674,212**	**4,301,248**	**$2.89**	**$183,781,005**

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. If budget appropriations are approved that allow the continuation of these add-ons for the July through December 2021 period, the following table of impacts will apply for that period.

VBP (July 2021–December 2021)				
COA	**Projected MMs**	**Prop 56 Add-on Projected Units**	**Total PMPM**	**Total Dollars**
Child	27,008,172	1,425,319	$2.38	$64,147,939
Adult	10,046,621	851,774	$3.62	$36,375,338

VBP (July 2021–December 2021)				
COA	**Projected MMs**	**Prop 56 Add-on Projected Units**	**Total PMPM**	**Total Dollars**
ACA OE	20,992,820	1,595,618	$3.05	$64,014,910
SPD	4,533,126	356,462	$3.56	$16,153,368
LTC	72,510	5,860	$3.53	$255,736
OBRA	852	92	$4.66	$3,970
WCM	154,314	7,415	$2.15	$331,083
AIDS Non-Duals	2,100	187	$4.17	$8,757
All COAs	**62,810,515**	**4,242,726**	**$2.89**	**$181,291,101**

According to the Pre-Print, the add-on rate payment for this payment initiative will be subject to a two-sided risk corridor specific to VBP. As outlined in the Pre-Print, the risk corridor will be based on the MEP achieved by each MCO. The MEP shall be calculated in aggregate as the percentage of the medical portion of the add-on rates paid to eligible providers for eligible services across all applicable COA and rating regions where the MCO operates. DHCS will perform the risk corridor calculation no sooner than 12 months after the end of the rating period. Further details can be found in Attachment 1 of the Pre-Print.

Hospital Directed Payments

The following directed payments: Private Hospital Uniform Dollar Increase (UDI), DPH FFS UDI, DPH Capitation, and DPH/DMPH Quality Incentive Pools (QIP) outlined below have been submitted to CMS, and the actual payments associated with these directed payments will be paid in the future. However, information included in the second tab of the attached spreadsheet *(Summary Exhibit CY 2021 Medi-Cal MC Pass-through and Directed Payment Exhibits 2021 01 28.xlsx)* includes the estimated PMPM impacts associated with these directed payments.

Private Hospital Uniform Dollar Increase

Private Hospital UDI directed payment Pre-Prints for this payment initiative have been approved for prior rating periods and the renewal version applicable to the current rate period has been submitted to CMS for approval on December 31, 2020, with no changes to major terms and conditions. The approach for developing the anticipated Private Hospital UDI impacts was very similar to the approach utilized for the private hospital HQAF Pass-through payments. The upper bound GME PMPM from the rates for the impacted COS (IP and OP/ER) was adjusted based on the SDR information for not only the private hospital share (please note DMPHs are excluded within the directed payment calculations with the exception of DMPH QIP) of expenditures, but also for the contracted share of those expenditures (payments associated with the MCO having a contract in place with the private facilities). This “contracted private share” of revenue was then further broken down into unit cost and utilization

levels based upon information provided within the SDR. These calculations produced estimated private contracted days or visits that then form the basis for creating a uniform dollar increase that would total the intended directed payment target. The directed payment target for the IP and OP/ER adjustments was $3,527.53 million for the entire 12-month rating period. The IP uniform add-on of $990 and the OP/ER uniform add-on of $111 produced impacts of $2,469.27 million and $1,058.26 million for the respective COS. The excerpt below is from a prior PDF exhibit of "Exhibit Ia" which contains the calculations for the IP COS. The attached exhibit (*Exhibit I CY 2021 Private Hospital Directed Payments 2021 01 28.pdf*) contains the full detail of these calculations for the IP and OP/ER COS. The rows align with the COA presented in the excerpt from the Private Hospital HQAF exhibit and are listed in "Exhibit Ia". The final results are included in the second tab of the attached spreadsheet (*Summary Exhibit CY 2021 Medi-Cal MC Pass-through and Directed Payment Exhibits 2021 0128.xlsx*) as noted previously.

