Mercer

Government Human Services Consulting

Medi-Cal Managed Care

Capitation Rate Development and Certification Amendment

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

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Section 1

Executive Summary

The California Department of Health Care Services (DHCS) contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to develop actuarially sound capitation rates for use during the calendar year (CY) 2024 rating period. The original capitation rates were developed by Mercer and certified in a report dated December 8, 2023. Please see the attached document: *CA CY 2024 (01 01 2024 - 12 31 2024) Rate Cert Report 2023 12.pdf.* Subsequent to the submission of the report, further revisions to the capitation rates were needed for the following items:

- Addition of a new policy change for the Children and Youth Behavioral Health Initiative (CYBHI).
- Addition of a new add-on for the Federally Qualified Health Centers (FQHC) Alternative Payment Method (APM), effective July 1, 2024.
- Addition of the Distinct Part Nursing Facilities (DP NF) pass through payment pursuant to 42 CFR § 438.6(c).
- Revision of the projected enrollment for the CY 2024 time period, informed by enrollment through April 2024 and supplemental information through May 2024.
- Revision of policy changes:
  - Targeted Rate Increases (TRI) were updated to account for an identified data discrepancy for one managed care organization (MCO) in one region.
  - Transitional Care Services were updated to remove the adjustment to Unsatisfactory Immigration Status (UIS) Federal rates that were incorrectly adjusted in the CY 2024 original rates.
  - Foster Care in new County Organized Health Systems (COHS) Counties was removed from Single-Plan counties as this population will now transition into managed care starting January 1, 2025.
  - Long-Term Care (LTC) and Hospice rate changes were updated to incorporate fee schedule changes associated with the termination of the public health emergency (PHE) and final CY 2024 fee schedule rates, including the Skilled Nursing Facility (SNF) Workforce Standards Program for AB1629 facilities.
  - Ground Emergency Medical Transportation (GEMT) Assembly Bill (AB) 1705 was updated to incorporate the final $1,049.98 add-on amount.
- Revision of Risk Adjustment factors for:

  - Chronic Illness and Disability Payment System (CDPS) + Pharmacy (Rx)
  - Behavioral Health Treatment (BHT)
  - LTC Stays
  - Community-Based Adult Services (CBAS)
  - Enhanced Care Management (ECM)
- Revision of rate add-ons for updated enrollment and underlying base rates:
  - MCO Tax
  - Hospital Quality Assurance Fee (HQAF)
  - Martin Luther King Jr. Community Hospital (MLK)
  - Benioff Children's Hospital Oakland (BCHO)
- Revision of the Major Organ Transplant (MOT) add-on for the Central California rating region to account for MOT experience in Mariposa County.

Please see the attached documents detailing the revised rates for the CY 2024 rating period:

- CA CY 2024 (01 01 2024 - 12 31 2024) Rate Cert Amendment Report 2025 01.pdf
- CY 2024 Medi-Cal Rate Summaries 2025 01.xlsx
- CY 2024 RAR Final Methodology Letter 2024 09.pdf
- CY 2024 CA Quality Component Methodology Letter 2025 01.pdf
- CY 2024 Medi-Cal Detail CRCS Package LB Rate Smry 2025 01.xlsx
- CY 2024 Medi-Cal Detail CRCS Package UB Rate Smry 2025 01.xlsx
- Exhibit A CY 2024 DMPH IP Pass-Through 2025 01.pdf
- Exhibit B CY 2024 Private Hospital IP HQAF Pass-Through 2025 01.pdf
- Exhibit C CY 2024 Private Hospital OP ER HQAF Pass-Through 2025 01.pdf
- Exhibit D CY 2024 MLK IP Pass-Through 2025 01.pdf
- Exhibit E CY 2024 BCHO Pass-Through 2025 01.pdf
- Exhibit F CY 2024 DP-NF Pass-Through 2025 01.pdf
- Exhibit II CY 2024 Directed Payments EPP 2025 01.pdf
- Exhibit III CY 2024 Directed Payments DHDP 2025 01.pdf

- Exhibit VI CY 2024 Directed Payments CHSP 2025 01.pdf
- CY 2024 Medi-Cal Hospital Directed Payment Summary 2025 01.xlsx
- CY 2024 Medi-Cal EPT Directed Payment Summary 2025 01.xlsx

All other rating elements not addressed in this revision remain unchanged from the CY 2024 capitation rates delivered previously.

This revision describes the updates made and provides the certification of actuarial soundness required by 42 CFR § 438.4. This revision was developed to provide the requisite rate documentation to DHCS and to support the Centers for Medicare & Medicaid Services (CMS) rate review process.

Overview

The revised capitation rates for the DHCS Single-Plan, Two-Plan, Geographic Managed Care (GMC), Regional, and COHS models' managed care programs were developed in accordance with rate-setting guidelines established by CMS and include the changes described in this revision letter. Highlights of the changes are described for the various rate components in the remainder of this report.

