Mercer

Government Human Services Consulting

# Medi-Cal Managed Care

## Capitation Rate Development and Certification

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

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# Contents

## Section 1

# Executive Summary

The State of California Department of Health Care Services (DHCS) contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to develop actuarially sound capitation rates for use during the rating period of January 1, 2024 through December 31, 2024 (calendar year [CY] 2024). The capitation rates that are the subject of this certification report include those developed for the following models:

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

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

This report describes the rate development process and provides the certification of actuarial soundness required by 42 CFR § 438.4. This report was developed to provide the requisite rate documentation to DHCS and to support the rate review process performed by the Centers for Medicare & Medicaid Services (CMS). This report follows the general outline of the CMS 2023–2024 Medicaid Managed Care Rate Development Guide dated May 2023, which is the applicable version of the guide for CY 2024. The rate development process includes the historical practice of developing rate ranges. However, this report certifies to a final rate within the developed rate ranges as federally required.

Actuarially sound is being defined by Mercer as follows; Medicaid capitation rates are “actuarially sound” if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For the purpose of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop loss cash flows, governmental risk adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, cost of capital, and government mandated assessments, fees, and taxes.

Multiple attachments are included as part of this rate certification package. These attachments include summaries of the CY 2024 capitation rates (including the final and certified capitation rates), capitation rate calculation sheet (CRCS) exhibits, and stand-alone methodology documents, which provide more detail around various rate setting components. These attachments are referenced throughout the body of this report. The final certified capitation rates by county/rating region and category of aid (COA) groupings (synonymous with rate cell), including a comparison to the prior CY 2023 certified capitation rates, can be found in the attached file, *CY 2024 Medi-Cal Rate Summaries 2023 12.xlsx*.

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

Within the CY 2024 rating period, there were several changes to the program and also in the development of the capitation rates. Some notable items are listed below:

- The implementation of the California Advancing and Innovating Medi-Cal (CalAIM) proposal is continuing, which is a multi-year initiative by DHCS to improve the quality of life and health outcomes for the Medi-Cal population. Multiple components of this initiative are addressed throughout the body of this report.
- The State is re-procuring the contracted health plans within the Medi-Cal managed care program. As part of this process, there are new contractors in various regions across the State, effective January 1, 2024.
- The capitation rates for CY 2024 were developed at the regional average level and are now subject to 100% risk adjustment. This process is described in various sections within this document.
- The State is including a quality withhold as part of the CY 2024 capitation rates, where apportion of the capitation rate will be withheld from the payments made to the managed care organizations (MCOs), and distributed to the MCOs after the rating period, if they meet certain quality metric thresholds. Any unearned portions of the quality withhold will then be used to fund an incentive program to be distributed to MCOs who meet further certain quality metric criteria.

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

A comparison of the certified CY 2024 capitation rates to the certified CY 2023 capitation rates is also provided in an attachment. Each certified CY 2024 rate (with new MCO and region groupings after the CY 2024 procurement) is compared to the capitation rates certified within the CY 2023 rating period. However, please note the current CY 2023 capitation rates were developed under the previous MCO and region groupings. The CY 2023 rates in this comparison are the same previously certified rates but are aggregated to align with the updated CY 2024 region groupings, where appropriate. There are instances where there are

large changes at the county/rating region and COA level in this comparison. There are many potential drivers of this depending on the rate cell being reviewed, including an updated year of base data, MCO tax, a new directed payment where the State is directing the MCOs to pay a minimum fee schedule for an expansive list of professional codes, and major managed care population expansions specifically for the UIS capitation rates. Further for the UIS population, it should be noted that a forthcoming certification amendment is planned to occur for the CY 2023 rates. In this amendment, the federal UIS capitation rates will largely increase due to updated logic to identify federally eligible services (namely, the logic to identify dialysis services and emergency transportation services was updated). As a result, the comparison of CY 2023 UIS rates to CY 2024 is impacted by this significantly.

It should also be noted there will be a future amendment to this certification that will be submitted to CMS. The potential updates include: a Child and Youth Behavioral Initiative program change, add-on increase for Assembly Bill (AB) 1705, Senate Bill (SB) 525 (Minimum Wage Increase), AB 2511 (Skilled Nursing Facility [SNF] Generators), Equity and Transformation Directed Payments, Pass Through Payments for Distinct Part Nursing Facilities (DP-NF), and the Alternative Payment Methodology for Federally Qualified Health Centers (FQHC APM). Other assumptions within rate setting will be reviewed, such as impacts of the Deferred Action for Childhood Arrivals federal eligibility change and an initiative to obtain newborns a Medi-Cal ID in a timelier fashion, but these will not necessarily require a capitation rate amendment, unless an amendment is deemed necessary.

# Section 2
# General Information

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

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

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

## Program History

California's managed care delivery models have been in existence since the 1980s. There have been various changes in the model types over the years. With the procurement effective in CY 2024, there are now five different managed care model delivery systems, listed below:

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

Pursuant to the Affordable Care Act (ACA) and the subsequent Supreme Court ruling, California elected to expand Medicaid coverage to low-income adults effective January 2014.

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

Effective January 1, 2023, the CCI program ended, and members previously covered under CCI transitioned into their respective non-CCI managed care models. The CY 2024 capitation rates were developed inclusive of these (and other) transitioning members; there are no longer rates specific to the CCI program. Now, capitation rate development for CCI Full-Dual eligible members, in addition to non-dual and partial dual members (as in prior years), are covered within this certification.

The COHS, GMC, Regional, Single-Plan, and Two-Plan models encompass all 58 counties within California. For a list of the counties within each model type, please refer to the Excel file titled *CY 2024 Medi-Cal Rate Summaries 2023 12.xlsx*, which has a tab listing each model and the applicable counties within each model. Please note that some counties have shifted model type with the procurement and any references to prior data would align with the model type applicable for that time period. For example, the Single-Plan counties of Alameda and Contra Costa were previously Two-Plan model and Imperial County was part of the Regional model. For capitation rate payment purposes, counties are consolidated into rating regions (with rating regions consisting of one or more counties). Within each rating region, MCOs are paid a capitation rate for each region in which they operate. For a list of rating regions and their applicable counties, please refer to the Excel file titled *CY 2024 Medi-Cal Rate Summaries 2023 12.xlsx*.

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

## Managed Care Organization Participation

For CY 2024, there are 22 distinct MCOs operating in the COHS, GMC, Regional, Single-Plan, and Two-Plan managed care programs. Each MCO has different counties in which they operate. Some MCOs only operate in one county while other MCOs operate in multiple counties. For a complete list of the MCOs and counties in which they operate, please see the rate summary sheets, which can be found in the attached Excel file titled *CY 2024 Medi-Cal Rate Summaries 2023 12.xlsx*. Capitation rates are set at the regional level and risk adjusted 100% to create capitation rates for each MCO at the rating region and COA level.

## Covered Services

Generally, services covered through the COHS, GMC, Regional, Single-Plan, and Two-Plan models include hospital services (including inpatient [IP], outpatient [OP], and emergency room [ER] services), physician services, applied behavioral analysis services, transportation services, laboratory and radiology services, hospice care services, and community-based

adult services (CBAS). Additionally, mental health (MH) services for members with mild to moderate MH needs and conditions are covered.

Historically, there have been differences in covered services between the COHS and non-COHS managed care models; most notably, LTC services. Effective January 1, 2023, pursuant to the CalAIM initiative, LTC services will now be covered for the entire period in which a member resides in an LTC facility in all COHS, GMC, Regional, Single-Plan, and Two-Plan models.

Notable services carved out of all managed care programs and counties (with exceptions listed below) include the following:

- Specialty MH services (including IP and OP behavioral health [BH] services, with exceptions noted below):
  - Kaiser in Sacramento County and Solano County covers specialty MH services not covered by any other MCO within the Medi-Cal program. These specialty MH services include psychiatric IP and OP (Sacramento County only).
- Alcohol and substance use disorder treatment services.
- Home- and Community-Based Services (HCBS) (apart from CBAS in all counties).
- Dental services (except medically necessary federally required adult dental services and fluoride varnish dental services that may be performed by a medical professional) are carved out, apart from members covered by the Health Plan of San Mateo (HPSM) under their pilot dental program.
- Administration and ingredient costs of Coronavirus Disease 2019 (COVID-19) vaccines.
- Services covered under the California Children's Services (CCS) program in certain COHS and all GMC, Regional, Single-Plan, and Two-Plan counties. In some COHS counties (counties that were COHS counties in CY 2023 excluding Ventura), CCS services are a managed care covered benefit. CCS-eligible members in these counties make up the WCM rate cell.
- Effective January 1, 2022, the following pharmacy benefits, when billed by a pharmacy on a pharmacy claim: covered OP drugs, including physician administered drugs, medical supplies, and enteral nutritional products.

Effective January 1, 2018, MCOs were no longer at risk for all eligible American Indian Health Services and are paid via a separate payment arrangement that is not part of these capitation rates. The MCOs manage these services under a non-risk arrangement with DHCS.

As part of the aforementioned CalAIM initiative and referenced in the CY 2023 certification letter, there were three major benefit/service changes effective January 1, 2022. These include the following:

- Major organ transplants (MOT) in GMC, Regional, Single-Plan, and Two-Plan counties (these were already covered in COHS counties and only kidney and corneal transplants were covered in non-COHS counties)
- Enhanced care management (ECM) services

- 14 Community Supports services are allowable in the managed care contracts in accordance with 42 CFR § 438.3(e) and/or the terms and conditions of California's 1115 and Section 1915(b) waivers.

## Covered Populations

The program currently covers children, parents/caretakers, adults without dependent children, pregnant women, and seniors and persons with disabilities (SPD), including those dually eligible for Medicare. Individuals served through California's Children's Health Insurance Program (CHIP) are covered under the same managed care contracts. Generally, managed care enrollment is mandatory for the COHS, GMC, Regional, Single-Plan, and Two-Plan models. Managed care enrollment is now mandatory for dual eligible beneficiaries in non-CCI and non-COHS counties effective January 1, 2023 (previously these beneficiaries were voluntary). Furthermore, mandatory managed care enrollment will now apply to members residing in San Benito County effective January 1, 2024, whereas it was voluntary prior to this.

As part of the CalAIM initiative, various additional populations have or will become enrolled in managed care effective from CY 2022 and through CY 2024. The populations identified to transition January 1, 2022, who were previously non-mandatory in managed care (at least in some counties) and/or enrolled in the fee-for-service (FFS) delivery system are as follows:

- Individuals with other health coverage
- Individuals residing in certain rural zip codes
- Trafficking and Crime Victims Assistance Program (TCVAP)
- Individuals participating in accelerated enrollment (AE)
- Child Health and Disability Prevention Infant Deeming (CHDPI)
- Pregnancy-related Medi-Cal
- Breast and Cervical Cancer Treatment Program (BCCTP)
- Partial Dual beneficiaries in GMC, Regional, Single-Plan, and Two-Plan Counties

The populations identified to transition January 1, 2023, who were previously non-mandatory in managed care (at least in some counties) and/or enrolled in FFS are as follows:

- Full-Dual beneficiaries
- Members previously subject to mandatory managed care, but not in managed care.
- Members residing in an LTC facility beyond the initial month of being institutionalized plus the following month (in non-CCI and non-COHS counties only).

The populations identified to transition January 1, 2024, who were previously non-mandatory in managed care (at least in some counties) and/or enrolled in FFS are as follows:

- The Intermediate Care Facilities-Developmentally Disabled (ICF-DD) and Subacute (SA) populations will transition January 1, 2024. These populations were previously enrolled in FFS in some counties beyond the initial month of admission plus the following month.

- Effective January 1, 2024, Foster Care children will be mandatorily transitioned to managed care in all new COHS and Single-Plan counties.

Lastly, the State enrolled members aged 50 and above, regardless of immigration status, into managed care effective May 1, 2022. Furthermore, the State will enroll members aged 26 to 49, regardless of immigration status, into managed care effective January 1, 2024.

Additional details on the transitioning populations can be found in the “Program Changes” section of this report.

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

# Rate Structure

The base data sets used to develop the COHS, GMC, Regional, Single-Plan, and Two-Plan CY 2024 capitation rate ranges were divided into cohorts representing consolidated COA (or aid code) or supplemental groupings, which inherently represent differing levels of risk. Rate ranges are developed for each of these cohorts. As noted for the COA and supplemental payment groupings below, there are differences that exist across the various counties. The COA groups for which capitation rates are paid and supplemental payment groupings are listed below (with variations noted as well).

## Capitation Rate Category of Aid Groups (Rate Cells)

- Child
- Adult
- ACA Expansion
- SPD
  - This COA consists of SPD members and partial dual eligible members with an SPD or ACA Expansion aid code.
- SPD/Full-Dual
  - This COA consists of SPD/Full-Dual members and Full-Dual eligible members with an ACA Expansion aid code.
- LTC
- LTC/Full-Dual
- WCM (only applicable in COHS counties that were COHS counties prior to January 1, 2024, except Ventura County)

In the development of rates for the COHS counties that were COHS counties prior to January 1, 2024, the SPD and LTC COA groups will be blended into one capitation rate payable for members in either COA group. Similarly, this will also happen for the

SPD/Full-Dual and LTC/Full-Dual COA groups in these counties. One nuance to this is Mariposa County. New for CY 2024, Mariposa County is now part of a rating region consisting of Merced, Monterey, and Santa Cruz counties. Since the membership volume in this county is very low and it is part of a much larger broader region, the blended SPD/LTC structure also applies in this county in CY 2024.

Additionally, for all counties, the LTC and LTC/Full-Dual COAs will only consist of beneficiaries with an applicable LTC aid code (13, 23, 53, and 63). Other beneficiaries residing in an LTC facility will be classified into the COA consistent with the beneficiaries' aid code.

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

### Maternity Supplemental Payment

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

## Federal Medical Assistance Percentage

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

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

In particular, populations that receive a higher FMAP than the regular FMAP include the BCCTP population (now a subset of the SPD population) who meet federal standards, the CHIP population, and the ACA Expansion population. For CY 2024, the BCCTP and CHIP populations receive 65% FMAP. For CY 2024, the ACA Expansion population receives 90%.

DHCS uses aid codes in its capitation payment system to identify qualifying recipients for higher FMAP. The full capitation rate for these recipients receives the higher FMAP, except for portions attributable to services subject to service-specific rates of FMAP.

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

groups are the Adult, ACA Expansion, and SPD/Full-Dual COAs, with the Adult and SPD/Full-Dual COAs both receiving a 50% FMAP and the ACA Expansion COA receiving the FMAP detailed above. The least expensive COA group is the Child COA, which receives a combination of the standard FMAP for the non-CHIP population and an enhanced FMAP for the CHIP population.

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

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

For the federal capitation rates for the UIS population, pregnancy-related services and emergency services are subject to different FMAP levels. Pregnancy-related services for all UIS beneficiaries are subject to a 65% FMAP, while emergency services are subject to a 90% FMAP for ACA Expansion members and 50% for all other populations. The portion of the UIS capitation rates for pregnancy-related and emergency services is shown within the attachments provided.

## Rate Methodology Overview

Capitation rates for the COHS, GMC, Regional, Single-Plan, and Two-Plan models were developed in accordance with rate setting guidelines established by CMS. As noted previously, Mercer continued the historical practice of rate range development for the COHS, GMC, Regional, Single-Plan, and Two-Plan models. However, this report certifies to a final rate within the developed rate ranges as federally required.

For rate range development for the COHS, GMC, Regional, Single-Plan, and Two-Plan model MCO populations, Mercer used July 1, 2021 through June 30, 2022 (state fiscal year [SFY] 2021–2022) MCO-reported encounter data, the SFY 2021–2022 rate development template (RDT) data (from direct contractors with DHCS and also the MCOs' global subcontractors) and other ad hoc claims data reported by DHCS and the COHS, GMC, Regional, Single-Plan, and Two-Plan model MCOs. The most recently available, quarterly submitted, Medi-Cal-specific financial reports at the time the rate ranges were determined were also considered in the rate range development process.

The RDT data used in the development of the rate ranges is data collected from each MCO within the Medi-Cal managed care program separately for each county (or rating region) in which each MCO operates. The data requested from each MCO is completed by the MCOs at the level of detail needed for rate setting purposes, which includes membership, medical utilization, and medical cost data for the most recent time periods (SFY 2021–2022 for the CY 2024 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 2024. Additional adjustments were then applied to the selected base data to incorporate:

- Prospective and historic (retrospective) program changes not reflected (or not fully reflected) in the base data.
- Budget-neutral relational modeling for smoothing.
- Any observed changes in the population case mix and underlying risk of the MCOs from the base data period.
- Trend factors to forecast the expenditures and utilization to the rating period.
- Administration and underwriting gain loading.

Further, DHCS takes additional steps in the measured matching of payment to risk:

- Application of a maternity supplemental payment.
- Application of risk-adjusted county/region average rates (where applicable).

The above approach has been utilized in the development of the rate ranges for the CY 2024 COHS, GMC, Regional, Single-Plan, and Two-Plan models. DHCS will offer the final certified rates within the actuarially sound rate ranges by region, with MCO-specific risk-adjustment factors applied. Each MCO has the opportunity and responsibility to independently review the rates offered by DHCS and to determine whether the rates are acceptable based on their individual financial requirements.

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

## Medical Loss Ratio

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

The CY 2024 internal rate ranges utilize a full rebase incorporating the most complete and current data period (SFY 2021–2022). This rebase, along with the non-medical loads, detailed below by model, result in aggregate priced-for effective MLRs greater than 85%.

By model, the aggregate priced-for effective MLR is greater than 85%:

- GMC, Regional, Single-Plan, and Two-Plan models:
  - Assumed upper bound MLR: 100%–12.9% (upper bound non-medical load) = **87.1%.**
  - Assumed lower bound MLR: 100%–9.1% (lower bound non-medical load) = **90.9%.**
- COHS models:
  - Assumed upper bound MLR: 100%–12.5% (highest upper bound non-medical load across COHS plans) = **87.5%.**

- Assumed lower bound MLR: 100%–9.5% (highest lower bound non-medical load across COHS plans) = **90.5%.**

For CY 2024, the State will impose remittance provisions related to this MLR. Any revenue will need to be remitted to the State up to 85% MLR, if the calculated actual MLR is less than 85% for an MCO.