- {H} is the upper bound GME PMPM from the rates
- {I} is the estimated private share based on the payment information from the SDR
- {J} is the contracted proportion of the private elements
- {K} = {H} * {I} * {J} is the product of these three elements
- {D} is calculated from {K} and {G} (contracted private PMPM and private unit costs)
- {L} is the uniform add-on unit cost based on the contracted days from {D}
- {N} reflects the add-on percent change, calculated based on the add-on unit cost that is applied to {K} to produce the PMPM impact {O}

{B}	{C} = {D} / {B}	{D}={A}*{K}/{G}	{E}	{F}	{G}={E}*(1 + {F})	{H}	{I}	{J}	{K}={H}*{I}*{J}	{L}	{M}={G}+{L}	{N}={L}/{G}	{O}={K}*{N}
Total Days from Rates	**Estimated Private Contracted Days (%)**	**Estimated Private Contracted Days**	**Rate Unit Cost**	**Estimated Unit Cost Differential**	**Estimated Private Unit Cost**	**Rate PMPM**	**Private Share of Total (PMPM)**	**Contracted Private % (PMPM)**	**Private Contracted PMPM**	**Uniform Unit Cost Add-on**	**New Unit Cost**	**Add-on %**	**Add-on PMPM**
4,827	86.2%	4,161	$ 3,907	1.6%	$ 3,968	$ 11.20	89.8%	97.5%	$ 9.81	$ 1,012.56	$ 4,981	25.5%	$ 2.50
18,291	65.4%	11,971	$ 3,153	6.0%	$ 3,340	$ 94.59	73.2%	94.7%	$ 65.59	$ 1,012.56	$ 4,353	30.3%	$ 19.88
39,104	49.4%	19,316	$ 3,823	6.8%	$ 4,082	$ 100.79	61.8%	85.3%	$ 53.16	$ 1,012.56	$ 5,095	24.8%	$ 13.19
41,247	54.7%	22,554	$ 3,571	6.9%	$ 3,819	$ 307.07	63.2%	92.6%	$ 179.55	$ 1,012.56	$ 4,832	26.5%	$ 47.60
32	47.6%	15	$ 2,661	6.4%	$ 2,831	$ 347.56	60.2%	84.2%	$ 176.11	$ 1,012.56	$ 3,843	35.8%	$ 62.99
-	0.0%	-	$ -	6.4%	$ -	$ -	0.0%	0.0%	$ -	$ 1,012.56	$ 1,013	0.0%	$ -
-	0.0%	-	$ -	6.4%	$ -	$ -	0.0%	0.0%	$ -	$ 1,012.56	$ 1,013	0.0%	$ -
103,501	**56.1%**	**58,017**	**$ 3,608**	**6.4%**	**$ 3,840**	**$ 87.73**	**Total Impact**	**59.3%**	**$ 52.05**	**$ 1,012.56**	**$ 4,853**	**26.4%**	**$ 13.80**

A similar process is performed for the OP/ER components and these calculations can be found in "Exhibit Ib" in the attached PDF exhibits.

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 CMS approved Pre-Print.

Designated Public Hospital Fee-For-Service Uniform Dollar Increase

DPH FFS UDI directed payment Pre-Prints for these payment initiatives have been approved for prior rating periods and the renewal versions applicable to the current rate period have been submitted to CMS for approval on December 31, 2020, with no changes to major terms and conditions. The approach for developing the anticipated DPH FFS impacts was very similar to the approach utilized for the Private Hospital UDI directed payments. The upper bound GME PMPM from the rates for the impacted COS (IP, LTC, OP/ER and non-facility [PCP, Specialist and other providers {FQHCs are excluded}]) was adjusted based on the SDR information for not only the DPH share of expenditures, but also for the contracted share of those expenditures (payments that were associated with the MCO having a contract in place with the DPH facilities). This "contracted DPH share" of revenue was then further broken down into unit cost and utilization levels based upon information provided within the SDR. These calculations produced estimated DPH contracted days or visits that then form the basis for creating a uniform dollar increase that would total the intended directed payment target for the given Classes of DPHs. The total impact of this directed payment across the Classes is targeted to be approximately $742.28 million. The excerpt below is from a prior PDF of exhibit "Exhibit IIa" which contains the calculations. The attached PDF exhibits ("Exhibit II" through "Exhibit VI" for the Class A to Class E impacts) contain the full detail of these calculations for the impacted COS. Classes A through E are outlined below:

- Class A is comprised of Santa Clara and San Francisco counties
- Class B is comprised of Alameda, San Bernardino, Kern, Monterey, Riverside, and Ventura counties
- Class C is comprised of Contra Costa, San Joaquin, and San Mateo counties
- Class D is comprised of all counties served by UC facilities
- Class E is comprised of LA County

The final results are also included in the second tab of the attached spreadsheet (*Summary Exhibit CY 2021 Medi-Cal MC Pass-through and Directed Payment Exhibits 2021 01 28.xlsx*). Within this second tab, a summary of the varied Class impacts for this adjustment is included at the bottom.