All Rate-Setting Elements Not Addressed Herein

There have been no changes made to any rate-setting components not addressed in this revision. For more detail related to these unchanged elements of the certification, please refer to the original December 8, 2023 certification report and any corresponding supporting documents.

Section 2
Projected Benefit Cost — Revisions

Program Changes

GEMT AB 1705

As mentioned in the original CY 2024 Certification, the AB 1705 add-on rate was subject to change. The add-on rate has been increased from $946.92 to the updated add-on of $1,049.98. This was the only update made to this program change.

Populations Transitioning from Fee-For-Service to Managed Care

Foster Care Mandatory Aid Code transition in Single Plan Counties

In the original development of the CY 2024 capitation rates, the members in Foster Care aid codes in Single-Plan counties were originally assumed to transition from fee-for-service (FFS) to managed care on January 1, 2024. After the development of the original version of these rates, the implementation of this transition was delayed to January 1, 2025. Therefore, the adjustment originally applied for this program change was removed in this amended version of CY 2024 capitation rates.

After the removal of this adjustment, the resulting relativity factors for all transitioning populations were ultimately aggregated across all transitioning population adjustments, including those from the prior original development of capitation rates that were not updated, to arrive at the final adjustment applied for all transitioning populations. This was completed by MCO, category of aid (COA), and category of service (COS) for both the Satisfactory Immigration Status and UIS populations separately.

Children and Youth Behavioral Health Initiative

Effective January 1, 2024, CYBHI is a policy change that implements a universal fee schedule for school-linked behavior health services. Local Education Agencies (LEAs) and Institutes of Higher Education (IHEs) participating in the program collaborate with providers to offer school and community-based behavioral health services to students aged 5–25. The providers then bill MCOs through the LEAs according to a universal fee schedule.

LEA participation in the program occurred in cohorts, with Cohort 1 LEAs beginning January 1, 2024, and Cohort 2 LEAs and IHEs beginning July 1, 2024.

To determine the impact of this program change, various data sets were analyzed. First, data from CY 2022 was used to determine the assumed percentage of

Medi-Cal members in each cohort and archetype (Low Needs, Moderate Needs, High Needs) per region. This data identified members aged 5–25 who reside in zip codes covered by LEAs in Cohorts 1 and 2. Additionally, these members were evaluated based on specific criteria, such as homelessness, foster care status, Adverse Childhood Experiences (ACEs) screening, and so forth, to place members into an archetype.

Service utilization assumptions were developed by archetype. Low Needs members were assumed to utilize two services per year, Moderate Needs members were assumed to utilize five services per year, and High Needs members were assumed to utilize 20 services per year. Unit costs assumptions were developed by analyzing the CYBHI fee schedule and considering the mix of services likely to be used by each archetype.

Finally, the regional CYBHI rate adjustments for CY 2024 were developed by determining the projected member count in each Cohort and using the utilization and unit cost assumptions to calculate the projected dollars. Ramp up assumptions, varying by cohort, were then implemented to produce the CY 2024 rate adjustments.

Long-Term Care and Hospice Rate Changes

Rate increases for LTC and Hospice services are largely handled through a program change adjustment and are based on legislatively mandated fee-for-service rate increases, including annual rate increases. This included a 10% increase for LTC facilities during the COVID-19 PHE. The underlying assumption in the original certified rates was that this PHE increase would be applicable for all facilities through the CY 2024 rating period. The revised capitation rates now reflect the following policy decisions regarding LTC facility rates:

1. Effective May 12, 2023, DHCS removed the increase in LTC facilities received during the duration of the PHE for Distinct Part Pediatric Subacute, Distinct Part Skilled Nursing Facilities, and Distinct Part Adult Subacute Units.
2. Effective January 1, 2024, the final schedule of LTC facility rates was used in this rate adjustment, including those set through the SNF Workforce Standard Program for AB 1629 facilities.

Transitional Care Services

In the original certified capitation rates, an adjustment intended to be applied to the UIS State Only rates was incidentally applied to the UIS Federal rates. This portion of the amendment was necessary to remove this adjustment from UIS Federal rates.

Medi-Cal Targeted Provider Rate Increases

This adjustment was updated to include corrected FQHC encounters within the Central California rating region. CY 2024 rate adjustments for all other rating regions are unchanged from the previous submission.

Revisions to Program Changes Applied as Add-ons to the Rate

Major Organ Transplants

MOT add-on rates were updated for the Central California rating region to account for MOT experience in Mariposa county. Since MOT was not a covered benefit in Mariposa County in the base data year, assumptions in the rates were needed to account for this additional managed care coverage in this county. Note that MOT was already covered in the three other counties within the Central California region. CY 2024 MOT add-on rates for all other rating regions are unchanged from the previous submission.