## Rate Ranges

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

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

# Section 3
# Data

## Base Data

The information used to form the base data for the COHS, GMC, Regional, Single-Plan, and Two-Plan models rate range development was MCO encounter data, requested MCO RDT data (including global subcontracting MCO RDTs), FFS data for certain transitioning populations, ad hoc claims data, and financial reporting. SFY 2021–2022 served as the base data period. The SFY 2021–2022 encounter and SFY 2021–2022 RDT claims data included utilization and unit cost detail by COA group, immigration status, county/region, MCO, and 18 consolidated provider types or COS, including:

- IP Hospital
- OP Facility
- ER
- LTC
- Primary Care Physician (PCP)
- Specialty Physician
- Federally Qualified Health Center (FQHC)
- Other Medical Professional (NPP)
- MH-OP
- Behavioral Health Treatment (BHT) Services
- Laboratory and Radiology
- Transportation
- CBAS
- Hospice
- Multipurpose Senior Services Program (MSSP)
- Other HCBS
- All Other

A requirement of 42 CFR § 438.3(c)(ii) is that all payment rates under the contract are based only upon services covered under the State Plan to Medicaid-eligible individuals. As described above, MCO RDT and encounter data served as the starting base data for rate setting as well as FFS data in all non-CCI GMC, Regional, Single-Plan, and Two-Plan "transitioning" counties described later in this section. Mercer assessed the quality, timeliness, and completeness of the data per ASOP No. 23, *Data Quality,* to deem the data

sufficient to support rate setting. This assessment included reviewing the submitted MCO RDT and encounter data for changes year-over-year, and inclusive of the FFS data, for errors in reporting, overall reasonableness, and consistency across data sources to ensure it was appropriate to incorporate into rate development. The RDT data submissions are thoroughly reviewed, vetted, and discussed with each MCO during the rate setting process. Encounter data undergoes considerable edits within DHCS to ensure quality and appropriateness of the data for rate setting purposes. Base period MCO COA eligibility (described below) and encounter data were pulled consistent with service code mappings from DHCS, including lists of excluded services, such as State-only funded abortion services. Mercer has relied on data and other information provided by the MCOs and DHCS in the development of these rate ranges. Mercer did not audit the data or information, and if the data or information is materially incomplete or inaccurate, Mercer's conclusions may require revision.

The RDT submissions already include incurred but not reported adjustments which are reviewed for appropriateness and discussed with the health plans as part of the rate development process. If necessary, adjustments were applied to amounts reported by the health plans based on this review. The encounter data did receive adjustments to reflect underreporting and additional runout. These underreporting factors are applied to recognize that the encounter data are likely underreported by the MCOs (e.g., encounters from providers who are paid via a capitation arrangement may be understated), and not reflective of all liabilities still outstanding for the base period. Actuarial judgment was used to ensure the factors were reasonable.

Ultimately, Mercer deemed the RDT data as the most reliable base data source. Therefore, the final plan-specific SIS base data for rate setting is tied back to each MCO's SIS RDT experience, after the adjustments and smoothing process detailed below. As for the UIS population, due to the low credibility of this population in the base period for certain regions and populations, a blend of adjusted RDT experience, acuity adjusted SIS RDT experience, and a smoothed UIS RDT data source was used to inform the UIS base. As a result, the final UIS base data is not necessarily tied back to the MCOs' RDT experience. Similar to prior rate development periods, there are some exceptions (Kaiser and Aetna Better Health [Aetna] in all counties/rating regions), which are described below.

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

The base data utilized was managed care data without any disproportionate share hospital payments or adjustments for FQHCs or Rural Health Clinic (RHC) reimbursements. FQHC costs considered in rate development, are the costs incurred by the MCOs, net of any wrap-around payment by DHCS to reimburse the FQHC at their Prospective Payment System rate. The data did not include any adjustments for catastrophic claims. MCOs report this information as part of the base data, and it is included in the aggregate rates. Information on catastrophic claims is reported separately by MCOs within the RDT submission and is reviewed and discussed with the MCOs. No adjustments are made to the base data, as all these amounts are already included; however, the data smoothing subsection below illustrates how these events were handled in the rate range development.

# Base Data Adjustments — Managed Care Organization-Specific

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

## Hospital Adjustments

Adjustments to MCO reported hospital costs were necessary in some select cases. These adjustments occurred for three MCOs; Health Plan of San Joaquin (HPSJ), San Francisco Health Plan (SFHP), and LA Care Health Plan. Details for each adjustment are described below.

### Health Plan of San Joaquin

In the RDT discussion guide process, HPSJ noted an ongoing dispute with a provider impacting the IP, OP Facility, and ER COS' dating back to dates of service starting in Q1 2021.

To appropriately account for this in the base data, DHCS/Mercer worked with HPSJ to identify the anticipated savings from both settlements listed above to develop an appropriate adjustment to apply to the base data. Across all COA groups, approximately $1.1 million in San Joaquin and approximately $5.5 million in Stanislaus were removed from the SFY 2021–2022 base data.

### San Francisco Health Plan

SFHP communicated to DHCS/Mercer of a contract change with a large hospital provider in San Francisco effective January 1, 2023. Previously, SFHP and the hospital had a capitation arrangement for provided services. However, the hospital requested a restructuring of the payment arrangement into an FFS contract. As this contract change was known prior to the rating period and not reflected in the base, DHCS/Mercer elected to make a base data adjustment and worked with SFHP to develop the adjustment.

SFHP repriced the services rendered at the hospital to provide an estimate of the change in base data costs due to the updated contracts. SFHP reviewed SFY 2021–2022 encounters and repriced them to be in line with the contracted FFS rate. DHCS/Mercer reviewed their analysis and, along with comparison to hospital costs for nearby health plans, found the results reasonable and appropriate. Across all COA groups, this adjustment, increased the SFY 2021–2022 base data costs by approximately $49.1 million.

### LA Care Health Plan Hospital Settlements

LA Care Health Plan informed Mercer of pending hospital settlements for inappropriately denied services incurred during the SFY 2021–2022 base period. These estimated settlements were not included in the RDT submission and were adjusted for based on

supplemental information provided by the plan. Across all COA groups, impacting only the IP and OP Facility COS, this increased base data costs by approximately $6.3 million.

## Global Coordinated Care Initiative Capitation Payment Risk Stratification

Some MCOs choose to enter into global subcapitation arrangements (defined here as delegating the entire or vast majority of the risk of a beneficiary to another MCO) to administer managed care coverage for some of their Medi-Cal population. The member months capitated, and the capitation amounts paid in these arrangements are reported within the RDT by COA and included in the base data. Mercer reviews this data and information (in conjunction with global subcontractor RDT submissions and encounter data) as part of the base data development process.

Within CCI counties, some MCOs utilized a blended rate for their globally subcapitated CCI Full-Dual populations, similar to the historical capitation payment structure from DHCS to the MCOs for these members. Consequently, some MCOs reported per member per months (PMPMs) in their RDT that were equivalent (or nearly equivalent) across all their globally subcontracted CCI Full-Dual COA groups (e.g., Adult, SPD/Full-Dual, and LTC/Full-Dual) and populations (eligible but not enrolled [EBNE] and ineligible [INEL]). In these instances, to appropriately reflect the relative risk of these COA groups, Mercer developed relativity factors based on direct member PMPMs and the population mix of global members for each of these MCOs, effectively shifting dollar amounts between COA groups and the EBNE/INEL populations in a budget neutral fashion.

## Global Unsatisfactory Immigration Status Capitation Payment Risk Stratification

As mentioned in the prior adjustment some MCOs choose to enter into global subcapitation arrangements to administer managed care coverage for some of their Medi-Cal population. Most MCOs reported subcapitated PMPM payments that were equivalent (or nearly equivalent) across their globally subcontracted SIS and UIS populations — effectively not reflecting acuity differences between the populations. As such, to appropriately account for the relative risk of these populations, Mercer leveraged risk score information to better match these global subcapitation payments to risk, shifting dollar amounts between UIS and SIS populations in a budget neutral fashion. Overall, this process shifted dollars from the SIS populations to the UIS populations, with some variations by COA group. For example, dollars generally shifted from UIS to SIS for the Child COA group, but this was outweighed by dollars shifting from SIS to UIS for the Adult, ACA Expansion, and SPD COA groups.

## Cal Medi-Connect Base Data Development

The base data starting point for the Cal Medi-Connect (CMC) populations in CCI counties was the combined Medi-Cal, Medicare, and “Unable to Separate” cost and utilization reported by the health plans in the RDT submissions. The CMC adjustment reduces the base data to reflect only the Medi-Cal liability. Similar to the historical CCI rate development process, Mercer reviewed each plan’s reported Medi-Cal expense as a percentage of the total to determine if the plan’s reporting of Medi-Cal liability was reasonable and appropriate for rate setting. If deemed reasonable, Mercer adjusted the total CMC spend to reflect the health plan-reported CMC Medi-Cal expense; otherwise, the CMC base utilization/PMPM

was set equal to that of the health plan's direct member experience for the CMC EBNE population. For health plans with a CMC contract in LA County, that are not also a direct contractor in that county, their CMC member months were assigned to the prime health plan they contract with for other populations (e.g., EBNE), along with a cost/utilization profile equal to that prime health plan's global EBNE population. This member transition is consistent with the sunset of CCI, and the exclusively aligned enrollment process as CMC health plans transition to D-SNPs.

This adjustment carved approximately $1.9 billion dollars out of the SFY 2021–2022 base period, representative of the Medicare liability for these CMC members.

## Coordinated Care Initiative and Non-Coordinated Care Initiative Base Data Consolidation

To facilitate the transition of CCI Full-Dual members into the non-CCI program after December 31, 2022, RDT reporting for Full-Dual members in CCI counties reflected member assignment consistent with non-CCI COA groups. The adjusted CCI RDT submission's member months, dollars, and units by COA were removed from the reported CCI populations (EBNE, INEL, and CMC) and added into the health plan's respective non-CCI Medi-Cal rate cells on a budget neutral basis. For health plans with a CMC contract in LA County that are not also a direct contractor in that county, their CMC experience was added into the prime health plan they contract with for all other populations, consistent with the exclusively aligned enrollment process as CMC health plans transition to Dual Eligible Special Needs Plans.

## Mental Health Services for Members Diagnosed with Serious Mental Illness Carve-Out

For members covered by Kaiser in Solano County, MH services to treat beneficiaries with a serious mental illness (SMI) have historically been included in the subcapitation rate paid by Partnership Health Plan (PHP) to Kaiser. This adjustment removed $3.1 million paid by PHP to Kaiser for SMI services from the Solano County base data leveraged for CY 2024 rate setting. Costs associated with these services will now be included as a capitation rate add-on outside of the base capitation rates.

## Pharmacy Carve-Out

Effective January 1, 2022, retail pharmacy services were carved out of managed care for all populations and covered by the State through the FFS delivery system. Specifically, the following pharmacy benefits, when billed by a pharmacy and on a pharmacy claim, are carved out of managed care; covered OP drugs (including physician administered drugs), medical supplies, and enteral nutritional products. To remove pharmacy costs from the capitation rates, the pharmacy COS line was zeroed out within the base data for all populations, based on MCO RDT reporting. The RDT data source was reviewed and validated against encounter data for reasonableness. This adjustment removed approximately $3.4 billion from the SFY 2021–2022 managed care base data.

## Multipurpose Senior Services Program Carve-Out

MSSP services were no longer a managed care covered benefit effective January 1, 2022. As a result, the MSSP experience for SFY 2021–2022 as reported in the RDT was removed from the base data.

For the SFY 2021–2022 base data period, approximately $10.5 million of MSSP costs were removed from the base data.

## Provider Incentive Adjustments

Within the MCO-submitted RDTs, there is a schedule for MCOs to describe their provider incentive arrangements, in addition to providing the amounts paid in provider incentives separately in the RDT. Through a review of this information, it was determined California Health & Wellness had a provider incentive arrangement not indicative of expected future cost levels during the contract period. This program, while reported under incentives, reflects a local initiative contract with the county, where California Health & Wellness will share 20% of any net profit that exceeds 3% of revenue. Through review of documentation and discussion with California Health & Wellness, it was determined the amounts paid out in incentive payments are solely determined by the net profits by COA and have therefore been removed from the base data and CY 2024 rate development. Approximately $2.0 million was removed from the SFY 2021–2022 base data due to this adjustment.

## Value-Added Services Adjustment

As part of the RDT data submissions, the MCOs were required to report costs for services that were not a part of the State Plan benefit package during the SFY 2021–2022 base data period but were provided as value-added services. Within this reporting, some services aligned with Community Supports services, which are defined in the MCO contracts effective January 1, 2022 (and also in CY 2024). Other services within this reporting do not align with the Community Supports services. This adjustment removed any costs aligned with the Community Supports services for the July 1, 2021 through December 31, 2021 time period, and all costs for the entire SFY 2021–2022 base data period for services not deemed to align with the Community Supports. Any Community Supports services reported from January 1, 2022 through June 30, 2022 remained within the base data unchanged, since it was allowable in the contract for this time period. Value-added services in the July 1, 2021–December 31, 2021 time period removed through this base data adjustment were also considered for a program change adjustment if the services aligned with one of the 14 approved Community Supports, which is described further in the program changes section.

Across all COHS, GMC, Regional, Single-Plan, and Two-Plan models, approximately $14.7 million was removed from the SFY 2021–2022 direct base data because of this adjustment.

## COVID-19 Temporary Unit Cost Increase Carve-Out

Due to the impact of the COVID-19 pandemic, some health plans made enhanced payments to various providers that otherwise would not have been made. These costs, characterized as temporary and related to the public health emergency (PHE), were collected by quarter on a supplemental schedule of the RDT. These are all expense that were voluntarily made by the MCOs with no direction of payment from the State. Examples of these costs include increased facility payments for COVID-19 isolations and incentive payments to encourage continued preventive care utilization. A description provided by the health plan was reviewed for each of these costs to confirm they were truly temporary in nature and would not be carried forward to the contract period. All costs from the SFY 2021–2022 period identified to be omitted from the contract period were carved out. In total, approximately $51.1 million was removed from the base data across all health plans, COA groups, and service categories.

## Maternity Base Data Carve-Out

The RDT-reported experience for maternity delivery events was removed from the SFY 2021–2022 base data by COA and COS. This was done since costs for delivery events are covered through a supplemental payment. The SFY 2021–2022 RDTs required MCOs to separately report maternity utilization and cost data for each of the COAs (Child, Adult, ACA Expansion, and WCM) that are subject to the maternity supplemental payment. For members in MCOs who directly contract with the State, this data was used for this base data adjustment. For members in MCOs with global subcontract arrangements, maternity supplemental payment amounts net of non-medical expenses made by the direct plan to their global subcontractors were used in conjunction with the global subcontractor MCOs actual maternity experience. The combined SFY 2021–2022 RDT-reported maternity experience for direct members and global members formed the maternity base data and was also used in the carve-out of maternity services from the base data. This adjustment removed approximately $1.079 billion from the SFY 2021–2022 base data.

## Kaiser and Aetna Base Data Development

Special adjustments to MCO-reported data were necessary in some select cases. These adjustments occurred for two MCOs, Kaiser and Aetna. Details for each adjustment are described below.

### Kaiser Foundation Health Plan

Consistent with prior rating periods, Kaiser's RDT-reported information was not deemed fully credible to use in the development of base data. For CY 2024, three sources for Kaiser base data were utilized, each described below:

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

    A. In developing this base data, adjusted RDT data from the other MCOs in Kaiser's counties was averaged together to form a county average base data excluding any Kaiser experience. In this process, BHT, CBAS, and long-term LTC costs were removed from the base data derived from the other plans. Next, a Kaiser relative risk score was calculated as Kaiser's unadjusted risk score divided by the remaining plans' unadjusted risk score, using the CDPS+Rx model. This relative risk score was applied to the average data across the other plans. For the BHT, CBAS and LTC COS lines, Kaiser's reported data was added to this risk-adjusted county average data, which formed the base data specific to Kaiser's members for this data source. This process was only used for the SIS population and for the Child, Adult, ACA Expansion, and SPD COA groups only.

2. A repriced version of the Kaiser RDT data

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

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

ii. Professional COS' (Physician Primary Care, Physician Specialty, FQHC, NPP, MH OP) — Kaiser reported unit costs were repriced with reasonable county average unit costs.

iii. Laboratory and Radiology — Kaiser reported unit costs were repriced to reasonable unit cost levels utilizing county average data.

iv. Other — Kaiser's reported Utilization Management/Quality Assurance/Care Coordination (UM/QA/CC) was replaced with a 50% blend of a county average UM/QA/CC PMPM and 50% statewide UM/QA/CC PMPM. This accounts for some additional UM/QA/CC dollars potentially removed in the repricing steps above, as Kaiser has indicated their full UM/QA/CC activities are embedded within professional capitation reported experience.

3. In instances where Kaiser is a global subcontractor, the payments made by the direct plan to Kaiser, adjusted to remove non-medical expenses (see "Global Rebase & Non-Medical Expense Adjustment" subsection below for more details on the non-medical expense adjustment).

For counties in which Kaiser is a directly contracting plan with the State within the base data period, the repriced RDT source was given a 25% credibility weight, and the risk-adjusted county average source was given a 75% credibility weight for the SIS Child, SIS Adult, SIS ACA Expansion, and SIS SPD COA groups. All other COA groups received 100% credibility on the repriced RDT data source.

For counties in which Kaiser is a global subcontractor to a directly contracted plan within the base data period, a 12.5% credibility weight each was given to the repriced RDT and direct to global payment sources (total of 25%), and the remaining 75% credibility was given to the risk-adjusted county average source for the SIS Child, SIS Adult, SIS ACA Expansion, and SIS SPD COA groups. For all other COAs, 50% weight was given to the repriced RDT source and 50% given to the direct to global payment source.