- {H} is the upper bound GME PMPM from the rates
- {I} is the estimated DPH share based on the payment information from the SDR
- {J} is the contracted proportion of the DPH elements
- {K} = {H} * {I} * {J} is the product of these three elements
- {D} is the contracted DPH days calculated from {K} and {G} (contracted DPH PMPM and unit costs)

- {L} is the uniform add-on cost based on the contracted days from {D}
- {N} reflects the add-on percent change that is applied to {K} to produce the PMPM impact {O}

{B}	{C} = {D} / {B}	{D}={A}*{K}/{G}	{E}	{F}	{G}={E}*(1 + {F})	{H}	{I}	{J}	{K}={H}*{I}*{J}	{L}	{M}={G}+{L}	{N}={L}/{G}	{O}={K}*{N}
Total Days from Rates	Estimated DPH Contracted Days (%)	Estimated DPH Contracted Days	Rate Unit Cost	Estimated Unit Cost Differential	Estimated DPH Unit Cost	Rate PMPM	DPH Share of Total (PMPM)	Contracted DPH % (PMPM)	DPH Contracted PMPM	Uniform DPH Add-on	New Unit Cost	Add-on %	Add-on PMPM
3,859	31.6%	1,218	$ 3,400	-4.4%	$ 3,252	$ 18.30	30.2%	100 0%	$ 5.52	$ 1,209.30	$ 4,461	37.2%	$ 2.05
11,031	21.9%	2,418	$ 1,876	-5.4%	$ 1,774	$ 83.36	20.7%	100 0%	$ 17.28	$ 1,209.30	$ 2,983	68.2%	$ 11.78
30,631	32.1%	9,832	$ 2,664	-4.0%	$ 2,558	$ 87.87	30.8%	100 0%	$ 27.08	$ 1,209.30	$ 3,767	47.3%	$ 12.80
29,822	22.4%	6,686	$ 1,668	-2.9%	$ 1,620	$ 208.21	21.8%	100 0%	$ 45.32	$ 1,209.30	$ 2,829	74.7%	$ 33.84
30	32.3%	10	$ 2,668	-2.9%	$ 2,591	$ 323.53	31.4%	100 0%	$ 101.47	$ 1,209.30	$ 3,801	46.7%	$ 47.36
-	0 0%	-	$ -	0 0%	$ -	$ -	0 0%	0 0%	$ -	$ 1,209.30	$ 1,209	0.0%	$ -
-	0 0%	-	$ -	0 0%	$ -	$ -	0 0%	0 0%	$ -	$ 1,209.30	$ 1,209	0.0%	$ -
75,373	**26.8%**	**20,164**	**$ 2,192**	**-3.9%**	**$ 2,108**	**$ 77.47**	**Total Impact**	**26.8%**	**$ 20.75**	**$ 1,209.30**	**$ 3,317**	**57.4%**	**$ 11.43**

A similar process is performed for the LTC, OP/ER and non-facility components and these calculations can be found in “Exhibit II” through “Exhibit VI” (sub-letters b through d) in the attached PDF exhibits.

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 CMS approved Pre-Prints. As described in the DPH Pre-Prints, 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.

Designated Public Hospitals Capitation

The DPH Capitation directed payment Pre-Print for this payment initiative has been approved for prior rating periods and the renewal version applicable to the current rate period has been submitted to CMS for approval on December 31, 2020, with no changes to major terms and conditions.