Section 3

Projected Non-Benefit Costs — Revisions

Managed Care Organization Tax

On December 20, 2024, CMS approved the updated MCO tax that would be retroactively effective starting on January 1, 2024. To calculate the total tax liability for each MCO, DHCS utilized enrollment from CY 2022. Based on this enrollment period, each MCO's member months were taxed at specific per member rates, categorized by tiers, which also varied depending on the member's type of coverage (Medicaid versus Non-Medicaid). Included below is a table that summarizes the submitted tax structure for the CY 2024 rating period.

CY 2024 MCO Tax Structure

Medicaid		Non-Medicaid	
Member Range	Tax per member	Member Range	Tax per member
0–1,250,000	$0.00	0–1,250,000	$0.00
1,250,001–4,000,000	$274.00	1,250,001–4,000,000	$1.75
4,000,001+	$0.00	4,000,001+	$0.00

For the revised CY 2024 calculations currently included in the accompanying exhibits, Mercer used projections and actual enrollment through June 2024.

Section 4

Risk Adjustment — Revisions

For the final CY 2024 risk-adjustment factors, each risk-adjusted component of the capitation rate was updated to reflect a four-month snapshot (January 2024 through April 2024), giving April 2024 a nine-month weighting, essentially extrapolating the latest snapshot month for the rest of the rating period. Credibility thresholds were updated to a threshold of at least 500 monthly scored recipients (unless otherwise specified) and at least a 2% market share within a county/region for a given MCO/COA combination to be deemed credible. If a given rate cell did not meet this credibility threshold, they were given a budget neutral factor of 1.0 (i.e., the county/region average). To the extent that UIS populations are credible based on this criteria, risk-adjustment factors were applied.

All Remaining Services

In addition to the updated snapshot and credibility thresholds, the CDPS+Rx risk-adjustment factors were also updated to reflect a June 2022 through May 2023 study period. For additional details of the risk adjustment methodology, please see the separate document *CY 2024 RAR Final Methodology Letter 2024 09.pdf*.

Behavioral Health Treatment Services

BHT risk-adjustment factors were updated using a January 2022 through December 2022 study period. This was the most recent and current data available to identify prior BHT supplemental payments, as this was the last rating period to have the supplemental payment structure.

The CY 2022 supplemental payment data was limited to beneficiaries enrolled in managed care in January, February, March, and April 2024. Managed care enrollment for these members was reviewed for the CY 2022 time period, and if a member had six or more months of managed care enrollment within the CY 2022 data period, the member was deemed scored; otherwise, the member was deemed unscored. Any member who had at least three BHT kick payments in CY 2022 was deemed a BHT utilizer. Based on this information, BHT utilizer statistics were generated based on each snapshot month. This process was done on scored recipients only. The BHT utilizer statistic for each month was calculated by dividing the number of BHT utilizers by total members in each MCO/region/rate cell in each month (based on scored members only).

The final BHT utilizer percentage for each MCO/region/COA group was calculated as a weighted average using scored membership for January, February, March, and April 2024, with April 2024 receiving nine months of weight versus January 2024 through March 2024 receiving one month of weight each. Unscored members (those that did not have at least six months of managed care enrollment in CY 2022) were

assumed to have the same utilizer mix as scored members, separate for each MCO, region, and COA group.

To derive the plan factors applicable to the BHT portion of the capitation rates, each MCO's plan-specific BHT utilizer percentage was divided by the region average. This was done separately for each region and COA group. In the event an MCO or region was not deemed fully credible, MCOs were assigned a 1.0 BHT plan factor. In order to be credible, the following criteria must be met (note that "weighted" means weighted by January 2024 through March 2024 receiving one month weight and April 2024 receiving nine months weight):

- Total weighted scored members for an MCO/region/COA group must be at least 6,000 (scored members for January 2024 through March 2024 and April 2024 times nine).
- Market share for an MCO/region/COA group must be at least 2%.
- There must be at least 360 weighted BHT utilizers in the region (separately for each COA group). Otherwise, all MCOs for that region/COA group will default to a 1.0.

This process apples to the Child and seniors and persons with disabilities (SPD) COA groups only.

Community-Based Adult Services

For CBAS services, the budget neutral risk-adjustment factors were created by the relative proportion of CBAS utilizers to the overall population, or CBAS utilizer prevalence (i.e., the ratio of scored CBAS utilizers to total scored members). Members were scored if they had at least six months of enrollment in the study period.

For these amended rates, risk-adjustment factors were updated using an October 2022 through September 2023 study period. Any member who had at least 25 days of CBAS utilization in the study period was deemed a CBAS utilizer. These members were tracked in the enrollment snapshot months (January 2024 through April 2024, with April 2024 receiving nine-months weight). Budget neutral risk-adjustment factors were calculated as the MCO-specific CBAS utilizer mix divided by the region average, where credible. Credibility thresholds also included an at least 30 average monthly utilizers threshold in the region/COA to be deemed credible.

This risk-adjustment process applies to the SPD and SPD/Full-Dual COA groups only.