### Aetna Better Health and United HealthCare

Consistent with prior rating periods, Aetna and United's RDT-reported information alone was not deemed fully credible to use in the development of base data. While both MCOs are not operating in the Medi-Cal managed care space in CY 2024, their members' experience needs to be accounted for as part of the base. To develop Aetna and United's portion of the Sacramento (for Aetna) and San Diego (for both Aetna and United) base data for CY 2024, a credibility weighted blend of the risk-adjusted county average data (consistent with the process for Kaiser described above) and a pure county average excluding Aetna and United was used, similar to the approach taken in the CY 2023 rating period.

## Global Rebase and Non-Medical Expense Adjustment

Within the CY 2024 rate development process, an increased reliance on global subcontractor RDT reporting was used. Consistent with this, a 50%/50% blend of global reported experience as well as the medical component of direct to global subcapitation payments was used to form the base data for members delegated in global subcontractor arrangements.

Similar to prior rating periods, these direct to global subcapitation payments were reduced by appropriate non-medical loads to reflect the medical component of subcapitation in the base; 6% for instances where the global subcontractor was Kaiser, 8% otherwise.

### San Benito Fee-For-Service Transitioning Population Base Data

Effective January 1, 2024, San Benito County will transition from a Voluntary Managed Care County to a Mandatory Managed Care County. During the SFY 2021–2022 time period, approximately 50% of members in San Benito County were in an MCO. With San Benito's transition, the MCO RDT does not sufficiently represent the base costs for these members in SFY 2021–2022. In order to supplement the existing San Benito MCO RDT data, FFS members, who would have been in managed care prior to the CalAIM transitioning populations (which began in CY 2022) if not for San Benito's voluntary status, were identified and their associated cost profile was combined with the existing MCO RDT data.

### Managed Care Organization and County Consolidation

With the move to county/region capitation rates, the adjusted MCO-specific base data, was consolidated into a county base across all MCOs, due to the new regional rate structure as part of the CY 2024 MCO procurement. Where counties in historical region groupings were rolled up at a broader region level in the RDT data (e.g., counties in the former 18 county rural region), encounters and risk adjustment information were used to inform the shift of member experience from the broader region level into counties.

## Data Smoothing

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

### Smoothing and Data Credibility Adjustment Process

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

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

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

The credibility factors can be different for each county, COA, and COS. Depending on the member months for the base data year (SFY 2021–2022) for a given county and COA combination, base factors are established, giving credibility to the county-specific RDT data, county-specific encounter data, smoothed RDT data, and smoothed encounter data. Larger member month counts correspond to more credibility given to the plan-specific RDT and encounter data and less to the smoothed amounts. For example, for a fully credible county based on member months exceeding 25,000, these amounts would be 45% county-specific RDT data, 45% plan-specific encounter data, 5% smoothed RDT data, and 5% smoothed encounter data. For a smaller COA, having less than 5,000 but greater than 2,500 member months, these amounts would be 36% plan-specific RDT data, 36% plan-specific encounter data, 14% smoothed RDT data, and 14% smoothed encounter data.

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

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

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

Due to the low credibility of the UIS population during the base period in some instances, a further smoothing step was taken to land on reasonable base costs. Using the same assumption of 25,000 member months for full credibility, a credibility weight calculated based on the UIS county base member months in a COA was given to the adjusted UIS RDT experience. Where full credibility was not reached, the remainder of the county, COA, UIS base was split between the acuity adjusted SIS RDT experience and smoothed UIS RDT data points. As such, unlike the SIS base, the final UIS base data is not necessarily tied back to the MCOs' RDT experience.

### Relational Modeling

While in aggregate, the Medi-Cal Managed Care program is very large, covering millions of beneficiaries, there are instances where there are concerns over a specific COA group's credibility. In these cases, Mercer analyzed data and information on a more aggregate level and from this, developed factors, or relativities, to overcome any excessive variation brought on by small membership, or extraordinarily high or low utilization or unit costs. Any needed adjustments would be made via a budget-neutral smoothing and relational modeling process where no dollars would be gained or lost in this process.

## Base Data Adjustments — County/Region-specific

After the smoothing process described above, the following adjustments were applied at the CY 2024 county/region level.

### Emergency Department Efficiency Adjustment

Mercer performed a retrospective analysis of the SFY 2021–2022 encounter data to identify emergency department (ED) visits considered preventable or preemptive. For the CY 2024 rate development, Mercer analyzed preventable or preemptive low acuity non-emergent (LANE) visits. This analysis was not intended to imply members should be denied access to EDs or MCOs should deny payment for ED visits. Instead, the analysis was designed to reflect DHCS' objective that MCOs provide effective, efficient, and innovative managed care — care that could have prevented or preempted some members' need to seek care in the ED setting for low acuity, primary care treatable conditions.

The criteria used to define LANE ED visits were based on publicly available studies, as well as input and evaluation from Mercer's licensed clinicians, including practicing ED physicians and those with primary and urgent care experience. International Classification of Diseases (ICD)-10 primary diagnosis code information was the basis for identifying a LANE ED visit. Preventable percentages ranging from 5% to 90% (opioid codes were set at 0% and excluded from the analysis) were assigned to each diagnosis code to account for external factors that can influence and impact variation in ED use.

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

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

The components of the replacement cost offset include:

- Physician office visit
- Laboratory
- Radiology

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

The adjustment is applied to the COA groups of Child, Adult, ACA Expansion, and SPD and varies by each region and immigration status (SIS and UIS) and reduced the base by approximately $108.7 million.

## Potentially Preventable Admissions

For CY 2024, DHCS is utilizing an adjustment to the managed care IP base data that analyzes levels of inefficiency and/or potentially avoidable expenses present in the MCO encounter data.

Potentially preventable admissions (PPA) were identified through the SFY 2021–2022 Medi-Cal MCO encounter data using criteria from the Agency for Healthcare Research and Quality (AHRQ) Guide to Prevention Quality Indicators (PQI) and Pediatric Quality Indicators (PDI). Additional exclusions for enrollment duration and risk were made as part of the analysis.

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

The adjustment is applied to the COA groups of Child, Adult, ACA Expansion, and SPD and varies by each region and immigration status (SIS and UIS) and reduced the base by approximately $298.9 million.

## Physician Administered Drugs

The final efficiency adjustment Mercer completed was to identify potentially avoidable costs due to reimbursement inefficiencies for physician-administered medications. Mercer reviewed the MCO SFY 2021–2022 professional and OP encounter data to identify drug-related Healthcare Common Procedure Coding System codes and potential savings associated with those codes.

To identify the potentially avoidable costs, Mercer compared the MCO per unit reimbursement rate to an industry benchmark. For the industry benchmark, Mercer used the Medicare Part B reimbursement rate (CMS average sales price plus 6%) for the same period. Prior to calculating the avoidable dollars, Mercer adjusted for outlier claims for which MCO unit prices were not consistent with the benchmark unit price or other MCO unit prices for a given Healthcare Common Procedure Coding System code.

Inefficient MCO spend is defined as the amount the MCO paid above the re-priced benchmark of average sales price plus 6%. Mercer recognizes MCOs may be able to price

more aggressively than the benchmark for some drugs. In these cases, inefficient spend is offset. Total net potential savings reflect the overall inefficient spend by MCOs when compared to the benchmark.

This adjustment was applied to both the OP and SP COSs to reflect where physician administered drugs are expected to occur.

## Reclassification of 19–20 Year Olds from the Adult to Child Category of Aid

Due to a change in COA age definitions from the base period to the contract period, a budget neutral adjustment was applied to shift any 19–20-year-olds and their associated costs from the Adult to Child COA for CY 2024. The statewide impact of this transition consisted of shifting a total of 1.9 million member months and $146.1 million from Adult to Child. This shift increases the statewide PMPMs for the two COAs but remains budget neutral to the total base.

## Long-Term Care Fee-For-Service Transitioning Population Base Data

Effective January 1, 2023, the LTC and LTC/Full-Dual COAs became managed care eligible in all non-CCI GMC, Regional, Single-Plan, and Two-Plan “transitioning” counties. These populations were already covered in managed care in CCI and COHS counties; hence, this subsection does not apply in these cases. Since MCO RDT data does not currently exist for these members in transitioning counties, the base data for these COAs is comprised of county-wide SFY 2021–2022 FFS data. The FFS data included utilization and unit cost detail by the same 18 COS noted in the beginning of this section. The base data pulled for this population was only for members with an applicable LTC aid code (13, 23, 53, and 63), as members residing in an LTC facility but without an LTC aid code will be classified into the COA consistent with the beneficiaries’ aid code.

All selected base data was adjusted (as appropriate) to reflect the impact of program changes between the base and contract periods as well as managed care payment levels. These items are discussed further in the *Program Changes* and *Population Adjustments* sections below.

As described above, FFS data served as the base data for rate setting. The FFS base data was limited to only services covered through the federal-specific managed care contracts, with the exception that all services for UIS beneficiaries were included at this step (state only services are removed at a step described later in this Section).

## Los Angeles County Cost-Based Reimbursement Clinics

In LA County for the SPD COA and FQHC COS only, in addition to the general base data development of the FQHC COS, the base data includes an additional adjustment to account for the portion of the cost-based reimbursement clinics (CBRC) costs not historically reflected in the base data and not reported in the RDT data. For CY 2024, these costs are reflected within the base data adding $53.03 (SIS) and $3.28 (UIS, Federal component) PMPM to the LA County SPD base.

The data for this adjustment utilized SFY 2021–2022 CBRC experience provided by LA County Department of Health Services. This data reflected the LA Care and Health Net SPD CBRC experience from this period, which aligned with the base data utilized for rate setting. The SFY 2021–2022 RDT information from each of the MCOs was also utilized as it represented the baseline information prior to the subsequent adjustment. The differential between the amounts of LA County Department of Health Services reported experience for each MCO and the underreported MCO experience dictated the needed adjustment.

It should be noted, due to higher costs associated with CBRCs and the disproportionate distribution of CBRC services across the MCOs within LA County for the SPD COA, a further refinement was necessary. The CBRC cost was divided in two components; an arms-length transaction amount reflective of cost levels in line with typical professional services, which includes administrative and underwriting gain loads and is subject to risk adjustment, and a "not subject to risk adjustment" carve-out amount, which includes only medical costs and is not subject to risk adjustment. This occurs at a later step in the rate development process and is described in more detail within Section 4 of this report.

## Major Organ Transplant Carve-Out

MOT became a managed care covered benefit effective January 1, 2022 in GMC, Regional, Single-plan, and Two-Plan counties. The CY 2024 capitation rates include PMPM add-ons to reflect the impact of MOT. The RDTs submitted by the plans and leveraged for CY 2024 rate setting included MOT costs for the first half of CY 2022. To not double count MOT add-on costs in both the base capitation rates and MOT add-on rates, a base data carve-out was applied to remove MOT costs for the first half of CY 2022. This carve-out was done only for non-COHS counties considered in the base data period. This adjustment was based on MOT encounter data for the time period of January 1, 2022 through June 30, 2022 and removes approximately $48.1 million from the base data. The amount of this base carve-out is included in the CY 2024 MOT PMPM add-on rates.

## Institution for Mental Disease

Covered benefits associated with these capitation rates do not include services associated with an Institution for Mental Disease (IMD). In addition, if a managed care member is in an IMD in a given month, the state does not pursue federal match for that individual for that month. Therefore, the only potential rate impact from a federal perspective for members utilizing an IMD for more than 15 days in a given month would be associated with the potential impact of those members experiencing significantly higher or lower costs than other non-IMD utilizing members. Within the development of the base data, members in an IMD for more than 15 days in a given month were identified, and their associated costs and member months were removed from the base data. This adjustment had very minimal impact on the base data.

## Existing Care Coordination Carve

The WCM program includes some care management services comparable to those provided through ECM. The rate adjustment for ECM is described later within this certification. Through clinical review of the CM requirements of both programs, Mercer assumed WCM ECM enrollees have 25% of their ECM services are accounted for through the WCM base data. As such, 25% of the WCM ECM medical component PMPM is carved out of the WCM

base data, to avoid double counting of these costs. These historical care management costs in the WCM base data are now assumed to be included within the ECM rate adjustment.

## Roll Into Rating Regions

All adjustments noted above were done at the county level. As noted previously, some counties stand on their own as rating regions and some rating regions have multiple counties. In this step, the base data, after the adjustments described in this section, was aggregated to the region level, consistent with the regions that capitation rates are paid out to the MCOs.

## Unsatisfactory Immigration Status Federal Percentage Development

Up to this point, all base data for the UIS population contained all services, including federally eligible and state only services. As a result, an adjustment was needed to limit the UIS base data to federal services only. In the development of the percentage of the UIS base data for federally eligible services, SFY 2021–2022 encounter data for the UIS population was utilized by analyzing both pregnancy-related and emergency services PMPM spend as a percentage of total UIS PMPM spend. The percentage of UIS dollars for pregnancy-related services and the percentage of UIS dollars for emergency services were analyzed and developed separately. However, the total of the two components makes up the total federal percentage that drives the base data calculation. Within the coding logic, various flags in the data were derived and services were flagged as either pregnancy-related or emergency using a hierarchy logic so each encounter or FFS claim only flagged once as either pregnancy-related or emergency. No encounters or FFS claims were flagged twice in the event that a service was flagged as both pregnancy-related and emergency-related. The coding logic used to derive the federal percentages (both emergency- and pregnancy-related services) can be found in Appendix A.

In terms of the hierarchy used for the federal percentages, the first service flagged in the hierarchy was labor and delivery services, and these services were identified as emergency services. Then, pregnancy-related services were identified next in the hierarchy and the remaining emergency services were last in the hierarchy. Using this hierarchy logic, pregnancy-related and emergency services were grouped and separated in the analysis, in order to derive the applicable pregnancy-related and emergency percentages.

The result of this was PMPM amounts by region, COA, and COS for the UIS population for pregnancy-related and emergency services, as a percentage of the total UIS PMPMs, separately. In the development of the percentages utilized for the federal capitation rate development, smoothing ranges were developed at the COA and COS level separately for pregnancy-related and emergency services. The smoothing ranges were developed based on a review of each region’s data points for the same COA and COS combination. In the smoothing process, if a region-specific percentage fell within the smoothing range, this value was accepted and used in the calculation of a statewide average percentage of total UIS dollars. This was done separately for pregnancy-related and emergency percentages. The result of this was a statewide average percentage of total UIS PMPM spend that is for pregnancy-related and emergency services, by COA and COS. These statewide federal percentages (the sum of pregnancy-related and emergency percentages) were then blended with the region-specific federal percentages to derive the federal percentages applied for each region, by COA and COS. A 50% factor was used for the region percentages and the remaining 50% factor was used for the statewide average percentages. This blend was done

to introduce variation seen in the percentages by region. These final blended percentages were then applied to the UIS base data in total by region, COA, and COS to derive the UIS base data for federal services only. Remaining services for the UIS population are included in the state-only rates that are not part of this certification.

# Maternity Supplemental Payment

To further enhance the measured matching of payment to risk, DHCS utilizes a maternity supplemental payment for all health plans. Pertaining to gender, the primary issue that could result in significant variance among the MCOs' enrolled population and hence their risk, is the event of maternity and its related cost. Costs for pregnant women are on average substantially higher than the average medical cost of care for men and non-pregnant women with similar demographic characteristics. To mitigate the maternity risk issue within the rates, DHCS includes a maternity supplemental payment, which represents costs for the delivery event. Prenatal and postpartum care costs are not part of the supplemental payment but remain within the capitation rates for their respective COA. An MCO receives the lump sum maternity supplemental payment when one of its current members within the Child, Adult, ACA Expansion, or WCM COA groups gives birth, and DHCS is appropriately notified a birth event has occurred. Non-live birth expense data and non-live birth outcomes are excluded from the maternity supplemental payment analysis and the corresponding development of the CY 2024 maternity supplemental payments. This results in non-live birth expenses being included in the base capitation rates rather than being included in the supplemental payment. Separate maternity supplemental payments enhance matching payment to risk in large part because they mitigate potential adverse selection effects across plans for the non-COHS models and protect the COHS plans from the impact of changing delivery prevalence.

## Maternity Supplemental — Design

- Payment made on delivery event that generates a state vital record.
- One supplemental payment per delivery regardless of number of births.
- One blended supplemental payment combining caesarean and vaginal deliveries.
- Supplemental payment varies by county//region, but not by MCO within a county/region.
- Supplemental payment reflects cost of delivery event only (mother and baby, excluding prenatal and postpartum care).
- Supplemental payment is for the entire CY 2024 time period.
- Same supplemental payment is utilized for the Child, Adult, ACA Expansion, and WCM COA groups if a delivery event occurs.

## Maternity Supplemental — Base Data Development Approach

In general, a similar process used for the development of the base data by COA group is utilized in the development of the base data for the maternity supplemental payment. The RDT data for maternity for the SFY 2021–2022 base data includes both direct and global members as the main source for this base data development. The inclusion of global members is a change from the SFY 2020–2021 approach and was driven primarily by the continued expansion of utilizing global data. In addition, only the SIS population was used for

the maternity base data development which is also a change to SFY 2020–2021. The UIS population data was reviewed, but given the large influx of deliveries anticipated with the expansion of full-scope Medi-Cal beneficiaries ages 26 to 49 regardless of immigration status, it was assumed that the base data for the UIS population will be the same as the SIS population. This is consistent with the actual UIS data for SFY 2021-2022, which suggested no major differences in maternity per member delivery costs, and prior analyses for historical rates. The general process for the development of the maternity base data is described below:

- Calculate per delivery costs and utilization from SFY 2021–2022 MCO RDT data by delivery type and COS.
- Same general data selection process used as in regular rate range development:
  - Smoothing and data selection process done by delivery type (caesarean and vaginal).
- Develop smoothed data points to replace missing or unreasonable data.
- Blend reported and smoothed base costs from the MCOs to generate base data by MCO, delivery type, and COS.
- Aggregate base data across county/region and delivery type.