The DPH Capitation directed payment increase impacts Class A (Santa Clara and San Francisco Counties) and Class E (LA County). The approach for producing the uniform increase leveraged the estimated capitation payments DPH assigned members anticipated during the rating period relative to the targeted amounts for each class and the projected MMs for the DPH assigned members. The DPH Capitation directed payment leverages total GME expenditures across all COS within the calculations. The excerpt below is a sample from a prior PDF exhibit of “Exhibit IIe” which contains the calculations. The attached PDF exhibits (“Exhibit IIe” and “Exhibit VId” for the Class A and Class E impacts respectively) contain the full detail of these calculations. The final results are also included in the second tab of the attached spreadsheet (*Summary Exhibit CY 2021 Medi-Cal MC Pass-through and Directed Payment Exhibits 2021 01 28.xlsx*). The total results produce a $1,050.25 million impact across Class A ($312.02 million) and Class E ($738.23 million).

- {H} is the estimated total cap expenditures based on {B} (projected DPH assigned members MMs) and {G} (DPH assigned members capitation payments)
- {I} is the uniform percentage that will produce the target amount when applied to {H}
- {L} is the total cap change
- {M} = {L} / {E} produces the add-on percentage relative to the total GME expenditures
- {N} = {D} * {M} produces the final add-on PMPM

{A}	{B}	{C} {B} / {A}	{D}	{E} {A} * {D}	{F}	{G} {D}*(1 + {F})	{H} {B} * {G}	{I}	{J} {G}*(1 + {I})	{K} {J} - {G}	{L} {B} * {K}	{M} {L} / {E}	{N} {D} * {M}
Projected Member Months	Projected Cap MMs	Estimated Cap MMs (%)	Rate PMPM	Estimated Total GME Expenditures	Estimated Payment Differential	Estimated Cap Payment	Estimated Cap Expenditures	Uniform % Add	New Cap	Cap Change PMPM	Cap Change Total	Add-on %	Add-on PMPM
716,871	275,664	38.5%	$ 103.97	$ 74,536,441	-56.6%	$ 45.11	$ 12,434,489	89.2%	$ 85.35	$ 40.24	$ 11,092,683.40	14.9%	$ 15.47
248,309	92,440	37.2%	$ 290.76	$ 72,197,286	-59.2%	$ 118.49	$ 10,953,103	89.2%	$ 224.19	$ 105.70	$ 9,771,153.57	13.5%	$ 39.35
928,723	476,604	51.3%	$ 352.52	$ 327,389,099	-55.5%	$ 156.79	$ 74,728,689	89.2%	$ 296.67	$ 139.87	$ 66,664,716.15	20.4%	$ 71.78
238,950	138,415	57.9%	$ 749.94	$ 179,198,639	-56.9%	$ 323.21	$ 44,737,685	89.2%	$ 611.55	$ 288.34	$ 39,910,041.51	22.3%	$ 167.02
249	81	32.4%	$ 1,083.04	$ 269,676	-54.9%	$ 488.60	$ 39,577	89.2%	$ 924.48	$ 435.88	$ 35,306.08	13.1%	$ 141.79
-	-	0.0%	$ -	$ -	0.0%	$ -	$ -	89.2%	$ -	$ -	$ -	0.0%	$ -
-	-	0.0%	$ -	$ -	0.0%	$ -	$ -	89.2%	$ -	$ -	$ -	0.0%	$ -
2,133,102	**983,204**	**46.1%**	**$ 306.40**	**$ 653,591,141**	**-52.6%**	**$ 145.33**	**$ 142,893,543**	**89.2%**	**$ 274.99**	**$ 129.65**	**$ 127,473,900.71**	**19.5%**	**$ 59.76**

The methodology used to allocate actual payments associated with these directed payments will be consistent with the methods discussed in this certification and the CMS approved Pre-Print.

Designated Public Hospital Quality Incentive Pool and District and Municipal Public Hospital Quality Incentive Pool

The DPH QIP and DMPH QIP directed payments provide value-based payments to DPHs and DMPHs, respectively, linked to performance on specified quality measures. Multi-year directed payment Pre-Prints encompassing the CY 2021 rating period were submitted to CMS on December 31, 2020.