Long-Term Care Long-Term Stays Services

For long-term LTC services, the budget neutral risk-adjustment factors were created by the relative proportion of long-term LTC utilizers to the overall population, or LTC utilizer prevalence (i.e., the ratio of scored LTC utilizers to total scored members).

Members were scored if they had at least three months of enrollment in the study period.

For these amended rates, risk-adjustment factors were updated using a January 2023 through September 2023 study period. Any member who had at least 90 consecutive days in an LTC in the study period was deemed an LTC utilizer. These members were tracked in the enrollment snapshot months (January 2024 through April 2024, with April 2024 receiving nine months weight). Long-term stay LTC utilizers were categorized between three different risk groups hierarchically: DP/NF, Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), and Other (e.g., SNF-B, etc.). LTC utilizers were classified as DP/NF if they had at least 30 days at a DP/NF in the study period and received a cost weight of 2.35. Remaining utilizers were then classified as ICF/DD if they had at least 30 days at an ICF-DD in the study period and received a 1.15 cost weight. Remaining LTC utilizers received a 1.00 cost weight.

Budget-neutral risk-adjustment factors were calculated as the MCO-specific cost-weighted LTC utilizer mix divided by the region average, where credible. Credibility thresholds included at least 500 (for non-LTC COAs) or 200 (for LTC COAs) average monthly scored recipients in the MCO/Region/COA and at least 30 average monthly utilizers in the region/COA for a given MCO/Region/COA to be deemed credible.

Enhanced Care Management

For the ECM add-on per member per month (PMPM), the budget-neutral risk-adjustment factors were created by the relative proportion of members enrolled in ECM to the overall population, or ECM prevalence (i.e., the ratio of ECM member months to total member months). Each MCO's ECM prevalence was divided by the region average ECM prevalence to arrive at the risk-adjustment factors. Similar to the CDPS+Rx process described above, the process to develop the final risk-adjustment factors used actual MCO enrollment from January, February, March and April 2024 to evaluate each MCO's ECM prevalence. To identify members enrolled in ECM, ECM enrollment rosters submitted by MCOs in quarterly reporting for January, February, and March 2024 were used. Only MCOs with sufficient ECM prevalence and population size were risk adjusted. For MCOs that did not have sufficient population size, a factor of 1.0 was applied. Credibility thresholds also included an at least 30 average monthly ECM members threshold in the region/COA to be deemed credible. The budget neutral factors are averaged with a 1.0 to dampen the impacts of risk adjustment as the program is still ramping up enrollment from the program's inception in January 2022. The ECM risk adjustment process only applies to the Child, Adult, Affordable Care Act (ACA) Optional Expansion, SPD, and SPD Full-Dual COA groups. The ECM risk adjustment was applied to the region average ECM add-on rate component only.

Section 5

Special Contract Provisions Related to Payment — Revisions

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

- State directed payments
- Pass-through payments

None of these items explicitly appear within the capitation rate calculation sheet (CRCS) but were considered within the rate development process.

State Directed Payments

There are several State directed payments applicable to the Two-Plan, GMC, Regional, and COHS model CY 2024 capitation rates. Directed payments, which are being revised, or added, in this amendment, are summarized in the table below. The following subsections provide more detail around each initiative. There have been no changes made to any other State directed payments not addressed in this revision.

Control Name of the State Directed Payment	Type of Payment	Brief Description	Is the Payment Included as a Rate Adjustment or Separate Payment Term?
CA_Fee_IPH.OPH.AMC.PC.SP.NF_Renewal_20240101-20241231 — Enhanced Payment Program (EPP)	Uniform dollar or percentage increases	Uniform percentage increases to capitation payments and uniform dollar increases for FFS services limited to predetermined pool amounts by DPH class and Inpatient (IP)/non-IP service sub-pools	Separate payment term
CA_Fee_IPH.OPH.NF_Renewal_20240101-20241231 — District	Uniform dollar increase	Uniform dollar increases for services limited to predetermined pool amounts for IP/non-IP service sub-pools	Separate payment term

Control Name of the State Directed Payment	Type of Payment	Brief Description	Is the Payment Included as a Rate Adjustment or Separate Payment Term?
and Municipal Public Hospital Directed Payment (DHDP)			
CA_Fee_IPH.OPH.Oth_New_20240701-20241231 — Children's Hospital Supplemental Payment Program (CHSPP)	Uniform dollar increase	Uniform dollar increases for services limited to predetermined pool amounts by CHSPP class and IP/non-IP service sub-pools	Separate payment term
CA_Fee_OPH.PC.SP.BHO_New_20240101-20241231 — Equity and Transformation	Performance-adjusted uniform dollar increase	Uniform dollar increase for contracted services modified based on performance on designated measures and limited by assigned lives	Separate payment term
FQHC APM	Minimum fee schedule using State Plan approved rates	PMPM payment to participating FQHCs, paid per assigned member. Full PPS payment to participating FQHCs for MCOs without assigned membership at that FQHC.	Rate adjustment

There are no additional directed payments in the program for CY 2024 that are not addressed in either this amendment or in the original rate certification. There are no requirements regarding the reimbursement rates the MCOs must pay to any providers unless specified in the certification or this amendment as a directed

payment or pass-through payment, or authorized under applicable law, regulation, or waiver.