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

Section 4

# Projected Benefit Costs and Trends

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

- Trend from SFY 2021–2022 to CY 2024
- Program Changes
- Population Adjustments
- CBRC in LA County
- Maternity Supplemental Payment Rate Development

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

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

## Trend

Trend is an estimate of the change in the overall utilization and cost of medical services over a finite period of time. Trend factors are necessary to estimate the expenses of providing health care services in a future period. As part of the CY 2024 rate range development for the COHS, GMC, Regional, Single-Plan, and Two-Plan model programs, Mercer developed trend rates at the COA level and for the maternity supplemental payment for each provider type or COS separately by utilization and unit cost components. Notably, Mercer selected the same trends for the SIS and UIS populations for each COA. This was done, as it is Mercer's expectation that utilization or unit cost trends will not differ substantially between the populations on a service category basis. Though Mercer did not vary trend selections between SIS and UIS, the exhibits contained in this section are created using the aggregated SIS population (without Maternity services), where the large majority of program costs are associated. For all COA group cohorts in the CY 2024 rating period, the SFY 2021–2022 base data was trended forward 30 months from the mid-point of SFY 2021–2022 to the mid-point of CY 2024.

Mercer reviewed and utilized multiple sources of data and information for trend development. These include recent MCO encounter and RDT data, MCO Medi-Cal-only financial statements, Medi-Cal specific hospital IP and OP payment data, Consumer Price Index, National Health Expenditures updates, and multiple industry trend reports including the CMS

Medicaid actuarial report[1]. Each of these data and information sources has strengths and challenges, and those strengths and challenges may change over time. Hence, no one, or combination of data and information source(s), was utilized within a prescribed formula. Rather, each was reviewed for its potential applicability and utilized collectively with other data and information via actuarial judgement in order to inform the final trends.

The overarching trend development approach remains consistent with prior rate periods as a combination of "top down" and "bottom up" claim cost trend development. Mercer conducted historical annual trend calculations to inform directional changes of emerging trends for consolidated service categories at the major COA level. To the extent the emerging trends, along with the host of data and information described above, indicated a material increase or decrease of service utilization or unit cost; Mercer adjusted the trends established in the prior year's rates incrementally as the new trends for the current rates in order to reflect the directional changes. This is also referenced as a "change in the change" approach for the purpose of continuity of trend assumptions between different rating periods. In addition to "bottom up" claim cost trend analysis, a considerable amount of actuarial judgement was used in the final trend development based upon Mercer's longstanding Medi-Cal specific program knowledge and extensive experience in working with the majority of the largest Medicaid programs in the country.

There are 12 COS where significant changes in annual claim cost trends took place to reflect the more recent trend experience. In these instances, the annual PMPM trend factors changed more than 0.50% and at least one of the incremental changes to utilization and/or unit cost trend factors changed more than 0.25% from CY 2023 to CY 2024. These large changes from the prior year are a result of reviewing newer and emerging information (as described above) to appropriately align prospective payment levels. Please see the table below for detailed changes of trend assumptions by COS for the indicated COA groups.

| Annual Trend Factors — All COAs | | | |
|---|---|---|---|
| **COS** | **CY 2023** | **CY 2024 (SIS, Non-Maternity)** | **Change** |
| **Emergency Room** | 4.34% | 5.35% | 1.01% |
| **PCP** | 1.44% | 3.11% | 1.67% |
| **Specialty Physician** | 2.12% | 3.38% | 1.26% |
| **FQHC** | 1.42% | 3.09% | 1.67% |
| **BHT** | 5.73% | 5.00% | -0.73% |
| **Laboratory and Radiology** | 5.06% | 3.25% | -1.81% |
| **Transportation** | 5.01% | 6.04% | 1.03% |
| **Hospice** | 2.75% | 1.75% | -1.00% |
| **Other HCBS** | 3.02% | 4.26% | 1.24% |
| **All Other** | 3.02% | 4.26% | 1.24% |

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

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

After the mid-point/best estimate trends were determined, a trend range was created by adding 0.25% to each of the utilization and unit cost components as the upper bound and subtracting 0.25% as the lower bound. In aggregate, the annualized lower bound claim cost trends for the SIS population, across all MCOs, all COA groups, and all COS, average 0.4% for utilization and 2.6% for unit cost, or 2.9% PMPM. This represents an increase of 0.3% over the aggregate trend figures at the lower bound from those developed for the CY 2023 capitation rates.

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

# Program Changes

Program change adjustments recognize the impact of benefit or eligibility changes that took place during or after the base data period. The program changes incorporated in the development of the rates were based on information provided by DHCS staff as of November 1, 2023. The program changes detailed below were viewed to have a material impact on capitation rates and were reviewed, analyzed, and evaluated by Mercer with the assistance of DHCS.

The next several subsections are the program changes adjustments explicitly accounted for within the CY 2024 capitation rates. A summary showing the managed care impact by county/region, MCO, and COA group can be found within the program change charts provided within the Excel file titled *CY 2024 Medi-Cal Rate Summaries 2023 12.xlsx*. Additionally, the program change adjustments identified below are applied in columns (F) and (G) of the CRCS, unless otherwise indicated.

## Ground Emergency Medical Transportation Fee Increase

Pursuant to approved State Plan Amendment (SPA) 18-0004, and subsequent continuances in approved SPAs 19-0020, 20-0009, 21-0017 and 22-0040, and anticipated future continuances, DHCS makes add-on payments to Ground Emergency Medical Transportation (GEMT) providers in the State's FFS program who meet specified requirements using proceeds from a GEMT provider quality assurance fee (QAF). Both State law (Welfare & Institutions Code § 14129.3[b]) and the approved SPAs establish the combination of the State's FFS base and add-on payments constitute the Rogers rates MCOs must pay to non-contracted GEMT providers serving Medi-Cal managed care enrollees for those fiscal years in which the GEMT add-on is effective. Similar to prior years, a program change adjustment has been included in the certified capitation rates to account for this MCO obligation. To develop the program change adjustment, applicable codes were queried in the encounter data, and a per trip add-on of $220.80 was assumed for each applicable trip. In

instances where Medicare is anticipated to cover costs for GEMT trips for Full-Dual/Part B eligible members, the total Medi-Cal paid amount was compared to the Medicare fee schedule and smaller add-on amounts were assumed for these trips based on these differences. Further, this add-on only applies to non-contracted trips and non-public GEMT providers. All trips were assumed to be non-contracted in the development of this adjustment since historical reporting by the MCOs on contracts for GEMT services has shown very minimal levels of contracting in the program. Further, DHCS provided a list of public GEMT providers, and the trips within this adjustment were only based on providers not in this public provider list.

## Ground Emergency Medical Transportation Rate Increase AB 1705

Effective January 1, 2023, AB 1705 established the Public Provider GEMT program, resulting in a per trip rate increase for GEMT public service providers. Based on the data, assumptions, and methodology used in the previous subsection pertaining to the GEMT QAF add-on, a separate rate increase of $946.92 was applied to the assumed public GEMT provider trips. Specific to the dual's population, this per trip add-on puts all GEMT trips for the applicable codes above the Medicare fee schedule. As such, all Full-Dual/Part B only public provider GEMT trips have been adjusted to only reflect Medi-Cal's liability of the total GEMT payment rate inclusive of the AB 1705 add-on. In order to ensure only non-contracted GEMT provider trips were included in this adjustment, supplemental data requests were collected for transportation information, which included plans indicating levels of contracting with GEMT providers. Based on this historical reporting, a decreasing (and minimal) portion of GEMT trips were reported as contracted and the proportion of contracted trips was very small. Since only non-contracted trips are subject to the GEMT add-on amounts (both QAF and AB 1705), it was assumed no GEMT trips would be contracted in the development of the GEMT adjustment in the CY 2023 rates.

The state intends on submitting an add-on rate increase for CY 2024 to account for trend. Any rate impacts associated with this increase will be captured in a future rate amendment.

## Assembly Bill 97 Buybacks

Effective July 1, 2022, Medi-Cal restored the 10% AB 97 FFS payment reductions previously applied for various provider types that will now be exempt from AB 97 payment reductions, including the following:

- Air Ambulance Transportation Services
- Alternative Birth Centers-Specialty Clinics — services provided to adults
- Assistive Device and Sick Room Supply Dealers (Durable Medical Equipment)
- Audiologists
- Chronic Dialysis Clinics — services provided to adults
- Community Clinics — services provided to adults
- Hearing Aid Dispensers

- Nurses, including certified nurse-midwives, nurse anesthetists, certified pediatric nurse practitioners, certified family nurse practitioners, and group certified pediatric nurse practitioners.
- Occupational Therapists
- Optometrists
- Orthoptists
- Portable X-Ray
- Psychologists
- Rehabilitation Clinics — services provided to adults
- Respiratory Care Practitioners
- Speech Therapists
- Surgical Clinics — services provided to adults

Additionally, effective January 1, 2023, Medi-Cal will be restoring the 10% AB 97 payment reductions previously applied for the following provider types that will now be exempt from AB 97 payment reductions:

- Podiatrists
- Prosthetists

Adjustments were developed using encounter data, by COA and separated for SIS and UIS beneficiaries, for the provider types listed above during the period of July 1, 2021 to June 30, 2022. This adjustment accounts for pricing pressures based on FFS payment increases which managed care plans are anticipated to pay.

## CalAIM Community Supports

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

1. Housing Transition/Navigation Services
2. Housing Deposits
3. Housing Tenancy and Sustaining Services
4. Short-Term Post-Hospitalization Housing
5. Recuperative Care (Medical Respite)
6. Respite Services
7. Day Habilitation Program

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

### Managed Care Organization Voluntarily Covered In Lieu of Services Adjustment

The “MCO Voluntarily Covered ILOS Adjustment” specifically adjusts for value-added services dollars reported in the RDT that align with one of the newly covered Community Supports services. These were services voluntarily provided by the MCOs in the July 1, 2021 through December 31, 2021 time period that were removed within the “Value-Added Services Adjustment” base data adjustment. If a value-added service reported in this period was deemed by DHCS and Mercer to align with one of the 14 Community Support services, then those dollars were carved into the rates in the form of a program change adjustment. As these services were reported by COS and COA by each region, this adjustment is COS, COA, and MCO specific. The data used to apply the adjustment was based on the RDT data reported by the MCOs.

### Whole Person Care Adjustment

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

- Costs reported by the WPC entities, reported at the county level for CY 2021.
- List of WPC utilizers for CY 2021, provided by DHCS.

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

### In Lieu of Services Documentation

For requirements outlined in CMS’ communication on In Lieu of Services with SMD # 23-001, please refer to the following sources included in the certification package for CMS’ convenience. The state of California calls In Lieu of Services ‘Community Supports’:

- For service definitions and a description of each ILOS in the program, please see page 9 of the CA In Lieu of Services (ILOS) Policy Guide 2023 12.
- For state plan services crosswalk, please see page 62 of the DHCS Community Support Policy Guide.
- For target populations, please see page 66 of the DHCS Community Support Policy Guide.
- For the projected ILOS Cost Percentage, please refer to the CY 2024 Prospective ILOS Cost Percentage 2023 12
- For a review on cost effectiveness, please refer to the CA ILOS Literature Review 2023 12.

## Doula Benefit

Effective January 1, 2023, Doula services encompass the health education, advocacy, and physical, emotional, and nonmedical support provided before, during, and after childbirth or end of a pregnancy, including throughout the postpartum period.

No Medi-Cal claims experience specific to doula services were available at the time the adjustment was derived. Therefore, various assumptions were used to develop a PMPM adjustment for the Child, Adult, ACA Expansion, and WCM COAs, detailed below:

1. Projected CY 2024 live birth counts and abortion counts based on the distributions by COA from SFY 2021–2022 Medi-Cal managed care data. Assumptions of pregnancies resulting in different birth outcomes (live births, stillbirths, miscarriages) were based on national statistics published by the Centers for Disease Control and Prevention (CDC)[2], the Mayo Clinic[3], and various other sources.
2. The proportion of the eligible beneficiaries who would utilize the doula services during CY 2024, ramp-up assumptions, and the percentage of pregnancies and delivery events under each birth outcome scenario, were based on discussions with DHCS, consultation with clinical resources, and actuarial judgement.
3. The projected reimbursement rates for eligible doula services are based on information provided by DHCS.

A projected PMPM for doula services was derived using the assumptions noted above, which are the same for SIS and UIS members. The portion of the cost for postpartum care was estimated to be 10% of total costs of all doula services. As such, the program change adjustment for UIS Federal rates was assumed to be 90% of the program change adjustment for SIS rates.

## Community Health Worker

Effective July 1, 2022, community health worker (CHW) is an addition to the group of skilled and trained individuals who are currently able to provide clinically appropriate Medi-Cal covered benefits and services to Medi-Cal beneficiaries. Effective January 1, 2023, CHWs

[2] https://www.cdc.gov/ncbddd/stillbirth/facts.html
[3] https://www.mayoclinic org/diseases-conditions/pregnancy-loss-miscarriage/symptoms-causes/syc-20354298

were also allowed to be reimbursed for asthma remediation services and violence prevention services. While CHWs are also providers of ECM, this program change is separate from the ECM add-on detailed later in this certification.

Leveraging research on CHW staffing and using a build-up similar to the ECM model in identifying potential CHW utilizers, approximately 4.8% of the Medi-Cal managed care population were estimated to be utilizers of CHW services.

An average number of service hours per month was then developed, taking into account elements such as contact types (i.e., face-to-face, telephonic, etc.), frequency and duration of contacts, CHW enrollee program tenure, and level of need for members receiving CHW services. Ultimately, 2.0 service hours per month was assumed for the CHW program. This assumption was then multiplied by a California-specific CHW provider cost per hour to price this adjustment. The methodology used to develop the CHW cost per hour is consistent with that used in the ECM rate development for the same provider type. Given the emphasis on staffing the ECM program with CHWs for the CY 2024 rating period, a 20% ramp-up of this program benefit is assumed for CY 2024.

## Rapid Whole Genome Sequencing

Rapid whole genome sequencing became a managed care covered benefit effective January 1, 2022. This benefit is available to infants one year old and younger receiving IP hospital services in an intensive care unit and covers individual sequencing, trio sequencing for parent(s) and their child, and ultra-rapid sequencing.

This adjustment was priced based on managed care intensive care unit utilization of the eligible population and an assumed mix of tests (individual or trio sequencing; rapid or ultra-rapid sequencing) seen from a previous state-funded rapid whole genome sequencing program. Further, this benefit is covered as a CCS covered service when case review confirms the study is warranted and when the test relates to a CCS eligible condition. As a result, this program change only impacts the WCM COA in managed care and was halved, acknowledging that this was already accounted for in six months of the base data period.

## Dyadic Services

Effective January 1, 2023, the dyadic services program change considers an integrated BH care model providing health care for the child delivered in the context of the caregiver and family. Families are screened for various BH problems, including interpersonal safety, tobacco and substance misuse, and social drivers of health such as food insecurity and housing instability. Families who are given referrals receive follow-up to ensure they received the services. Dyadic services are available for Medi-Cal beneficiaries ages 0–20 years old, and any services rendered during the dyadic visit or child's medical visit are billable to the child's Medi-Cal ID. This program change offers the new benefits of dyadic services and general BH integration services, along with changes to a variety of existing services, in an effort to improve the health care of children by addressing developmental and BH concerns as soon as they are identified. The following is a full list of impacted services under the dyadic services policy:

New Benefits from Dyadic Services Policy:

- Dyadic Behavioral Health (DBH) Visit

  - DBH visits occur on the same day, or close to the same day, as the medical well-child visit.
- Dyadic Comprehensive Community Support Services
- Dyadic Psychoeducational Services
- Dyadic Family Training and counseling for Child Development

Existing Benefits Impacted by Dyadic Services Policy:

- Psychiatric Diagnostic Evaluation
- Caregiver Depression Screening
- Health and Behavior Assessments/Interventions
- Adverse Childhood Experiences (ACEs) Screening
- Tobacco Cessation Counseling
- Alcohol Use Screening and Alcohol Misuse Counseling
- Brief Emotional/Behavioral Assessment
- Provisional Postpartum Care Extension for Perinatal MH Conditions

### General Methodology

To determine the impact of this program change on the capitation rates, Mercer calculated the aggregate dollar impact based on the anticipated utilization of impacted services and their prospective unit costs. The starting point for anticipated utilization was to determine the average number of monthly members with BH needs through clinical assumptions and SFY 2021–2022 eligibility; furthermore, how many of those members would utilize dyadic visits during their well-child visits. The assumed dyadic visits vary by age groups that align with the suggested well-child visits from the Bright Futures Periodicity Schedule[4]. Using this utilization of dyadic visits, Mercer estimated the number of additional services provided (for both new and existing benefits) as a result of the dyadic services policy. This expected new utilization of the impacted benefits was analyzed based on the following two categories:

- During the Dyadic Visit
  - In addition to the new utilization of the dyadic visit itself, Mercer analyzed the remaining impacted services for the likelihood of them also being provided during the dyadic visit on a by service basis. Based on these likelihoods, Mercer calculated the total utilization of all services (both new and existing) to be performed during dyadic visits throughout the CY. Per DHCS' policy, all services provided during the dyadic visit are billable under the child's Medi-Cal ID. As such, this new utilization during the dyadic visit is mostly attributable to the Child and WCM COA groups, with smaller amounts impacting the SPD (for disabled children ages 0–20) and ACA Expansion (for children ages 19–20 years old) COAs.

[4] *https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf*

- After the Dyadic Visit (Downstream Services)
  - Given that referrals for certain services are an expected outcome of dyadic visits, it was necessary to include an estimate for the increase in existing services beyond the dyadic visit resulting from the dyadic services policy in the calculation of new utilization. For the estimate of this increase, Mercer analyzed managed care encounters to determine baseline utilization levels of the specific impacted services in the SFY 2021–2022 base period. Mercer then assumed a growth percentage of 10% for these existing services as a result of the dyadic services policy and included this growth within the expected new utilization from this program change. Per DHCS' policy, only services provided during the dyadic visit are billable under the child's Medi-Cal ID. Given this category of new utilization occurs outside of the dyadic visit, this increased utilization of existing services was allocated to the various COA groups according to the baseline amounts initially determined in the SFY 2021–2022 data.

To calculate the financial impact associated with this expected new utilization of services, Mercer relied upon CY 2024 reimbursement rates provided by DHCS for certain services, where available, supplemented by aggregate Medi-Cal managed care unit cost data (for applicable procedure codes). Using these various unit costs and the expected new utilization of services, Mercer determined a fully ramped-up prospective impact of the dyadic services program change for CY 2024 Ultimately, an adjustment was applied for the following five COA groups: Child, Adult, ACA Expansion, SPD, and WCM.