The DPH QIP directed payment increase calculations contain a county specific approach for the counties with non-UC DPHs and a statewide approach for the UC facilities. For the DMPH QIP, the county/region specific approach similar to the non-UC DPHs was utilized. Each county/region and UC facilities are allocated a portion of the total respective QIPs. The approach for producing the targeted PMPMs associated with the portions of the QIP leveraged the estimated total GME payments (either by county/region for the non-UC DPHs or DMPHs and statewide for the UC) anticipated during the rating period. Similar to the capitated directed payment approach, the QIP directed payment also leveraged total GME expenditures across all COS, but with the further refinement of only considering the contracted DPH or DMPH share of the total in a fashion similar to the approach utilized in the DPH FFS adjustment.

The excerpt below is a sample from a prior PDF exhibit of “Exhibit VIIa” which contains the calculations for a non-UC DPH QIP.

- {B} is the upper bound GME PMPM from the rates
- {D} is the estimated DPH (or DMPH) share based on the payment information from the SDR
- {E} is the contracted proportion of the DPH (or DMPH) elements
- {F} = {B} * {D} * {E} is the product of these three elements
- {G} is the total DPH (or DMPH) expenditures
- {H} is the uniform QIP percent based on the target amount {P1} relative to {G} (across county/region or state for UCs)
- {I} = {G} * {H} is the targeted QIP dollars by COA
- {J} = {I} / {C} is the QIP dollars as a percent of total expenditures
- {K} = {B} * {J} is the final add-on PMPM based on the percentage from {J}

{B}	{C} {A} * {B}	{D}	{E}	{F} {B}*{D}*{E}	{G} {A}*{F}	{H} {P1}/"county"{G}	{I} {G}*{H}	{J} {I}/{C}	{K} {B}*{J}	{L}	{M}	N} {K}+{L}+{M}	{O} {A} * {N}	{P}
Rate PMPM	**Total Expenditures**	**DPH Share of Total (PMPM)**	**Contracted DPH % (PMPM)**	**DPH Contracted PMPM**	**DPH Expenditures**	**Uniform QIP %**	**QIP Dollars**	**Add-on %**	**Add-on PMPM**	**Admin**	**UW Gain**	**Total PMPM**	**Total Dollars**	**Total Dollars**
$ 84.47	$ 142,186,124	2.3%	97.1%	$ 1.88	$ 3,159,827	50.50%	$ 1,595,657	1.1%	$ 0.95			$ 0.95	$ 1,599,107	
$ 268.41	$ 163,636,518	9.2%	98.4%	$ 24.28	$ 14,803,595	50.50%	$ 7,475,552	4.6%	$ 12.26			$ 12.26	$ 7,474,272	
$ 330.56	$ 490,269,431	11.2%	97.5%	$ 36.12	$ 53,573,416	50.50%	$ 27,053,621	5.5%	$ 18.24			$ 18.24	$ 27,052,820	**{P1}**
$ 849.65	$ 407,608,554	10.1%	98.8%	$ 84.66	$ 40,615,968	50.50%	$ 20,510,340	5.0%	$ 42.75			$ 42.75	$ 20,508,714	**County Target**
$ 1,129.44	$ 277,841	2.7%	100.0%	$ 30.57	$ 7,521	50.50%	$ 3,798	1.4%	$ 15.44			$ 15.44	$ 3,798	$ 69,719,701
$ -	$ -	0.0%	0.0%	$ -	$ -	50.50%	$ -	0.0%	$ -			$ -	$ -	Target %
$ -	$ -	0.0%	0.0%	$ -	$ -	50.50%	$ -	0.0%	$ -			$ -	$ -	50.5%
$ 282.89	**$ 1,203,978,467**	**Total Impact**	**9.3%**	**$ 26.35**	**$ 112,160,327**		**$ 56,638,967**	**4.7%**	**$ 13.31**			**$ 13.31**	**$ 56,638,712**	
$ 67.94	$ 25,456,786	2.4%	65.2%	$ 1.06	$ 398,182	50.50%	$ 201,075	0.8%	$ 0.54			$ 0.54	$ 202,335	
$ 252.09	$ 31,541,085	11.8%	88.4%	$ 26.34	$ 3,295,510	50.50%	$ 1,664,174	5.3%	$ 13.30			$ 13.30	$ 1,664,056	
$ 238.36	$ 103,425,792	12.6%	87.7%	$ 26.27	$ 11,397,873	50.50%	$ 5,755,723	5.6%	$ 13.26			$ 13.26	$ 5,753,673	**{P2}**
$ 893.80	$ 91,127,815	12.6%	94.5%	$ 106.03	$ 10,810,433	50.50%	$ 5,459,076	6.0%	$ 53.54			$ 53.54	$ 5,458,724	**QIP Total**
$ 1,050.77	$ 37,828	3.6%	100.0%	$ 37.71	$ 1,358	50.50%	$ 686	1.8%	$ 19.04			$ 19.04	$ 685	$ 69,718,186
$ -	$ -	0.0%	0.0%	$ -	$ -	50.50%	$ -	0.0%	$ -			$ -	$ -	
$ -	$ -	0.0%	0.0%	$ -	$ -	50.50%	$ -	0.0%	$ -			$ -	$ -	
$ 242.91	**$ 251,589,306**	**Total Impact**	**10.3%**	**$ 25.01**	**$ 25,903,357**		**$ 13,080,734**	**5.2%**	**$ 12.63**			**$ 12.63**	**$ 13,079,474**	