Federally Qualified Health Centers Alternative Payment Model

Effective July 1, 2024, an Alternative Payment Methodology (APM) which provides reimbursement to participating FQHCs on a capitated basis was implemented. For this rating period, two FQHCs have opted into the APM program.

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

The proposed APM would pay FQHCs a monthly capitated payment for each Medi-Cal managed care member assigned to the FQHC. This monthly capitation is developed using actuarial methods, projecting historical member FQHC utilization into the contract period, and applying the PPS rate to the utilization to develop this PMPM. Acknowledging some FQHC utilization naturally comes from unassigned/walk-in members, the utilization assumed in the APM capitation includes unassigned members, subject to reasonable limitations. If a member is assigned to a clinic, but visits another, different APM participating clinic, no payment for this visit will be made to the rendering clinic as that member would be considered unassigned to the other clinic. In situations where there is no assignment between an MCO and an APM participating clinic, and therefore no APM capitation paid, if a member from the MCO visits said clinic the MCO will reimburse the full PPS rate.

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

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

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

Control Name of the Directed Payment	Rate cells affected	Impact	Description of the adjustment	Confirmation the Rate Development is Consistent with the Preprint
FQHC APM	All non-dual populations	Please see the 'FQHC APM Add-On' section of the 'Sum – Add-On Details' exhibits in the 'CY 2024 Medi-Cal Rate Summaries 2025 01.xlsx' attachment	Described above	Not applicable

The original CY 2024 certification letter included a two-sided risk corridor for the FQHC APM for the July 2024 through December 2024 time period; however, this was not approved by CMS and therefore there is no risk corridor for the FQHC APM in place.

Hospital Directed Payments

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

Control Name of the State Directed Payment	Aggregate Amount Included in the Certification	Statement that the Actuary is Certifying the Separate Payment Term	Magnitude on a PMPM Basis	Confirmation the Rate Development is Consistent with the Preprint	Confirmation that the State and Actuary will Submit Required Documentation at the End of the Rating Period (as applicable)
CA_Fee_IPH.OPH.AMC.PC.SP.NF_Renewal_20240101-20241231 — EPP	$2,478.19 million	The actuary certifies the incorporation of the separate payment term	See pink labeled columns in file titled *CY 2024 Amendment Medi-Cal Hospital Directed Payment Summary 2025 01.xlsx* for the PMPM estimates	Confirmed; the preprint is approved.	Confirmed
CA_Fee_IPH.OPH.NF_Renewal_20240101-20241231 — DHDP	$207.29 million	The actuary certifies the incorporation of the separate payment term	See exhibit referenced above	Confirmed; the preprint is approved.	Confirmed.

Control Name of the State Directed Payment	Aggregate Amount Included in the Certification	Statement that the Actuary is Certifying the Separate Payment Term	Magnitude on a PMPM Basis	Confirmation the Rate Development is Consistent with the Preprint	Confirmation that the State and Actuary will Submit Required Documentation at the End of the Rating Period (as applicable)
CA_Fee_IPH.OPH.Oth_New_20240701-20241231 — CHSPP	$115.00 million	The actuary certifies the incorporation of the separate payment term	See exhibit referenced above	Confirmed. The preprint was amended and submitted to CMS on December 11, 2024.	Confirmed.

Enhanced Payment Program — Revised

The EPP directed payment preprint encompassing the CY 2024 rating period was approved by CMS on April 17, 2024, under control name CA_Fee_IPH.OPH.AMC.PC.SP.NF_Renewal_20240101-20241231. The preprint itself was not amended for CY 2024 rates. However, the pool amount used in the original CY 2024 certification was a draft pool amount and represented the best information available at the time of certification. This amendment contains the pool amount in the approved preprint of $2,478.19 million. There were no other changes to the payment structure.

The approach for developing the estimated EPP uniform percentage increases to capitation payments and uniform dollar increases for FFS services and PMPM impacts is unchanged from the original certification. Please see the original certification dated December 8, 2023 for more detail.

The total impact of the EPP directed payment across the classes is targeted to be approximately $2,478.19 million. The attached exhibits (*Exhibit II CY 2024 Amendment Directed Payments EPP 2025 01.pdf*) contain the full detail of these calculations by Class, sub-pool, and impacted COS. The resulting estimates on a PMPM basis by rate cell are provided in the attached spreadsheet (*CY 2024 Amendment Medi-Cal Hospital Directed Payment Summary 2025 01.xlsx*).

The methodology that will be used to allocate actual payments associated with this directed payment will be consistent with the methods discussed in this certification and the 42 CFR § 438.6(c) preprint.