This adjustment was only applied to the SIS capitation rates. No impact was assumed for the UIS rates since these services are considered state only.

## Long-Term Care Fee-For-Service Equivalent Directed Payment Adjustment

Effective January 1, 2023 for SNF services, and effective January 1, 2024 for ICF-DD and SA services, DHCS is implementing a delivery system reform State directed payment under 42 CFR § 438.6(c) for the facility per diem reimbursement of LTC services. All Plan Letter (APL) 23-004 provides further detail regarding these requirements, in accordance with Welfare and Institutions Code § 14184.201(b) and (c). Health plans that operate in non-COHS and non-CCI counties are required to reimburse network LTC providers at, and those providers are required to accept, the payment rate that would otherwise have been paid in the FFS delivery system (e.g., Medi-Cal FFS per diem rate). This requirement applies to all LTC services, both for services transitioning from FFS and all LTC services previously covered by the health plans in these counties.

LTC data used for rate development in non-COHS and non-CCI counties comes from two sources: RDT data and FFS claims. The RDT data for these MCOs reflect the LTC services historically covered in managed care in these counties, which are short-term stays and the beginning portion of long-term stays (i.e., the month of entry plus the subsequent month); the FFS claims represent all transitioning populations and services, the large majority of LTC services in these counties. Given the FFS claims data was already representative of Medi-Cal FFS per diem rates, no additional adjustment for the State directed payment was required for this portion of the rate development data. However, through RDT discussion guide conversations with the MCOs, along with other data analysis and benchmarks (e.g., FFS per diem rates, other MCO reporting, etc.), it was determined many of the MCOs were paying at levels higher than FFS per diem rates for the LTC experience already covered in

managed care. As such, Mercer developed adjustments to reduce the RDT-reported LTC unit costs for certain health plans to reflect the FFS equivalent levels for the base period. This adjustment was applied as a program change to the managed care portion of LTC experience for the Child, Adult, ACA Expansion, and SPD COA groups.

It is notable, within the APL listed above, as part of the delivery system reform State directed payment, requirements were also set forth by DHCS within COHS and CCI counties that MCOs are required to pay a minimum of the Medi-Cal FFS per diem rate, rather than exactly the FFS per diem rate. RDT discussion guide conversations with these MCOs revealed none of them were paying under 100% of the FFS rates. As such, Mercer did not apply any adjustments to the LTC portion of the rates within COHS and CCI counties for this consideration[5].

## Populations Transitioning from Fee-for-Service to Managed Care

Certain Medi-Cal populations within the FFS delivery system, including some designated by the CalAIM initiative, transitioned to managed care in CY 2022 or after.

The populations that transitioned from FFS to managed care on January 1, 2022, designated as part of CalAIM — Phase I, are as follows:

1. TCVAP, excluding the share of cost population
2. AE
3. CHDPI
4. Pregnancy-related Medi-Cal
5. BCCTP
6. Beneficiaries with Other Healthcare Coverage (OHC)
7. Beneficiaries in rural zip codes (Rural)

For pregnancy-related Medi-Cal members, only newly enrolled members enrolled in managed care on January 1, 2022 or later, and members who were already in FFS prior to this did not transition.

The populations that transitioned from FFS to managed care on January 1, 2023, specifically in regions that were GMC, Regional, Single-Plan, and Two-Plan counties in the base period, are as follows:

1. Full-Dual beneficiaries
2. Populations previously subject to managed care, but not transitioned prior to CalAIM
3. Beneficiaries residing in an LTC facility
4. Partial Dual Beneficiaries

[5] https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-004.pdf

The populations transitioning from FFS to managed care on January 1, 2024, specifically in regions that are GMC, Regional, Single-Plan, and Two-Plan counties are as follows:

1. ICF-DD and SA LTC Populations
2. Foster Care Mandatory Transition for new COHS and Single-Plan counties
    A. San Benito Mandatory Managed Care Transition

The capitation rate impacts of each of the populations were developed as follows.

### General Methodology

For these populations, both expected membership volume and costs were considered in the calculation of the program change adjustment.

Members and their associated claims were identified in both the SFY 2021–2022 FFS data and emerging managed care encounter data for any transitions that occurred in CY 2022.

1. For FFS data, once the appropriate members and claims were identified, the following adjustments were made to make FFS claims more appropriate for these analyses:
    A. Repriced FQHC FFS units to managed care costs, which do not reflect wrap-around payments made by DHCS.
    B. Excluded claims for services that would not be covered by Managed Care plans.
    C. Excluded delivery claims for the Child, Adult, ACA Expansion, and WCM COAs.
2. Emerging managed care encounter data was utilized to inform the rate adjustments for all population transitions with an effective date of January 1, 2022. Emerging membership was utilized to inform membership impact for populations transitioning in CY 2022 and CY 2023.

For beneficiaries with an applicable LTC aid code the claims and enrollment associated with these beneficiaries was produced as its own set of base data for its own specific rate cell, described previously in the Data section. Further, the claims and enrollment for members in FFS in San Benito County that will be mandatorily enrolled in managed care was based on FFS claims and enrollment. This data from FFS claims and enrollment supplemented the managed care data for members already in managed care within this county.

The following populations were evaluated separately, but combined and applied as an aggregate rate adjustment, referred to as Populations Transitioning from FFS to Managed Care (CalAIM — Phase I).

1. TCVAP, excluding the share of cost population
2. AE
3. CHDPI
4. Pregnancy-related Medi-Cal
5. BCCTP

The following populations were developed and applied as separate programmatic change adjustments:

1. Beneficiaries with OHC
2. Rural
3. Partial Duals
4. Full-Duals
5. Populations previously subject to managed care, but not transitioned
6. Beneficiaries residing in an LTC facility, but in non-LTC COAs
7. ICF-DD and SA LTC Populations
8. Foster Care Mandatory Transition for new COHS and Single-Plan region/counties

The following populations were developed and applied as adjustments in the CY 2024 base data development, described previously in the Base Data section.

1. Beneficiaries with an applicable LTC aid code
2. San Benito Mandatory Managed Care Transition

The resulting relativity factors for all transitioning populations listed in this subsection titled "Populations Transitioning from Fee-for-Service to managed Care" were ultimately aggregated across all transitioning populations. This was done by region/county, COA, and COS for both the SIS and UIS populations separately.

More details for the rate adjustments pertaining to the above populations are provided below.

### Populations Transitioning from Fee-For-Service to Managed Care (CalAIM — Phase I)

As part of this aggregate adjustment, the identified FFS data and Managed Care Data for each population was analyzed to project the expected PMPM cost profile of this population compared to the appropriate managed care population. In this review, expected managed care cost levels were assumed in combination with projected utilization informed by both data sources. From this analysis, PMPM relativity factors were developed for the transitioning populations compared to the base population already in managed care.

The assumed projected Membership impact by Model and COA are below.

For SIS members, the membership volume impact of the members transitioning into managed care for each relevant COA are shown in the table below.

| COA | COHS | Two-Plan, GMC, Regional |
|---|---|---|
| Child | 0.1% | 0.1% |
| Adult | 0.2% | 0.2% |
| SPD | 0.0% | 0.1% |

For UIS members, the membership volume impact of the members transitioning into managed care for each relevant COA are shown in the table below.

| COA | COHS | Two-Plan, GMC, Regional |
|---|---|---|
| Child | 0.9% | 14.2% |
| Adult | 0.3% | 0.5% |
| SPD | 0.0% | 0.4% |

The PMPM relativity factors for each population were weighted by the membership volume for each population (at the region/county level) and aggregated to develop rate adjustments for this transition. The descriptions of the population aggregated into this rate adjustment are as listed below.

### Trafficking and Crime Victims Assistance Program

The TCVAP provides eligible non-citizen victims of human trafficking, domestic violence, and other serious crimes services such as cash assistance, food, employment, and social services. This population was identified to be in the Child and Adult COAs.

### Accelerated Enrollment

The AE population refers to the Medi-Cal population where enrollment is expedited as acceptance into Medi-Cal is deemed likely. This population was identified to be in the Child and Adult COAs.

### Child Health and Disability Prevention Infant Deeming

The CHDPI program is a preventive program which delivers periodic health assessments and services to low-income children and youth in California. This population was identified to be in the Child COA.

### Pregnancy-related Medi-Cal

The pregnancy-related Medi-Cal population refers to the Medi-Cal members whose income is within 138%–213% of the Federal poverty level. As mentioned before, members who are currently in FFS in this population prior to January 2022 will remain in that delivery system. Only new pregnancy-related Medi-Cal members were enrolled in managed care starting January 1, 2022. This population was identified to be in the Child and Adult COAs in all model types.

### Breast and Cervical Cancer Treatment Program

The BCCTP provides urgently needed cancer treatment coverage to individuals diagnosed with breast and/or cervical cancer. This population moved into the SPD COA group.

### Beneficiaries with Other Healthcare Coverage

Beneficiaries with OHC are FFS members who were previously blocked from entering into managed care because of their OHC status. This population was identified to be in the Child, Adult, ACA Expansion, SPD, and WCM COAs.

For SIS members, the membership volume impact of the members transitioning into managed care for each relevant COA are shown in the table below.

| COA | COHS | Two-Plan, GMC, Regional |
|---|---|---|
| Child | 0.1% | 0.4% |
| Adult | 0.3% | 0.7% |
| ACA Expansion | 0.1% | 0.5% |
| SPD | 0.3% | 1.2% |
| **WCM** | 0.0% | N/A |

For UIS members, the membership volume impact of the members transitioning into managed care for each relevant COA are shown in the table below.

| COA | COHS | Two-Plan, GMC, Regional |
|---|---|---|
| Child | 0.3% | 0.3% |
| Adult | 1.9% | 1.6% |
| ACA Expansion | 0.0% | 0.2% |
| SPD | 0.0% | 0.1% |
| **WCM** | 0.0% | N/A |

Using the aforementioned methodology, Mercer analyzed the identified FFS population data and emerging Managed Care encounters related to this population and developed PMPM relativity impacts by model and COA.

### Beneficiaries in Rural Zip Codes

This population consists of FFS beneficiaries in rural zip codes who have been previously blocked from entering into managed care because of their zip code. These members transitioned into the managed care delivery systems in the Inland Empire, Kern, and Los Angeles regions. This population can fall into any COA group within the Two-Plan model.

In LA County, the volume of the members transitioning into managed care regardless of immigration status is expected to be very small, and as a result, no rate impact was assumed.

For SIS members, in Kern and Inland Empire regions, the membership volume impacts for each county compared to the base managed care population are shown in the table below.

| COA | Kern | Inland Empire |
|---|---|---|
| Child | 1.7% | 1.3% |
| Adult | 1.9% | 1.7% |
| ACA Expansion | 2.0% | 1.8% |
| SPD | 2.1% | 1.7% |

For UIS members, in Kern and Inland Empire regions, the membership volume impacts for each county compared to the base managed care population are shown in the table below.

| COA | Kern | Inland Empire |
|---|---|---|
| Child | 0.7% | 0.6% |
| Adult | 0.9% | 1.3% |
| ACA Expansion | 0.8% | 0.8% |
| SPD | 0.6% | 0.5% |

Using the aforementioned methodology, Mercer analyzed the identified FFS population data and emerging Managed Care encounters related to this population and developed PMPM relativity impacts by model and COA.

### Partial Duals Transitioning from Fee-For-Service to Managed Care (CalAIM — Phase I)

This population consists of FFS beneficiaries with either Medicare Part A or Medicare Part B in regions that were previously GMC, Regional, Single-Plan, and Two-Plan counties prior to CY 2024. This population transitioned from voluntary managed care status to mandatory managed care status on January 1, 2023. The identified population found in the SFY 2021–2022 FFS data was primarily impactful to the SPD COA.

The membership volume impact, in aggregate, for GMC, Regional, Single-Plan, and Two-Plan counties in the base period was 2.9% to the SIS population and 0.8% to the UIS population. For this population, the associated FFS data was used to derive the assumed utilization and PMPMs by county across all services. Additionally, an adjustment was made to recognize the MCOs' obligation to provide UM/QA/CC services, which inherently does not exist within the FFS data utilized. Existing managed care enrollment distributions by region/county and COA were then used to determine an appropriate mix of transitioning members per region/county and COA group.

Mercer developed utilization and PMPM relativities by county/region, COA, and COS. For the SIS population, relativities were developed using a blend of county/region specific and model average data, with varying weights applied to each based on transitioning SIS population size in each county/region and COA. For the UIS population, relativities were developed using a blend of county/region specific and corresponding SIS county/region specific relativities with varying weights applied to each county/region and COA.

Existing managed care enrollment distributions by county/region and COA were then used to determine an appropriate mix of transitioning members within any specific rating county/region and COA group.

The adjustment pertaining to this population is shown separately in the program change documentation provided within the attached capitation rate documentation.

### Full-Duals Transitioning from Fee-For-Service to Managed Care (CalAIM — Phase II)

This population consists of FFS beneficiaries with both Medicare Part A and Medicare Part B coverage in GMC, Regional, Single-Plan, and Two-Plan counties. This population

transitioned from voluntary managed care status to mandatory managed care status on January 1, 2023. The identified population found in the SFY 2021–2022 FFS data was primarily impactful to the Adult and SPD Full-Dual COA.

The membership volume impact, in aggregate, for Single-Plan, Two-Plan, GMC, and Regional models in the base period as follows:

| COA | SIS | UIS |
|---|---|---|
| Adult | 0.3% | 0.0% |
| SPD/Full-Dual | 21.5% | 12.3% |

There were larger percentage impacts in non-CCI counties and smaller percentage impacts in CCI counties. In the development of the assumed cost profiles for this population across all services, FFS data for the Full-Dual transitioning population was utilized to set utilization and PMPMs for each county/region.

For the SIS and UIS population, the identified FFS population data was reviewed for reasonability and directly utilized to set utilization and unit cost profiles by county and COS. Two main adjustments were made to this data in the development of the data attributable to this transitioning population:

1. An increase to the All Other COS was applied to recognize the MCO's obligation to provide UM/QA/CC services for these members, which inherently does not exist in the FFS claims data.
2. Adjusting the Behavioral Health Treatment (BHT) COS to reflect managed care levels of utilization and unit cost by county. BHT services for FFS members are reported via a separate claims system and are not present in the FFS claims data utilized for this adjustment. Thus, an adjustment for the BHT COS was developed by utilizing existing BHT Managed Care Costs and existing FFS age distributions.

Mercer developed utilization and PMPM relativities by county/region, COA, and COS. For the SIS population, relativities were developed using a blend of county/region specific and model average data, with varying weights applied to each based on transitioning SIS population size in each county/region and COA. For the UIS population, relativities were developed using a blend of county/region specific and corresponding SIS county/region specific relativities with varying weights applied to each county/region and COA.

Existing managed care enrollment distributions by county/region and COA were then used to determine an appropriate mix of transitioning members within any specific rating region and COA group. The adjustment pertaining to this population is shown separately in the program change documentation provided within the attached capitation rate documentation.

### Members Transitioning from Fee-For-Service to Managed Care Who Were Previously Subject to Managed Care Transition (CalAIM — Phase II)

This population consists of FFS beneficiaries who were enrolled in aid codes that should have been in managed care, but were not in managed care for various operational reasons in county/regions that were previously GMC, Regional, Single-Plan, and Two-Plan counties

prior to CY 2024. This population transitioned to mandatory managed care status on January 1, 2023.

The Statewide All COA membership volume impact for this population was approximately 1.3% and 1.0% across both the SIS and UIS populations respectively.

Within the development of the PMPM cost profile for this transitioning population, FFS claims were analyzed for these members. However, it should be noted, some of these beneficiaries will remain in FFS even after the transition. For example, some members can opt out of managed care if they have a medical exemption to do so. Within the FFS claims analyzed for this broader population, members with a medical exemption could not be separately identified, which likely skewed the PMPMs seen in the FFS data. Additionally, newly enrolled Medi-Cal beneficiaries will remain in the FFS delivery system until they are either eligible for managed care or choose a managed care health plan. Therefore, there will always inherently be FFS member months for members with a mandatory managed care enrollment status. While logic was refined to exclude these first months of enrollment for newly enrolled beneficiaries, it is still likely some member months that should stay FFS were included within the data. Based on the challenges associated with the data for this population, the transitioning beneficiaries were assumed to have a PMPM relativity factor of 1.0 compared to the base population already within managed care.

Existing managed care enrollment distributions by region/county and COA were then used to determine an appropriate mix of transitioning members within any specific rating region/county and COA group. The adjustment pertaining to this population is shown separately in the program change documentation provided within the attached capitation rate documentation.

### Beneficiaries with an Applicable Long-Term Care Aid Code

As mentioned previously, beneficiaries with one of the four LTC aid codes (13, 23, 53, or 63) transitioned into Medi-Cal managed care effective January 1, 2023 (along with members without an LTC aid code). Beneficiaries with an LTC aid code will be classified within the LTC and LTC/Full-Dual COAs for rate setting and capitation payment purposes. As a result, there is no program change adjustment specific for this population. Rather, this population's base data was SFY 2021–2022 FFS data, as described in the Data section of this certification. Additional rate setting assumptions such as trend, program changes, and non-medical loads apply to this population on its own, since this population has its own applicable rate cells.

### Long-Term Care Utilizers in Non-Long-Term Care Aid Codes (CalAIM — Phase II)

The LTC utilizers in non-LTC COA population consists of members in FFS who reside in an institutional setting, as identified via accommodation codes, which do not have one of the four Medi-Cal LTC aid codes (13, 23, 53, or 63). During the based period in GMC, Regional, Single-Plan, and Two-Plan non-CCI counties, MCOs would disenroll members to FFS that become institutionalized and had a length of stay of at least one full month plus the month of admission, consistent with the prior DHCS policy of excluding these members from managed care in these counties. Starting January 1, 2023, these beneficiaries who reside in an LTC facility have become a managed care covered population statewide (aside from ICF-DD and SA populations described in the next section). Further, DHCS pays capitation rates for these beneficiaries based on their aid code. As such, these LTC utilizers in non-LTC COA groups

will transition to managed care and merge with the existing Child, Adult, ACA Expansion, SPD, and SPD/Full-Dual COA groups for CY 2024.