The approach is the same for DMPH facilities and similar for the UC facilities except statewide totals are utilized versus county/region totals. The attached PDF exhibits ("Exhibits VIIa" for the non-UC DPHs QIP, "Exhibit VIIb" for the UC facilities QIP, and "Exhibit VIII" for the DMPH QIP) contain the full detail of these calculations. The final results are also included in the second tab of the attached spreadsheet (*Summary Exhibit CY 2021 Medi-Cal MC Pass-through and Directed Payment Exhibits 2021 01 28.xlsx*). The total DPH QIP results produce a $1,833.21 million impact across non-UC DPHs ($1,576.94 million) and UC facilities ($256.27 million). The total DMPH QIP results produce a $155.95 million impact across DMPH facilities.

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 CMS approved Pre-Prints.

Comparisons to Medicare and Commercial Payments

Similar to previously provided information associated with directed payments and CMS questions associated with Pre-Prints, a summary of a comparison to Medicare and Commercial rates is included for each of the add-on components.

The structure for the comparison to Commercial and Medicare is similar to prior years. Mercer is continuing to use the most currently available information for our comparisons. With the understanding that CMS thoroughly reviewed last year's value, we thought it was appropriate to provide a comparison table of the updated values, including PMPMs, for CY 2021 compared to annualized BP add-ons values and PMPMs. As displayed below, the total expenditures for non- Proposition 56 directed payments are up 5.9% in total and down (1.7%) in total on a PMPM basis.

		CY 2021		Bridge Period Annualized		% Change	
Hospital Class	COS	Target Add-on Dollars	Add-on PMPM	Target Add-on Dollars	Add-on PMPM	Target Add-on Dollars	Add-on PMPM
Private	Total	$ 3,527,530,769	$ 27.89	$ 3,278,823,966	$ 27.95	7.6%	-0.2%
DPH Class A	Total FFS	$ 55,062,447	$ 10.21	$ 44,115,630	$ 8.97	24.8%	13.8%
DPH Class A	Total Cap	$ 312,020,533	$ 70.09	$ 307,040,669	$ 75.51	1.6%	-7.2%
DPH Class B	Total	$ 295,970,540	$ 9.91	$ 283,129,224	$ 10.27	4.5%	-3.5%
DPH Class C	Total	$ 96,521,896	$ 14.14	$ 92,334,086	$ 14.73	4.5%	-4.0%
DPH Class D	Total	$ 255,874,687	$ 2.02	$ 226,366,828	$ 1.93	13.0%	4.8%
DPH Class E	Total FFS	$ 38,854,067	$ 1.12	$ 74,336,600	$ 2.28	-47.7%	-50.8%
DPH Class E	Total Cap	$ 738,227,273	$ 21.31	$ 669,029,400	$ 20.52	10.3%	3.8%
QIP DPH	Total	$ 1,833,210,574	$ 14.49	$ 1,772,507,549	$ 14.56	3.4%	-0.5%
QIP DMPH	Total	$ 155,948,147	$ 1.23	$ 151,852,500	$ 1.22	2.7%	1.3%
Total	**Total**	**$ 7,309,220,933**	**$ 57.79**	**$ 6,899,536,452**	**$ 58.81**	**5.9%**	**-1.7%**