District and Municipal Public Hospital Directed Payment — Revised

The DHDP directed payment preprint encompassing the CY 2024 rating period was approved by CMS on December 28, 2023, under control name CA_Fee_IPH.OPH.NF_Renewal_20240101-20241231. The preprint itself was not amended for CY 2024 rates. However, the estimated PMPM impacts are updated in this amendment due to a change in the calculation process for the estimated DHDP uniform dollar increase and PMPM impacts. Specifically, the estimated District and Municipal Public Hospitals (DMPH) contracted days for the LTC COS was updated to exclude transition counties not subject to DHDP for LTC services (so as not to overlap with the DP-NF pass-through payment) and to include LTC days for full-dual and Part A-Only partial dual members where Medi-Cal is the primary payor.

Aside from the above change, the approach for developing the estimated DHDP uniform dollar increases and PMPM impacts in this amendment is the same as described in the original certification. Please see the original certification dated December 8, 2023 for more detail.

The total impact of the DHDP directed payment is targeted to be approximately $207.29 million. The attached exhibit (*Exhibit III CY 2024 Amendment Directed Payments DHDP 2025 01.pdf*) contains the full detail of these calculations for each COS. The resulting estimates on a PMPM basis by rate cell are provided in the attached spreadsheet (*CY 2024 Amendment Medi-Cal Hospital Directed Payment Summary 2025 01.xlsx*) as noted previously.

The methodology that will be used to allocate actual payments associated with this directed payment will be consistent with the methods discussed in this certification and the 42 CFR § 438.6(c) preprint.

Children's Hospital Supplemental Payment Program — New

Children's Hospital Supplemental Payment Program (CHSPP) is effective only for the July 1, 2024–December 31, 2024 time period of the CY 2024 rating period. The CHSPP preprint was submitted to CMS on June 28, 2024, and has the control name CA_Fee_IPH.OPH.Oth_New_20240701-20241231. DHCS and CMS have acknowledged that this preprint submission was incomplete. The complete preprint was submitted on December 11, 2024.

The CHSPP is a uniform dollar add-on payment for services provided by three classes of private Children’s hospitals as defined in CA Welfare & Institutions Code § 10727, limited to a pre-determined pool amount, with 70% designated to IP services, and 30% to Outpatient (OP)/Emergency Room (ER) services. The CHSPP is a separate payment term; the actual uniform dollar increase will be calculated after the end of the CY 2024 period based on actual contracted IP and OP/ER services utilized within each class.

Classes 1 through 3 are outlined below:

- Class 1 is comprised of Children's hospitals who operate 27 or more Specialty Care Centers (SCCs).
- Class 2 is comprised of Children's hospitals who operate between 24 and 26 SCCs.
- Class 3 is comprised of Children's hospitals who operate 23 or less SCCs.

The approach for developing the estimated CHSPP uniform dollar increases and PMPM impacts is similar to the approach utilized for the Private Hospital Directed Payment. The estimated contracted share of revenue and unit cost differentials for each class were applied to the gross medical expense (GME) PMPM component of the capitation rate by rate cell for each impacted COS (IP and OP/ER). These calculations produced estimated class-specific contracted days (for IP) or visits (for non-IP), by rate cell and in total, that formed the basis for creating estimated uniform dollar increases that would total the intended directed payment target for the given provider class and COS.

The total impact of the CHSPP directed payment across the classes is targeted to be approximately $115 million (for the July 2024–December 2024 period). The attached exhibits (*Exhibit VI CY 2024 Amendment Directed Payments CHSPP 2025 01.pdf*) contain the full detail of these calculations by Class, sub-pool, and impacted COS. The resulting estimates on a PMPM basis by rate cell are provided in the attached spreadsheet (*CY 2024 Medi-Cal Hospital Directed Payment Summary 2025 01.xlsx*).

The methodology that will be used to allocate actual payments associated with this directed payment will be consistent with the methods discussed in this certification and the 42 CFR § 438.6(c) preprint.

Equity and Practice Transformation Directed Payment

The Equity and Practice Transformation (EPT) preprint was re-submitted to CMS for approval on December 31, 2024. This state directed payment is a performance based uniform dollar increase, for the first contracted service for each assigned member based on pre-determined milestones.

The total impact of the EPT directed payment is targeted to be approximately $11.19 million.