The SFY 2020–2021 data used to inform the program change adjustment for this population was FFS data specific to this population. This data was reviewed for reasonableness for rate-setting on a county-wide basis by COA, COS, and split by SIS and UIS populations. This data was then adjusted with the following two items:

1. Since the data was separated by COA, there were inherently differing unit cost levels within the same county for different COAs. In review of the data, it was noted, IP unit costs were drastically different for some COAs within the same county in some instances. This was not unexpected given some of the populations can be relatively small. To address the IP unit cost inconsistencies across COA, IP dollars were shifted among non-dual COA groups in a budget neutral manner so that the resulting IP unit costs were consistent for each COA.

2. An increase to the All Other COS was applied to recognize the MCO's obligation to provide UM/QA/CC services for these members, which inherently did not exist in the FFS claims data.

For the SIS population, Mercer then calculated relativity factors by COA and COS (for utilization per 1,000, unit cost, and PMPM statistics) by comparing the transitioning group of LTC utilizers in non-LTC COA groups to the initial base data.

For the UIS population, there was a low volume of transitioning UIS members related to these populations; to account for this non-credible volume, Mercer utilized statewide average utilization per 1,000, unit cost, and PMPM statistics from the SIS transitioning data to form credible cost profiles. These statewide averages were done separately for all non-dual (Child, Adult, ACA Expansion, SPD, and LTC) and Full-Dual (SPD/Full-Dual and LTC/Full-Dual) COA groups. These aggregate cost profiles were then used in conjunction with county and COA specific UIS transitioning member months to determine the rate adjustments for the UIS rate cells.

The adjustment pertaining to this population is shown separately in the program change documentation provided within the attached capitation rate documentation.

### Intermediate Care Facilities–Developmentally Disabled and Subacute Long-Term Care Populations (CalAIM — Phase II)

The ICF-DD and SA populations consist of members in FFS who reside in either type of these two institutional settings, as identified via accommodation codes. ICF-DD members were carved out of managed care in all GMC, Regional, Single-Plan, and Two-Plan counties during the base period, while SA beneficiaries were carved out of managed care in only GMC, Regional, Single-Plan, and Two-Plan non-CCI counties. As such, historically MCOs would disenroll these members to FFS that become institutionalized in these settings and had a length of stay of at least one full month plus the month of admission. Starting January 1, 2024, ICF-DD and SA beneficiaries will transition to mandatory managed care in all counties in which they were carved out. These ICF-DD and SA groups will merge with the existing Child, Adult, ACA Expansion, SPD, SPD/Full-Dual, LTC, and LTC/Full-Dual COA groups for CY 2024 rates upon the transition to managed care.

The SFY 2020–2021 data used to inform the program change adjustment for this population was FFS data specific to this population. This data was reviewed for reasonableness for rate-setting on a county-wide basis by COA, COS, and split by SIS and UIS populations. This data was then adjusted with the following two items:

1. A budget neutral adjustment to IP costs between COA groups within a county was applied to achieve reasonable and appropriate IP unit cost levels for every COA group, similar to the adjustment notes for the prior item.
2. An increase to the All Other COS for all non-LTC COA groups was applied to recognize the MCO's obligation to provide UM/QA/CC services for these members, which inherently did not exist in the FFS claims data.

Due to the low volume of transitioning members related to these populations, Mercer utilized statewide average utilization per 1,000, unit cost, and PMPM statistics from the transitioning data to form credible cost profiles. These statewide averages were done separately for all non-dual (Child, Adult, ACA Expansion, SPD, and LTC) and Full-Dual (SPD/Full-Dual and LTC/Full-Dual) COA groups, as well as separately for ICF-DD and SA members. These aggregate cost profiles were then used in conjunction with region and COA specific ICF-DD and SA transitioning member months to create a single blended cost profile for each region and COA for use when adjusting the CY 2024 rates for these populations.

The adjustment pertaining to this population is shown separately in the program change documentation provided within the attached capitation rate documentation.

### Foster Care Mandatory Managed Care Transition in New County Organized Health Systems and Single-Plan Region/Counties

This population consists of FFS beneficiaries with a Foster Care aid code in new COHS and Single-Plan counties. This population is currently voluntary managed care and will transition into the managed care delivery systems in the Alameda, Contra Costa, San Benito, Imperial, Rural Upper Central (RUC), and Central California regions. This population can fall into the Child and Adult COAs.

For SIS members, in the aforementioned regions, the membership volume impacts for each county/region compared to the base managed care population are shown in the table below.

| Region/County | Child COA | Adult COA |
|---|---|---|
| Alameda | 1.4% | 1.4% |
| Contra Costa | 1.5% | 0.7% |
| San Benito | 2.0% | 0.9% |
| Imperial | 1.5% | 0.5% |
| RUC | 2.5% | 0.9% |
| Central California | 0.0% | 0.0% |

For UIS members, in the aforementioned regions, the membership volume impacts for each county/region compared to the base managed care population are shown in the table below.

| Region/County | Child COA | Adult COA |
|---|---|---|
| Alameda | 0.5% | 0.6% |
| Contra Costa | 0.4% | 0.2% |
| San Benito | 0.6% | 1.2% |
| Imperial | 3.0% | 0.3% |
| RUC | 0.5% | 0.3% |
| Central California | 0.0% | 0.0% |

Using the aforementioned methodology, Mercer analyzed the identified FFS population data and developed PMPM relativity impacts for each county/region by COA.

### San Benito Mandatory Managed Care Transition

As noted previously, FFS members in San Benito will be transitioned into Medi-Cal managed care effective January 1, 2024. As this county currently has a significant number of members in FFS, this population's SFY 2021–2022 data was combined with existing managed care data to develop this county's base data, as described in the Data section of this certification. Additional rate setting assumptions such as trend, program changes, and non-medical loads apply to this population on its own, since this population has its own applicable rate cells.

## Unsatisfactory Immigration Status Population Ages 50 and Older

Effective May 1, 2022, the State transitioned Medi-Cal members ages 50 and older to full-scope Medi-Cal and moved them into managed care, regardless of the member's immigration status. Adjustments were applied to UIS rates for the Adult, ACA Expansion, SPD, SPD/Full-Dual, and LTC COAs. No adjustments were applied to SIS rates for this transitioning population.

The UIS membership volume impacts for each model and COA compared to the corresponding SFY 2021–2022 managed care UIS population are shown in the table below.

| COA | COHS | GMC, Regional, Single-Plan, and Two-Plan |
|---|---|---|
| Adult | 42.8% | 34.7% |
| ACA Expansion | 56.0% | 67.6% |
| SPD | 100.5% | 138.1% |
| **SPD/Full-Dual** | 57.6% | 51.8% |
| **LTC** | 18.9% | 31.6% |

Prior to May 1, 2022, this population was enrolled in the FFS delivery system and only eligible for restricted scope services, namely pregnancy-related and emergency services. In developing the cost profile for this population, managed care encounter data from May 2022 through December 2022 was the main data source. In pulling data for the transitioning population, encounter data and associated member months were split between existing

managed care members as of April 2022 and new members to managed care effective May 2022, when the transition took place.

Using data specific to the new members in managed care effective May 2022, Mercer developed PMPM relativities by county/region, COA, and COS. Relativities were developed using a blend of county/region specific and model average data, with varying weights applied to each, based on transitioning UIS population size in each county/region and COA. These PMPM relativities were then used in combination with the expected increase in managed care enrollment by county/region and COA to derive the program change adjustment applied for this transitioning population.

The adjustment pertaining to this population is shown separately in the program change documentation provided within the attached capitation rate documentation.

## Unsatisfactory Immigration Status Population Ages 26 to 49

Effective January 1, 2024, the State will transition Medi-Cal members ages 26 to 49 to full-scope Medi-Cal and move them into managed care, regardless of the member's immigration status. Adjustments were applied to UIS rates for the Adult, ACA Expansion, and SPD COAs. No adjustments were applied to SIS rates for this transitioning population.

The UIS membership volume impacts for each model and COA compared to the corresponding SFY 2021–2022 managed care UIS population (prior to the inclusion of the full undocumented aged 50 and older population) are shown in the table below.

| COA | COHS | GMC, Regional, Single-Plan, and Two-Plan |
|---|---|---|
| Adult | 274.1% | 254.5% |
| ACA Expansion | 90.6% | 88.8% |
| SPD | 2.0% | 4.9% |

Prior to January 1, 2024, this population is enrolled in the FFS delivery system and only eligible for restricted scope services, namely pregnancy and emergency related services. As this population is restricted scope, Mercer pulled multiple data points to understand the potential cost profile of this population.

1. SFY 2021–2022 managed care encounter data was reviewed for the ages 26 to 49 population currently in managed care compared to encounter data for the total UIS population in managed care by COA group.

2. SFY 2021–2022 FFS data for the actual population transitioning was also reviewed. However, since this population was restricted scope in SFY 2021–2022, the comparison to managed care encounter data for the base population by COA was done only for the IP Hospital and ER services categories. This is because restricted scope eligibility means members are only eligible for emergency and pregnancy-related services. These two service categories provide for a more apples to apples comparison.

Using the two data sources described above, Mercer developed PMPM relativities by COA and by county/region. Relativities were developed using a blend of county/region specific and

model average data, with varying weights applied to each based on transitioning UIS population size in each county/region and COA. These PMPMs were then used in combination with the expected increase in managed care enrollment by county/region and COA to derive the program change adjustment applied for this transitioning population.

The adjustment pertaining to this population is shown separately in the program change documentation provided within the attached capitation rate documentation.

## Long-Term Care Rate Changes

As noted in the Trend subsection, unit cost trend factors were not developed for the LTC COS. In lieu of a trend adjustment, rate increases for LTC services are handled through a program change adjustment and are based on legislatively mandated annual FFS rate increases. Effective January 1, 2023, DHCS implemented a delivery system reform State directed payment under 42 CFR § 438.6(c) for the facility per diem reimbursement of LTC services. As noted previously, the LTC data utilized in rate development for non-COHS and non-CCI counties was adjusted to reflect these State directed payments, reflecting the FFS equivalent in the base period. The FFS rate increases adjust these payment levels to reflect the FFS equivalent in the prospective rating period. In general, managed care payment levels in non-transitioning counties 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, FFS rate increases for all LTC facilities typically occurred August 1 of each year. Beginning CY 2021, rate increases for AB 1629 LTC facilities occur January 1 of each year, while rate increases for non-AB 1629 LTC facilities continue to occur on August 1 of each year. The LTC rate increase factors are developed separately for each county (or rating region) within the COHS, GMC, Regional, Single-Plan, and Two-Plan 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.

## 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 October 1 of each year, and the rate increases for Hospice room and board that occur on August 1 of each year. To calculate the adjustment factor applied in the capitation rates, the rate increases for Hospice services are weighted with the rate increases for Hospice room and board. One adjustment factor is developed at a statewide level across all populations.

## Transitional Care Services

Effective January 1, 2023, Transitional Care Services (TCS) were required for the following populations: IP discharges as a result of pregnancy, discharges for Children with Special

Health Care Needs, and discharges for members in the Specialty MH and Drug Medi-Cal programs. These members were all considered high-risk for purposes of TCS.

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

For the CY 2024 rating period, PMPM adjustments were made at a county/region level for all TCS services with an assumed 18% ramp-up period as part of the program change adjustment. CY 2021 and CY 2022 managed care encounter data was averaged to develop estimated totals for CY 2023 and CY 2024 TCS population groups. An average number of service hours per discharge was then developed for each low-risk and high-risk discharge. Ultimately, an average of 3.5 service hours per discharge was assumed for high-risk members and an average of 1.07 hours for low-risk members. The staffing model produced for ECM was leveraged for TCS services, and a weighted staffing cost was developed assuming 15% licensed and 85% unlicensed staff for low-risk members, and 70% licensed and 30% unlicensed staff for high-risk members.

## Medi-Cal Targeted Provider Rate Increases

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

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

- Physicians
- Physician Assistants
- Nurse Practitioners
- Podiatrists
- Certified Nurse Midwife
- Licensed Midwives
- Doula Providers
- Psychologists
- Licensed Professional Clinical Counselor
- Licensed Clinical Social Worker
- Marriage and Family Therapist

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

The development of the rate impact for this policy change is as listed below.

### Identification of Applicable Data

Utilizing SFY 2021–2022 encounter data as well as SFY 2021–2022 FFS data utilized for the base data development of beneficiaries in an applicable LTC aid code and the San Benito Mandatory Managed Care transition, detailed claim lines with the applicable procedure codes are used for the basis of this adjustment. For the select primary care services, the data was limited to the applicable providers subject to the directed payment, as noted above.

### General Repricing Methodology

Adjustments were developed by region/county and COA and separated for SIS and UIS beneficiaries.

For the following types of claims, different repricing methodologies are utilized to adjust for this policy change.

#### Non-Dual or Part A Only Non-Capitated Claims

For these claims, the targeted rate increase for each claim detail line was assumed to be the difference between the targeted rate and the current managed care payment level per each detailed claim line. Since the intent of the minimum directed payment is to only increase the payment to providers, if the identified unit cost on the claim is more than the targeted rate, then no additional increase is adjusted in the rate.

For codes subject to the Prop 56 physician supplemental payment, the minimum targeted rate increase is always set to the historical supplemental amounts.

The targeted rate developed by the State is further adjusted for the following:

- Reduction of the targeted rate by 20% for professional services performed at a facility
- Increase of the targeted rate by 39.7% for physician CCS claims for WCM members

Current managed care payment levels are calculated as the unit cost on each detailed claim line with the following adjustments:

- Increasing the unit cost on the claim to account for the AB 97 Buyback program change
- Trending the unit cost on the claim to bring costs to proxy the cost of these claims in CY 2024

For claims associated with a delivery event impacted by this policy, the increase is accounted for in the maternity supplemental payment.

#### Non-Dual or Part A Only Capitated Claims and Federally Qualified Health Centers Claims

For these claims, the targeted rate increase for each claim detail line is the greater of the following two amounts:

- The Targeted Rate Increase assuming the same regional average per procedure code developed for the non-dual or Part A only non-capitated claims
- The Targeted Rate increase assuming that each claim detailed line is equivalent to 130% of the Medi-Cal Fee Schedule

This approach is applied to non-dual or Part A Only capitated claims as these claims do not have a reported paid amount on the claim.

For codes subject to the Prop 56 physician supplemental payment, the minimum targeted rate increase is always set to the historical supplemental amounts.

For applicable services performed at an FQHC facility, these facilities are not a technical part of the policy but are applied an average increase since plans must pay no less than what is paid to other providers to remain in compliance with federal regulations.

For claims associated with a delivery event impacted by this policy, the increase is accounted for in the maternity supplemental payment.

#### Full-Dual or Part B Only Claims

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

For claims with codes that are not eligible for Medicare reimbursement, the targeted rate increase is assumed to follow the same methodology as the non-dual or Part A Only non-capitated claims.

Additional utilization is also projected for this population since the new targeted rate cannot be less than 87.5% of the lowest Medicare Region. For this reason, the increase is assumed to induce additional billing to MCOs of services rendered for this population. For the SPD and LTC COAs, the utilization is projected using the difference in Part B Only and Non-Part B Only utilization. For the Adult COA, the utilization is projected using the difference in Full-Dual Only and Non-Full Dual utilization. For SPD/Full-Dual and LTC/Full-Dual, the utilization is projected using the difference in the SPD and LTC utilization respectively — after these COAs have been adjusted for Part B Only utilization. This program change will be referenced as TRI (targeted rate increase) through the remainder of this document.

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

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

### Major Organ Transplants

CY 2024 capitation rates include PMPM add-ons to reflect the impact of MOT becoming a managed care covered benefit effective January 1, 2022, in GMC, Regional, Single-Plan and Two-Plan counties. MOTs were already a covered benefit within the COHS model. Add-on

rates were developed for the following transplant types: bone marrow, liver, heart, lung, intestine, and pancreas. Kidney and cornea transplants are already covered in all managed care models.

For the PMPM add-on development, Mercer reviewed historical CY 2021 FFS and CY 2022 managed care encounter data and identified individuals who received an MOT by each transplant type listed above through All Patients Refined Diagnosis Related Groups and/or surgical codes. Mercer then reviewed eligibility to establish, by individual, the pre- and post-transplant periods. In the CY 2021 FFS data, the pre-transplant period was identified when an individual disenrolled from an MCO to FFS prior to an MOT surgery event. The post-transplant period was identified as the period where, after an MOT surgery, the average number of months before an individual re-enrolled into an MCO. Costs for the transplant event itself were reviewed and defined as costs incurred during the IP stay of the transplant surgery. Average costs for these transplant periods (pre, event, and post) were then converted to per utilizer per month figures.

Except in WCM counties, individuals enrolled in the CCS program will continue to have their transplant costs covered through FFS when the transplant is related to their CCS-eligible condition, which is nearly always anticipated to be the case. As such, Mercer excluded their historical costs from the base data.

Mercer reviewed and identified outliers in the CY 2021 FFS and CY 2022 managed care data and adjusted unit cost pricing to account for outliers. Mercer also applied unit cost pricing adjustments to the CY 2021 FFS data to account for the shift in coverage from the FFS delivery system to managed care in GMC, Regional, Single-Plan and Two-Plan model counties.

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

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

Adjusted base period unit costs and utilization per 1,000 statistics were trended from the midpoint of the base period (January 1, 2022) to the midpoint of the contract period (July 1, 2024) for a total duration of 30 months. Further, county-specific historical prevalence of transplant events was reviewed to develop PMPM add-ons that vary by county/region. Annual trends by service category are consistent with lower bound trends used for the broader rates. Add-on rates reflect a full administration load consistent with lower bound assumptions used for the broader capitation rates. The fully loaded rates have an impact of approximately $266 million for the CY 2024 rating period, limited to the SIS population only. MOT encounter data for UIS and SIS members were separated for CY 2024 rate development and MOT capitation rates are calculated separately for both populations. MOT

for UIS beneficiaries is applicable to the state only UIS capitation rates and therefore not part of this certification.