Further detail is provided on the third, fourth, fifth sixth tabs of the attached summary exhibits (*Summary Exhibit CY 2021 Medi-Cal MC Pass-through and Directed Payment Exhibits 2021 01 28.xlsx*) where a comparison of Medi-Cal unit costs to Medicare and Commercial unit costs is provided. The tables provide a comparison of the Medi-Cal unit costs relative to the Medicare and Commercial unit costs by directed payment/pass-through COS subcomponent. The subcomponents are then expenditure weighted to produce aggregate comparisons across the various pass-through and directed payments. The sources for the Medi-Cal comparisons would be associated with the final total amounts within each of the prior detailed exhibits. For example, the last page of the "Exhibit A" IP section contains the total days (3,368,715), the estimated component days (2,854,339) and the accompanying unit cost components carried into the fourth and fifth tabs within the summary worksheet. This same approach is utilized across the balance of the exhibits to summarize the varied components used in the calculation of the Medi-Cal to Medicare and Commercial unit cost comparisons.

The data utilized in these comparisons came from various sources. For Medi-Cal, the upper bound GME for the varied COS for the CY 2021 have been utilized. We continue to utilize the California's

OSHPD experience to provide consistent comparisons. Mercer is now using the latest CY 2019 OSHPD data. This OSHPD data provides county specific (or groups of counties) IP and OP Medicare and Commercial payment levels. Professional unit cost information leveraged the CY 2019 CMS provider detail files numbers 3 and 4. Time periods utilized in the analysis were the CY 2021 Medi-Cal capitation rates (upper bound), CY 2019 OSHPD data, and the CY 2019 professional Medicare data. The Medicare and OSHPD data was trended forward 24 months to align with the CY 2021 Medi-Cal rates utilizing Medi-Cal rating trends from the rating period (annual trends of 3.89% for IP, 4.07% for OP/ER, and 1.97% for professional). The supporting documentation of these data sources is included in the final two tabs of the attached spreadsheet (*Summary Exhibit CY 2021 Medi-Cal MC Pass-through and Directed Payment Exhibits 2021 01 28.xlsx*).

If specific unit cost add-ons were not applicable for a given component, then the unit cost impacts were based upon the total expenditures for the given adjustment relative to the total expenditure within that COS. For example, the $21.96 unit cost adjustment for the $694.3 million Proposition 56 directed payments component was based upon the relationship of the Proposition 56 adjustment of $694.3 million relative to the underlying professional total costs of $3,692.7 million. This $3,692.7 million professional cost is based on the visits (31,614,182) and unit cost ($116.81) from the non-facility detail in “Exhibit Vc” (the UC exhibits contain statewide totals). This 18.8% relationship produced the additional $21.96 unit cost adjustment (18.8% times the $116.81 base unit cost). The new total unit cost of $138.77 is then compared to Medicare and Commercial unit costs trended to the midpoint of the CY 2021 period. A similar approach was utilized for the other components with consideration of the new add-on unit costs. As stated previously, these comparisons are displayed on the third, fourth, fifth and sixth tabs of the attached summary exhibit (*Summary Exhibit CY 2021 Medi-Cal MC Pass-through and Directed Payment Exhibits 2021 01 28.xlsx*).

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Certification and Final Rates

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

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

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

Mercer certifies that the capitation rates for the CY 2021, January 1, 2021 through December 31, 2021, were developed in accordance with generally accepted actuarial practices and principles, and are appropriate for the Medi-Cal covered populations and services under the managed care contract. Capitation rates are "actuarially sound" if, for the business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees and taxes The undersigned actuary is a member of the American Academy of Actuaries and meets its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

Capitation rates developed by Mercer are actuarial projections of future contingent events. All estimates are based upon the information and data available at a point in time, and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely, and potentially wide, range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use. Actual AHF 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, reinsurance, or incentive arrangements in these rates. Use of these rates for any purpose beyond that stated may not be appropriate.

AHF is 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 AHF for any purpose. Mercer recommends that any MCO, including AHF, 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.

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, please feel free to contact Marcie Gunnell at marcie.gunnell@mercer.com.

Sincerely,

Marcie S. Gunnell, ASA, MAAA, FCA
Principal

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