Control Name of the Directed Payment	Aggregate Amount Included in the Certification	Statement that the Actuary is Certifying the Separate Payment Term	The Magnitude on a PMPM Basis	Confirmation the Rate Development is Consistent with the Preprint	Confirmation that the State and Actuary will Submit Required Documentation at the End of the Rating Period (as applicable)
CA_Fee_OPH.PC.SP.BHO_New_20240101-20241231 — EPT	$11.19 million	The actuary certifies the incorporation of the separate payment term	See file titled 2024 Medi-Cal EPT Directed Payment Summary 2025 01.xlsx for the PMPM Estimates	Confirmed	Confirmed

Pass-Through Payments

Hospital Pass-Though Payments

As described in detail in the original certification letter, the following hospital pass-through payment PMPM add-on amounts were estimated as a uniform percentage increase to the estimated share of the capitation rate GME PMPMs for the applicable COS attributable to the applicable hospital class(es). These estimates resulted in total expenditures projected across applicable rate cells for the 12-month rating period matching a targeted amount for each pass-through payment. The pass-through payment add-on PMPMs were recalculated to use updated CY 2024 projected enrollment and reflect the revised GME PMPM components, adjusted as described earlier within this certification amendment. Mercer updated the uniform percentage increase for each of the hospital pass-through payment programs such that the total expenditures returned to the original targeted amounts. No other assumptions were revised. The following pass-through payment add-ons were revised, and the detailed build-up of the add-ons are provided in various attachments:

- Private HQAF and DMPHs — detailed in Exhibit A CY 2024 Amendment DMPH IP Pass-Through 2025 01.pdf, Exhibit B CY 2024 Amendment Private Hospital IP HQAF Pass-Through 2025 01.pdf, and Exhibit C CY 2024 Amendment Private Hospital OP ER HQAF Pass-Through 2025 01.pdf.

- MLK IP component of the LA County SPD and ACA Expansion rate cells — detailed in Exhibit D CY 2024 Amendment MLK IP Pass-Through 2025 01.pdf.
- BCHO in Alameda County for the Child and SPD rate cells — detailed in Exhibit E CY 2024 Amendment BCHO Pass-Through 2025 01.pdf.

Distinct Part Nursing Facilities

This passthrough payment is for public DPNF services that transitioned from the FFS delivery system to the managed care delivery system under 42 CFR § 438.6(d)(6). The passthrough payment transitions existing State Plan approved supplemental payments for DPNF services that were covered for the first time under a managed care contract following the carve-in of LTC services from the FFS delivery system on January 1, 2023. The supplemental payments were made during the 12-month period immediately two years prior (CY 2021) to the first year of the transition period (CY 2023).

The approach for making these adjustments within the capitation rates are being addressed through 42 CFR § 438.6(d)(6). The pass-through components of the DP-NF adjustments are paid as a PMPM add-on amount by rate cell, included within the certified rates.

For purposes of spreading the pool amount across all applicable MCOs and counties where DP-NF services are transitioning to managed care, the approach was to develop an estimated uniform dollar increase and PMPM impacts, similar to the approach utilized for the hospital and SNF WQIP directed payments. The estimated contracted share of LTC days and unit cost differentials for the DP-NF class were applied to the GME PMPM component of the capitation rate by rate cell for the LTC COS. These calculations were performed separately for Alameda County, San Francisco County, and all other counties. These calculations produced estimated DP-NF contracted days, by rate cell and in total, which formed the basis for creating an estimated uniform dollar add-on payment that would total the intended pass-through payment target amount.

The total target impact of $117.2 million is projected across all counties in which DP-NF services are transitioning from FFS to managed care (non-COHS and non-CCI- counties), where public DP-NF facilities exist, for the 12-month rating period, which is inclusive of only federally eligible days. The development of these add-on amounts did not impact the underlying data or assumptions associated with the regular development of the capitation rates. No additional administrative load or underwriting gain is included within these add-on amounts for DP-NF.

The DP-NF pass-through PMPM adjustments are added to the post risk-adjusted rates.

Included is an attachment labeled *Exhibit F CY 2024 DP-NF Pass-Through 2025 01.pdf* containing the detailed components behind these calculations. The resulting PMPM add-on rates by rate cell are provided in the “Sum — Add-On Details” tabs

within the attached spreadsheet *FINAL CY 2024 Medi-Cal Detail CRCS Package LB Rate Smry 2025 01.xlsx*.

DP-NF Pass-Through Payment Base Amount Calculation

There are three components of the calculation to determine the aggregate amount of the pass-through payment: actual supplemental paid amounts for the 12-month period immediately 2 years prior to the rating period, ratio of services transitioning to managed care, and fee schedule adjustments for the applicable DP-NF facilities.

The actual supplemental paid amounts for the 12-month period two years prior (CY 2021) was $113.1 million. The actual supplemental payments are based on the total payments made for dates of service in CY 2021 paid in the FFS Supplemental Payment Rate Year (August–July) 2020–2021 and 2021–2022. The FFS Supplemental payments are made in accordance with State Plan Amendment 4.19-D pages 18–21a.

Actual utilization was extracted from the DHCS Management Information System/Decision Support System (MIS/DSS) for dates of service in CY 2021 and January 2024 through April 2024 based on National Provider Identifiers for all Public DP-NF where Medi-Cal was the primary payor and the MCO was in one of the 31 transitioning counties.