## Enhanced Care Management

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

The impact of the program to the CY 2024 capitation rates was developed at a statewide level, with county/region-specific adjustments, to derive health plan and county/region specific PMPM add-ons to the capitation rates. Without limited prior claims experience, the development of this adjustment focuses on the needs of the ECM-eligible population — specifically who meets the criteria and the assumed amount of care management utilized.

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

The ECM rate setting development continued to use a caseload and provider hour breakdown for varying severity levels of ECM members. At a statewide level, the hours spent by Care Managers (CM) and CHW at varying severity levels, the distribution of these severity levels over the course of the rating period, as well as the distinction between the ECM rate development groups were reviewed as part of the process.

Continuing for CY 2024 ECM rates, in order to account for the multiple start dates for various ECM groups and counties, caseload assumptions were modified to be based on the length of time an individual is enrolled in ECM (1–6 months, 7–12 months, and greater than one year). This methodology allowed for more flexibility with population changes and provided the ability to reflect caseload assumptions more appropriately as the ECM program ramps up.

Layering onto the caseload assumptions related to the CM and CHW positions, fully loaded employee cost assumptions including salary and bonus pay, benefits, and Federal/State employer taxes were taken into account. Similar to the rate development for HHP, the rate impact calculation then incorporates a provider overhead assumption of 20% which includes provider costs in addition to ECM staff members such as facility costs, hardware/software, transportation costs associated with care management services, management staff, general administration, information technology, and human resource function costs. The rate development includes costs associated with ECM provider outreach efforts to ECM-eligible individuals prior to enrollment in the program.

Since the base per enrollee per month (PEPM) was developed using SFY 2021–2022 salary information, 30 months of 5.0% annual provider cost trend was applied to bring the base data to the CY 2024 contract period.

#### County-specific Adjustments for Per Enrollee Per Month and Outreach

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

1. County Wage Adjustment (applied to unit cost) — an adjustment was applied to factor in wage differences for ECM providers between counties/regions in California.
2. County Rural Adjustment (applied to utilization) — similar to HHP, a 25% upward adjustment factor was applied to account for the additional service hours required to serve ECM enrollees residing in a rural setting.
3. Overlapping CM Program Adjustments — an important responsibility of ECM providers is to ensure there are not duplication of services with other CM programs. As such, the ECM rates contain offset adjustments for the portion of the projected population enrolled in multiple CM programs.
    A. Medicare Part B Dual Enrollees — this adjustment accounts for Part B eligible ECM enrollees who are eligible for CMS' Chronic Care Management (CCM), Behavioral Health Integration (BHI), or Medicare Advantage CM programs. ECM providers are expected to collaborate with the member's physician in order to pursue the appropriate CCM and BHI payments from CMS for their ECM enrollees with Part B coverage. Additionally, National Committee for Quality Assurance-accredited Medicare Advantage Plans have CM requirements similar to some ECM services. As CMS will be covering ECM-like services through the CCM, BHI, and Medicare Advantage Plans programs, a portion of the CMs service hours (utilization) were reduced. The result is a downward rate adjustment to the SPD, SPD/Full-Dual, LTC, and LTC/Full-Dual COAs to account for the overlap in services rendered.
    B. County-run Targeted Case Management (TCM) Services Adjustment (applied to utilization) — this adjustment accounts for the overlap between TCM and ECM services for ECM enrollees enrolled in both programs.
    C. Short Doyle TCM Services Adjustment (applied to utilization) — this adjustment accounts for the overlap between the county-run Short Doyle MH TCM program and ECM services for ECM enrollees enrolled in both programs.
    D. CCS — similar to TCM, it is appropriate to apply a carve-out adjustment to the ECM rates for CM services children receive through CCS that overlap with ECM services.
    E. Existing Care Coordination Adjustments — the WCM program includes some CM services comparable to those provided through ECM. The WCM CM services are accounted for the base data for the WCM population. Through our clinical review of the CM requirements of both programs, Mercer determined WCM ECM enrollees have 25% of their ECM services are already accounted for through the WCM base data. As such, 25% of the WCM ECM medical component PMPM is carved out of the WCM base data. This adjustment is also documented in the Data section.

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

The entirety of the ECM rate development is done at a PEPM-level. To convert this to a PMPM, projected targeted individuals and ECM enrollees are used to convert the PEPM and monthly outreach costs to a PMPM[6].

[6] *Identifying ECM "Eligible" Members for Outreach and Enrollment*

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

Ultimately, accounting for ramp-up assumptions, the rate development assumes, by the fourth quarter of CY 2024, 1.5% of managed care members will be enrolled in ECM. After a full ramp up of the ECM program, it is expected 1.5%–2.5% of managed care members will be enrolled in ECM.

Half of the midpoint administrative load and the full underwriting gain (3.0%) load were used for the ECM add-on.

#### Enhanced Care Management Rates for Unsatisfactory Immigration Status and Satisfactory Immigration Status Populations

The rate methodology and assumptions for UIS and SIS populations remain the same in the development of the monthly PEPM cost based on their length of time enrolled in ECM (i.e., 1–6 months, 7–12 months, and greater than 13 months). At this time, there is insufficient data to support variation in PEPM-related assumptions between the UIS and SIS populations. However, there is sufficient data to support variations in projected ECM enrollment for the UIS and SIS populations. As such, the CY 2024 rates reflect a variation in PMPMs between the UIS and SIS populations.

ECM for UIS beneficiaries is only applicable to the state only UIS capitation rates and therefore not part of this certification.

### Health Plan of San Mateo Dental

Effective January 1, 2022, dental services are covered in San Mateo County. This add-on is applicable only to the SIS population, and the add-on for the UIS population is considered state only. Given this was a new managed care benefit after the base period, the data utilized was CY 2022 Medi-Cal Dental FFS data in San Mateo County. The data was then adjusted for the following items:

1. Annualized trend factors were applied for 24 months to the midpoint of the CY 2024 rating period.
2. As part of the CalAIM initiative, an adjustment was applied to the base data to reflect additional utilization of Lab Process Crowns associated with this new benefit.
3. Lower bound administration and underwriting gain loads consistent with the broader rate development were utilized in the development of the PMPM add-on.

The Prop 56 Dental State directed payment under 42 CFR § 438.6(c) is applicable to services covered under this pilot program. The impact of this State directed payment is displayed as an additional PMPM add-on. The data was adjusted for the following items:

- Annualized utilization trend factors were applied for 24 months to the midpoint of the CY 2024 rating period.

- An adjustment to reflect the Lab Processed Crowns benefit, which is subject to Prop 56 supplemental payments.
- Lower bound administration and underwriting gain loads consistent with the broader rate development were utilized in the development of the PMPM add-on.

### Specialty Mental Health Services for Kaiser Members (Sacramento and Solano)

Specialty MH services in Sacramento and Solano counties for Kaiser members are a managed care covered benefit in these instances. Kaiser is a direct contracting health plan in both counties for the CY 2024 time period, with Solano County being a subset of the larger North Bay rating region. Since these two items are applied as capitation rate add-ons, they are included with other capitation rate add-ons noted previously in this subsection. This benefit will be carved out completely to FFS effective January 1, 2025, as noted previously.

To develop the Kaiser SMI PMPM add-ons in Sacramento and Solano counties, Mercer utilized supplemental SFY 2021–2022 data Kaiser submitted which isolated to MH services for members diagnosed as having a SMI. This data was reviewed and adjusted as appropriate for rate setting purposes. Specifically, the unit cost levels were reviewed and adjusted similar to the process used for the SFY 2021–2022 RDT data used for rate setting. Mercer also removed any member month, cost, and utilization experience associated with members residing in an IMD facility for greater than 15 days in a given month, pursuant to 42 CFR 438.6(e). All other IMD experience for members with shorter-term IMD stays were confirmed to be priced at the State fee schedule for these facilities. Once the initial data was adjusted, it was trended forward to the CY 2024 rating period, with administration and underwriting gain loads being applied consistent with the broader rate development process (using lower bound trends, administration, and underwriting gain load assumptions). The final adjustment then applied is with respect to the planned transition of specialty MH services from Kaiser to the counties throughout the second half of CY 2024. Mercer assumed a linear ramp-down of liability from July 1, 2024 through December 31, 2024, applying a 0.750 ramp-down factor to the rates (as compared to full utilization throughout all of 2024).

The PMPM add-ons are applied to capitation rates for both the Kaiser Sacramento and Kaiser North Bay (Solano county only, but PMPMs have been adjusted to account for full region enrollment) rating regions outside of the risk-adjustment process. Please note, these PMPMs are effective for the entire 12-month rating period (January 1, 2024–December 31, 2024) due to the aforementioned carve-out not going into effect until afterwards.

## Program Changes Considered, but Not Adjusted For

In addition to the program changes mentioned in the sections above, Mercer analyzed several program and policy changes for inclusion in CY 2024 capitation rates, but ultimately found these to have no rate impact.

### Populations Transitioning from Managed Care to Fee-for-Service

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

- Omnibus Budget Reconciliation Act

- Share of Cost in COHS and CCI

Structurally, the Omnibus Budget Reconciliation Act population has historically been set at its own rate. As this population will be transitioning to FFS effective January 1, 2022, a rate was simply not set for this COA.

For the Share of Cost population, the estimated membership volumes were ultimately an immaterial proportion of the total population and was therefore found to have a minimal impact on the capitation rates.

### Asset Thresholds

Asset limit qualifications will be eliminated for non-Modified Adjusted Gross Income, LTC, and Medicare Shared Savings Program Medi-Cal applicants effective July 1, 2024.

From discussions with DHCS surrounding the incoming population, the projected incoming membership is minimal, and there is no reasonable indication these incoming members would have a different cost profile than the members currently in managed care. Therefore, no explicit adjustment was made for this program change.

### Populations Transitioning into Managed Care or Extending Managed Care Coverage

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

1. Post-partum Expansion — identified beneficiaries who receive pregnancy-related services would be eligible for Medi-Cal postpartum care for up to 12 months after the last day of the pregnancy effective January 1, 2022.
2. Health Insurance Premium Payout Transition — the Health Insurance Premium Payout program was discontinued effective January 1, 2022, and these members will be transitioned to managed care.
3. Veteran's Home Centers in New COHS and Single-Plan Counties — effective January 1, 2024, this population, who is currently voluntary managed care, will transition into the managed care delivery systems in Alameda, Contra Costa, San Benito, Imperial, RUC, and Central California county/regions due to new CY 2024 contracting changes.

### Telehealth — Post Public Health Emergency

Pursuant to the Welfare and Institutional Code, WIC 14124.12(f), telehealth modality flexibilities present during the PHE were extended through December 31, 2022, regardless of the PHE end date. With the PHE ending on May 11, 2023, per APL 23-007, the flexibilities will remain in place except for RHCs and FQHCs. Potential utilization and reimbursement levels under managed care were assessed and this was determined to be immaterial with no explicit rate adjustment applied.

### Annual Cognitive Health Assessment for Eligible Members Age 65 or Older

Effective July 1, 2022, California SB 48 expanded the Medi-Cal schedule of benefits to include an annual cognitive assessment for Medi-Cal members who are 65 years of age and

older if they are otherwise ineligible for a similar assessment as part of an annual wellness visit through the Medicare program. Given that this change only impacts non-dual and partial dual members without Medicare Part B coverage, in conjunction with relatively low reimbursement levels, this was determined to be immaterial, and no explicit rate adjustment was applied.

### Biomarker Testing

Effective July 1, 2022, California SB 535 prohibited managed care plans which already cover biomarker testing, from requiring prior authorization for biomarker testing for plan members with advanced or metastatic stage III or stage IV cancer. This bill also prohibited managed care plans from requiring prior authorization for biomarker testing for cancer progression or recurrence in members with advanced or metastatic stage III or stage IV cancer. Initial plan surveys found, the vast majority of plans would not need to change their current policy to comply with SB 535.

### COVID-19 Masks

Effective March 11, 2021, COVID-19 masks are no longer considered personal protective equipment and will not fall under medical necessary provisions but will instead be considered as a "preventative" therapy. Per APL 22-009 (under American Rescue Act), non-pharmacological items, part of "preventative" therapies, must be covered regardless of medical necessity determinations. Additionally, per DHCS, members with any positive COVID-19 test are eligible to receive COVID-19 masks. However, with declining COVID-19 test positivity in the State of California, this benefit was determined to be immaterial with no explicit rate adjustment applied.

### COVID-19 and Pediatric Vaccine Counseling

COVID-19 and pediatric vaccine counseling-only visits for children under 21 years of age, and COVID-19 vaccine counseling-only visits for adults when covered within the scope of practice of the provider, were added as a benefit with an effective date of December 2, 2021, the date CMS issued the press release announcing this requirement. Potential utilization and reimbursement levels under managed care were assessed and this was determined to be immaterial with no explicit rate adjustment applied.

### Routine Cost of Clinical Trials

Effective July 1, 2022, SB 583 would expand an existing benefit mandate to require coverage of health care services related to participation in clinical trials connected to any life-threatening disease. Prior to July 1, 2022, routine costs were only covered for Stage IV Cancer trials. Potential utilization and ramp up assumptions were assessed for this new benefit, and it was determined to be immaterial to managed care capitated rates.

### Genetic Disease Screening Program Prenatal Screening Fee Changes

Effective September 19, 2022, the California Department of Public Health prenatal screening program will be the only authorized entity allowed to bill Medi-Cal managed care plans for screening for fetal trisomies and/or neural tube defects. Fees charged under this program were found to be marginally lower than what managed care plans currently pay for prenatal screenings, resulting in minimal savings for the health plans. Therefore, an adjustment was not applied to managed care capitated rates for CY 2024.

### Acupuncture

Effective January 1, 2023, the FFS reimbursement for acupuncture services was increased from a maximum of $17.37 per session to a maximum of $60.00 per session. Encounter data was reviewed for the relevant acupuncture CPT codes to assess potential utilization under managed care. Given the fact this is a fee schedule change under the FFS delivery system, coupled with low utilization observed in managed care encounters, this program change was determined to be immaterial for managed care capitated rate setting.

### Continuous Glucose Monitoring

Effective January 1, 2022, Continuous Glucose Monitoring (CGM) was expanded to members who are 21 and older. Encounter data was reviewed for the relevant CGM CPT codes to assess potential utilization under managed care. From assessment of current encounter data, MCOs were already reimbursing for CGM for adults 21 and over under the GHPP program. Given the aforementioned statement, coupled with low utilization observed in managed care encounters, this program change was determined to be immaterial for managed care capitated rate setting.

### Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services

Effective January 1, 2023, this program change will provide guidance to MCOs on standardized, statewide Screening and Transition of Care tools to guide referrals of youth members to the appropriate Medi-Cal MH delivery system and ensure members requiring transition between delivery systems receive timely and coordinated care. As health plans are already responsible for some form of care coordination, and the tool will not change existing MCO responsibilities, this program change was determined to have no rate impact.

# Population Adjustments

For CY 2024, two additional adjustments were applied to the managed care data. Both adjustments are applied within columns (K) and (L) of the CRCS in the Excel files titled *CY 2024 Medi-Cal Detail CRCS Package LB Rate Smry 2023 12.xlsx* and *CY 2024 Medi-Cal Detail CRCS Package UB Rate Smry 2023 12.xlsx*. More detail on each adjustment is described in the next two subsections.

## Long-Term Care Category of Aid Utilization Management/Quality Assurance/Care Coordination Adjustment

An increase was applied to the All Other COS for both the LTC and LTC/Full-Dual COAs in non-CCI GMC, Regional, Single-Plan, and Two-Plan “transitioning” counties to recognize the MCO’s obligation to provide UM/QA/CC services for members under managed care. The base data for these COAs in these counties was FFS data, and therefore did not reflect expenses for UM/QA/CC services. An adjustment was applied within column (L) of the CRCS.

## Population Acuity Adjustment

Since the beginning of the PHE (beginning March 1, 2020), Medi-Cal ceased disenrolling members with certain exceptions such as members who moved out of state, passed away, or voluntarily requested to be disenrolled. As a result, the Medi-Cal managed care enrollment

numbers began increasing significantly; a reversal of the slightly declining trend observed prior to March 1, 2020. Numerous historical (and current) analyses have demonstrated members who disenroll from Medi-Cal are, on average, lower acuity than those who remain enrolled. The PHE continued throughout the entirety of the SFY 2021–2022 base period, resulting in a surplus of members remaining enrolled, and who's experience was represented in the base period.

Beginning April 1, 2023, the Maintenance of Effort ended, which included a 90-day processing period, and eligibility disenrollments restarted July 1, 2023. At this point members were subject to be disenrolled if they no longer met eligibility requirements, and the disenrollment of these surplus members is required to occur over a 12-month period, to June 30, 2024 (i.e., the unwinding). Mercer was able to observe and identify members who were disenrolled in July 2023, August 2023, and September 2023 (i.e., leavers). Using these three months of data, Mercer ran multiple analyses to determine two key elements of the overall population acuity adjustment:

1. The acuity differential between leavers and those who will remain enrolled (i.e., non-leavers)
2. The volume of the surplus members who accumulated during the PHE and are projected to be disenrolled through the unwinding.

### Leaver Acuity Differential

As mentioned above, Mercer identified leavers during the first three months of the unwinding and compared them to non-leavers by analyzing a few key metrics. These were encounter costs, non-utilizer statistics, and risk scores.

Encounter data was reviewed for the SFY 2021–2022 base period, as well as more recent encounter data through June 2023. Mercer analyzed and compared, PMPM costs along with the portion of each group that were non-utilizers. Additionally, using the CDPS+Rx risk model, the risk scores were also compared for leavers versus non-leavers. In each of the comparisons noted, Mercer varied the classification of leavers to measure the sensitivity of the results. Some examples of different iterations of leaver classification are: those who left in July 2023 only, those who left in July 2023 and remained disenrolled through September 2023, and all those who were disenrolled as of September 2023. Mercer also varied the time periods used for the comparisons, looking at different date ranges across July 2021 through June 2023.

Furthermore, the findings were compared to historical studies utilized for prior rating periods, showing historical differentials to be very similar to current, both in direction as well as degree. Additionally, the results were very consistent across the various methods used in the current analyses, all demonstrating leavers are lower cost PMPMs, higher percent non-utilizer, and lower risk scores.

### Surplus Member Volume

To calculate the overall magnitude of the population acuity adjustment, the model weighs the acuity differential against the relative volume of leaver member months in the rating period versus the base period.