Prior to January 1, 2023, MCOs operating in 31 counties covered Medically Necessary SNF services for members from the time of admission into a SNF and up to one month after the month of admission into the SNF. Members were disenrolled from the MCO to Medi-Cal FFS after this time.

Utilizing this FFS data provided by DHCS, Mercer annualized the available 2024 utilization and reviewed the difference in the volume of FFS bed days between the CY 2021 and CY 2024 time periods. This volume difference for FFS was then used to determine the percentage of DP-NF supplemental payment-eligible days that remained in FFS in CY 2024, and the remainder had transitioned to managed care in CY 2024. Mercer assumed a level (e.g., equivalent) volume of bed days between the two time periods. As such, the difference between FFS days in CY 2021 and FFS days in CY 2024 yielded the number of managed care days assumed for CY 2024.

These managed care days were the numerator of the ratio of services transitioning to managed care, with the denominator being total DP-NF supplemental payment-eligible days in CY 2024 (i.e., equivalent to FFS days in CY 2021). This resulted in a ratio of 97.5% that was applied as a reduction factor to the total DP-NF pool amount (i.e., 2.5% of days remained in FFS in CY 2024). In addition, 8.1% of the payments in CY 2024 were assumed to be for State-only services for members with UIS. An additional factor of 91.9% (or 1–8.1%) was applied.

These two factors combined yielded the final ratio of services transitioned from payment in a FFS delivery system to federally-eligible services covered under the managed care contract: 89.6%. The application of this ratio reduced the CY 2021 pool amount to $101.4 million.

Consistent with direction given by CMS, Mercer adjusted the CY 2021 pool amount forward to represent CY 2024 dollars through the application of DP-NF fee schedule adjustments. The fee schedule adjustments were developed consistent with other LTC rate changes that are applied as a program change within the rate-setting process and described within the original CY 2024 certification and this amendment.

More specifically, legislatively mandated annual FFS rate increases between the CY 2021 and CY 2024 time periods for all DP-NF, Level B facilities were compounded together to yield a three-year percentage increase to apply to the CY 2021 DP-NF pool amount. Given that the DP-NF pool amount reflected the FFS equivalent in the base period, the DP-NF rate increases adjust these payment levels to reflect the DP-NF FFS equivalent in the prospective rating period. The accumulative impact of these fee changes was 15.6%. The application of these fee schedule adjustments increased the DP-NF pool amount to $117.2 million for the CY 2024 rating period.

Section 6

Certification and Final Rates

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

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

Because modeling all aspects of a situation or scenario is not possible or practical, Mercer may use summary information, estimates, or simplifications of calculations to facilitate the modeling of future events in an efficient and costeffective 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 Single-Plan, Two-Plan, GMC, Regional, and COHS models' capitation rates for CY 2024, January 1, 2024 through December 31, 2024, were developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medi-Cal covered populations and services under the managed care contract. Capitation rates are "actuarially sound" if, for the business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop loss cash flows, governmental risk adjustment cash flows and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government mandated assessments, fees, and taxes. The undersigned actuaries are members of the American Academy of Actuaries and meet its qualification standards to certify to the actuarial soundness of these Medicaid managed care capitation rates.

Capitation rates developed by Mercer are actuarial projections of future contingent events. All estimates are based upon the information and data available at a point in time, and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely, and potentially wide, range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use. Actual MCO costs will differ from these projections. Mercer has developed these rates on behalf of DHCS to demonstrate compliance with the CMS requirements under 42 CFR § 438.4 and in accordance with applicable law and regulations. There are no stop loss or reinsurance arrangements in these rates. Use of these rates for any purpose beyond that stated may not be appropriate.

MCOs are advised that the use of these rates may not be appropriate for their particular circumstance, and Mercer disclaims any responsibility for the use of these rates by MCOs for any purpose. Mercer recommends that any MCO considering contracting with DHCS should analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to these rates before deciding whether to contract with DHCS.

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

This certification report assumes the reader is familiar with the Medi-Cal program, Medi-Cal eligibility rules, and actuarial rating techniques. It has been prepared exclusively for DHCS and CMS, and should not be relied upon by third parties. Other readers should seek the advice of actuaries, or other qualified professionals competent in the area of actuarial rate projections, to understand the technical nature of these results. Mercer is not responsible for, and expressly disclaims liability for, any reliance on this report by third parties.

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

DHCS agrees to notify Mercer within 30 days of receipt of this report if it disagrees with anything contained in this report or is aware of any information or data that would affect the results of this report that has not been communicated or provided to Mercer or incorporated herein. The report will be deemed final and acceptable to DHCS if nothing is received by Mercer within such 30 day period.

If you have any questions on the above or the certification report, please feel free to contact Robert O'Brien at robert.j.o'brien@mercer.com or Jim Meulemans at james.meulemans@mercer.com.

Sincerely,

Robert J. O'Brien, ASA, MAAA, FCA

Principal

James J. Meulemans, ASA, MAAA, FCA

Partner

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