For the base period, a baseline level of enrollment was established using historical enrollment counts and patterns from before the PHE. As disenrollments ceased in March 2020, the net increase over the historical baseline enrollment was classified as surplus member months. These surplus member months were quantified during the SFY 2021–2022 base period.

The amount of surplus member months peaked in June 2023 and then began to decline as the unwinding commenced in July 2023. The overall count of surplus member months in the rating period is based on the ramp down over the 12-month unwinding period, of which six months (January 2024 through June 2024) occurs in the rating period. The proportion of surplus member months is also influenced by the state and Mercer's enrollment projections through CY 2024, which includes new enrollments and disenrollments (i.e., "churn").

For the SIS population, the COA groups to experience the most significant enrollment changes from the start of the PHE were Child, Adult, and ACA Expansion. All other COA groups were included in the various analyses; however, the PHE enrollment effect was much smaller for these other groups and the analysis showed the acuity impact to be minimal. Historically, the volume of monthly churn for COA groups such as SPD has been much lower than Child, Adult, and ACA Expansion. Therefore, the population acuity adjustment was only deemed appropriate for the Child, Adult, and ACA Expansion COA groups.

For the UIS population, the Adult and ACA Expansion COA groups experienced a much larger enrollment increase due to the transitioning members mentioned in the previous section, which far outweighed the enrollment impact of the PHE. Acuity shifts due to the PHE were taken into consideration as part of the program change adjustments for these transitioning members. Therefore, for the UIS population, the population acuity adjustment was only deemed appropriate for the Child COA group.

The adjustment varied by county/region based on county/region-specific enrollment trends, as the effect the PHE had on enrollment varied by county/region. The statewide average adjustment for CY 2024 was directionally opposite of that applied in the CY 2023 rating period, due to CY 2023 including a much higher portion of leavers relative to its base period. This adjustment is applied to all COS' within column (K) of the CRCS in the Excel files titled *CY 2024 Medi-Cal Detail CRCS Package LB Rate Smry 2023 12.xlsx* and *CY 2024 Medi-Cal Detail CRCS Package UB Rate Smry 2023 12.xlsx*. In aggregate, the impact of this adjustment was as follows:

- Child SIS: 1.98% increase
- Adult SIS: 3.91% increase
- ACA Expansion SIS: 3.72% increase
- Child UIS: 1.05% increase

## Cost-Based Reimbursement Clinics in Los Angeles County

As discussed in Section 3, additional amounts for CBRCs were added to the FQHC base data for the SPD COA in LA County. These additional amounts were projected into CY 2024 using the FQHC trend factors. As a result, these CBRC amounts are fully reflected in column (O) of the CRCS for LA County for the SPD COA (in addition to the original FQHC and CBRC costs already reflected in the base data and projected to CY 2024). As noted

previously, due to the higher costs associated with CBRCs, the CBRC costs were split into two components. One component subject to risk adjustment, reflecting unit cost levels in line with typical professional services, and a "not subject to risk adjustment" carve-out amount containing the cost levels above and beyond typical professional services cost levels. Within column (S) of the CRCS, the carve-out amounts not subject to risk adjustment are removed from the county/region-specific rate calculation. These county/region-specific rates then flow through the risk-adjustment process, which is described later in this certification report. Once the risk-adjusted region average rates are calculated, the medical component of the "not subject to risk adjustment" carve-out amount is added back into the capitation rates for both LA Care and Health Net. For the SIS rates, the medical component carve-out amounts added back into the capitation rates are $59.84 and $34.09 for LA Care and Health Net, respectively, at the lower bound, and $61.33 and $34.94 at the upper bound. Similarly, $3.59 PMPM and $4.14 PMPM was added to the federal component of the UIS rates for SPD members in LA Care and Health Net, respectively ($3.68 and $4.25 at the upper bound). As Kaiser does not contract with LA DHS and does not utilize CBRCs, this "not subject to risk adjustment" add-on does not apply to Kaiser.

## Maternity Supplemental Payment Development

In the development of the maternity supplemental payment, the base data (as described in Section 3) was projected into CY 2024. The steps below describe the process utilized in the development of the CY 2024 maternity supplemental payment rates applicable to the Child, Adult, ACA Expansion, and WCM COA groups.

- Trend base costs forward to the midpoint of the rating period.
  - The trend development process is described in a previous subsection.
- Adjust for applicable program changes:
  - The program change for TRI was applied to the Professional service categories (i.e., PCP, Specialty, FQHC, and NPP).
- Add load for administration and underwriting gain:
  - The development of non-benefit load assumptions is described in Section 5 of this certification report. For the maternity supplemental payment, the assumed administrative expense load leveraged the process described in Section 5 for the standard CY 2024 capitation rates, with a focus on the variable component that typically represents approximately half of the total administrative loading. This is a supplemental payment and is consistent with the historical approach where only the variable portion of the administrative load is applied since the fixed portion is included in the member's monthly capitation payment. Section 5 provides a summary of the detailed administrative loading percentages specific to supplemental payments including maternity. The underwriting gain load for this payment rate is consistent with those applied for the standard CY 2024 capitation rates (2% at the lower bound, 3% at the midpoint, and 4% at the upper bound).
- SIS and UIS Payment Rates
  - As noted in Section 3, the maternity supplemental payment base data is the same for the UIS and SIS populations. Since no differences are assumed in trend and program

change factors by COS, the resulting supplemental payment rates are the same for the UIS and SIS populations by county/region. The maternity payment specific for the UIS population is considered 100% federal.

## Managed Care Adjustment

During the rate development process, PHP and Central California Alliance for Health (CCAH) reached out regarding contracting difficulties in the counties they were expanding into for CY 2024. For PHP, due to existing contracts with provider networks in their current areas of operation, the plan felt pressures to continue contracting at similar pricing levels for their 10-county expansion region, RUC. For CCAH, the plan shared with DHCS/Mercer the proposals and counterproposals with Hazel Hawkins Hospital and John C. Fremont Hospital. These are the only hospitals operating in San Benito and Mariposa, respectively, both of which are facing significant financial losses at existing funding levels. In both cases, PHP and CCAH further felt that members were underserved in these regions and expected utilization to increase after the procurement.

Over the course of the year, DHCS/Mercer had multiple discussions with the MCOs to further understand their concerns and communicate any adjustment made to the rates is not meant to eradicate any estimated losses but to build in costs that are reasonable, appropriate, and attainable for the San Benito, Central California (which encompasses Mariposa), and the RUC regions. This ultimately resulted in utilization adjustments to all three regions for the Professional COS' (PCP, Specialty, FQHC, NPP), BHT, and Transportation and unit cost adjustments to IP and Specialty for San Benito, and IP, OP, and ER for RUC. The impacts to each region are shown in the table below.

| | PMPM % impact | |
|---|---|---|
| **County/Region** | **SIS** | **UIS (Fed)** |
| **San Benito** | 17.0% | 21.4% |
| **RUC** | 10.0% | 13.6% |
| **Central Coast** | 0.3% | 0.0% |

## Other Items

### Health Care-Acquired Conditions

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

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

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

## Graduate Medical Education

Regarding Graduate Medical Education (GMED) costs and along with item AA.3.9 of "Documentation Requirements for Actuarially Sound Capitation Rates, Effective Date: November 15, 2014", DHCS staff has confirmed there are no provisions in the COHS, GMC, Regional, Single-Plan, and Two-Plan model managed care contracts regarding GMED. The COHS, GMC, Regional, Single-Plan, and Two-Plan model MCOs do not pay specific rates containing GMED or other GMED-related provisions. As MCO data serves as the base data for the rate ranges, GMED expenses are not part of the capitation rate development process.

## Third-Party Liability

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

## Member Cost Sharing

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

## Retrospective Eligibility Periods

MCOs in the COHS, GMC, Regional, Single-Plan, and Two-Plan model managed care programs are not required to cover retrospective eligibility periods for their enrollees. These periods are covered in the Medi-Cal FFS program. Since MCO data predominantly serves as the base data for the rate ranges and FFS data is adjusted for early months for use within managed care, retrospective eligibility periods are not part of the capitation rate development process. No further adjustments are necessary.

## Mental Health Parity and Addiction Equity Act

Regarding the MH Parity and Addiction Equity Act, DHCS staff has confirmed there are no provisions in the COHS, GMC, Regional, Single-Plan, and Two-Plan model managed care contracts in violation of MH Parity and Addiction Equity Act.

## Provider Overpayments

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

# Section 5
# Projected Non-Benefit Costs

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

- Administration
- Underwriting gain
- MCO Tax (the MCO Tax model is pending formal CMS approval, therefore any changes to the model or disapproval would be included in a rate amendment)

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

Below is a table detailing the aggregate mid-point administrative percentages assumed within the rate development for all model types for CY 2024. The range for the regular administrative loading is +/- 0.9% at the upper/lower bound from the mid-point value for the GMC, Regional, Single-Plan, and Two-Plan models and +/- 0.5% for the COHS model.

| Model or Region | CY 2023 Administrative Load | CY 2024 Administrative Load | CY 2024 Administrative Load For Supplemental Payments & Add-Ons |
|---|---|---|---|
| **GMC, Regional, Single-Plan, and Two-Plan** | 8.25% | 8.00% | 4.000% |
| **San Benito** | 8.25% | 8.00% | 4.000% |
| **RUC** | 8.25% | 8.00% | 4.000% |
| **Central California** | 8.15% | 7.90% | 3.950% |
| **Central Coast** | 7.50% | 7.60% | 3.800% |
| **Orange** | 5.40% | 6.00% | 3.000% |
| **San Mateo** | 8.00% | 6.75% | 3.375% |
| **Ventura** | 8.50% | 8.00% | 4.000% |
| **North Bay** | 5.50% | 5.25% | 2.625% |
| **Rural North** | 5.50% | 5.25% | 2.625% |
| **COHS Total** | 6.44% | 6.59% | 3.295% |

| Model or Region | CY 2023 Administrative Load | CY 2024 Administrative Load | CY 2024 Administrative Load For Supplemental Payments & Add-Ons |
|---|---|---|---|
| **Statewide** | 7.89% | 7.66% | 3.83% |

Similar to prior years, the administrative load for the Medi-Cal Managed Care program is developed in aggregate across all COA groups. For COHS counties, this is developed using MCO/region-specific experience, consistent with prior rating periods. For CY 2024, the following additional considerations were factored into the calculation of administrative load:

- PHE Unwinding — Due to end of the continuous coverage requirement, CY 2024 enrollment is expected to be lower than what was experienced in CY 2023. The maintenance of fixed administrative expenses from year-to-year is therefore expected to spread across less membership and revenue.
- New Contracting Requirements — Additional contracting requirements were mandated for population health management, care coordination, management information systems, provider management, quality improvement and health equity transformation, and a community advisory program as well as additional reporting requirements.
- Significant Program Changes — The TRI program change, which replaces the Prop 56 Physicians Supplemental Payment, now adds significant additional dollars to the base amounts. This is a large contributor as to why the CY 2024 administrative load is in most cases a lower percentage when compared to CY 2023.

Ultimately, part of the goal to use the same targeted administration percentage for all regions (other than COHS regions) is to increase program MCO administrative efficiency while providing appropriate funding for contractual requirements. Mercer believes DHCS continues to make long-term progress on that goal. The administration load factor is expressed as a percentage of the capitation rate (i.e., percent of premium).

As can be anticipated with a program the size and scope of Medi-Cal, a massive amount of historical and current data and information, from a wide variety of sources, is gathered and analyzed for each capitation rate setting component, with the administration load component being no exception. These sources include data and information collected from the RDTs used for rate setting (base year experience as well as contract year projections by the MCO), quarterly and annual Medi-Cal-specific financial reports submitted by the MCOs to DHCS, and quarterly and annual (and in some cases monthly) financial reports submitted by the MCOs to the California Department of Managed Health Care.

The mid-point percentage was developed in large part from a review of the MCOs' historical-reported administrative expenses. The administrative costs are reviewed to ensure they are appropriate for the approved State Plan services and Medicaid eligible members. Mercer also utilized its experience and actuarial judgment in determining the mid-point and lower/upper bound percentages to be reasonable. Based on the review of the most recent Medi-Cal specific administrative cost data and information, which indicates an overall decrease of administration percentage from multiple data sources including the most recent

quarterly financial data through the second quarter of CY 2023, Mercer developed the assumed administration percentage level accordingly for CY 2024 rates for COHS, GMC, Regional, Single-Plan, and Two-Plan plans.

It should also be noted, the aggregate percentages developed are across the entire program, which includes the SIS population in total as well as both the federal and state only components for the UIS population. While the percentages are the overall targeted aggregate administrative percentages, the administrative expense associated with each COA group and UIS/SIS distinction varies from the overall percentage. The administrative component can be viewed in two pieces, a fixed cost component and a variable cost component. The fixed cost component represents items such as accounting, salaries, rent, and information systems, while the variable cost component represents items such as claims processing and medical management per eligible. Allocating the administrative costs as a uniform percentage of capitation rate for each of the COAs and UIS/SIS distinction is an appropriate method; however, it does not consider the differences in fixed versus variable administrative costs for each.

Certain COA groups have capitation rates 10 (or more) times larger than other COAs. In these instances, the uniform percentage allocation methodology will produce an administrative component for the more expensive COA 10 (or more) times larger than the administrative component for the less expensive COA groups. While a more expensive eligible is probably more administratively intensive for the medical management component, this 10 (or more) to one relationship in administrative costs on a PMPM basis is most likely exaggerated since the fixed cost component is more likely, less variable between a more expensive COA group and a less expensive COA group.

If the fixed cost component of administrative costs is broken down and viewed on a PMPM basis, then this fixed dollar amount is a larger percentage of the capitation rate of the less expensive COA groups, and a smaller percentage of the capitation rate for the more expensive COA groups. This concept has been applied in a budget-neutral fashion (no administrative dollars have been gained or lost) to the capitation rates, whereby the administrative percentage will be greater for less expensive COA groups than the aggregate administrative percentage over the entire population. Similarly, the administrative percentage for the more expensive COA groups will be less than the aggregate administrative percentage over the entire population.

In the allocation of administrative dollars to COA and UIS/SIS capitation rates, fixed administrative dollars were calculated to be the same PMPM for both the UIS and SIS populations for all COA groups. For the UIS population, these fixed dollars were further allocated to the UIS federal and state only components based on projected medical spend for each component. All variable administrative dollars were allocated to COA and UIS/SIS capitation rates based on projected claim cost distributions.

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

## Underwriting Gain

The mid-point underwriting gain remained consistent with the prior rating period at 3% for the CY 2024 rating period across all COHS, GMC, Regional, Single-Plan, and Two-Plan model MCOs. The range for the underwriting gain component is +/- 1.0% at the upper/lower bounds

from the mid-point value for all models. Mercer has implicitly and broadly considered the cost of capital within our rating assumptions.

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

## Managed Care Organization Tax

DHCS submitted an MCO Tax proposal to CMS on June 29, 2023 that, if approved, would become effective retroactively to April 1, 2023. 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 | $182.50 | 1,250,001-4,000,000 | $1.75 |
| 4,000,001+ | $0.00 | 4,000,001+ | $0.00 |

For the CY 2024 calculations currently included in the accompanying exhibits, Mercer used projections that were informed by enrollment through August 2023 and supplemental information through October 2023. With the CY 2024 procurement, broad assumptions were made on member assignment where health plans operating within a county are changing going into the rating period. In cases where assumptions based on prior enrollment to a health plan proved challenging given the lack of historical Medi-Cal presence in the county, a percentage of the county's enrollment was assigned to the MCO to prevent an over- or under-allocation to any given plan in a county. This procurement, along with the PHE unwind, lends to uncertainty surrounding CY 2024 MCO-specific enrollment projections and as such, even with the approval of the MCO tax proposal, will require a re-calculation of the tax midway through the rating period.

DHCS is currently awaiting CMS approval on the MCO tax proposal. If the current structure is not approved or altered, the appropriate funding levels for the tax would be re-evaluated and incorporated in a future rate amendment.

# Section 6
# Risk Adjustment

Risk adjustment will be applied to certain COA groups and services with 100% credibility to the region average capitation rates. Within the risk-adjustment process used for the CY 2024 capitation rates, certain services are separated within the region average rates and specific risk-adjustment mechanisms are used to create MCO-specific rates, separate for these services. Within the development of the risk-adjustment factors, the following services will be separated out and risk-adjusted using different methodologies.

- BHT
- CBAS
- LTC Long-Term stays
- All remaining services

This was done since the traditional model used to risk adjust capitation payments does not necessarily explain MCO risk for certain services like BHT, CBAS and LTC long-term stays. For the “all remaining services” item (which represents the majority of costs within the capitation rates), the CDPS+Rx health-based payment model, Version 7.0, will be used. For the remaining services (BHT, CBAS, and LTC long-term stays), separate methodologies will be used to risk adjust those components of the capitation rates.

Due to the procurement of MCOs effective January 1, 2024, and the unwinding of enrollment due to the end of the PHE, final risk-adjustment factors have not yet been calculated. This is because there is uncertainty around the ability to predict membership by MCO before the new MCOs come on board, and uncertainties around how disenrollments will occur by MCO. As a result, a retrospective/prospective risk-adjustment process will be used. This process will utilize encounter data with dates of service from June 1, 2022 through May 31, 2023 and enrollment snapshot months from January, February, March, and April 2024. This process is planned to be done in the middle of the CY 2024 time period, once enrollment of members by MCO is known for these months.

This section describes the methodology that will be used to risk adjust each component of the capitation rates. It should be noted, interim risk-adjustment factors were calculated and applied to the region average rates in instances where MCO enrollment was assumed to be more predictable. However, these interim risk-adjustment factors will be re-calculated and overwritten by the retrospective/prospective process described in this section. The remainder of this section details the process planned to be used for the retrospective/prospective risk-adjustment process for each separate service that is being risk adjusted.

## All Remaining Services

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

Capitation rates for DHCS' GMC, Regional, Single-Plan, and Two-Plan models will be risk-adjusted using the CDPS+Rx health-based payment model, Version 7.0, developed by University of California, San Diego. This risk-adjustment process will apply to the UIS and SIS populations, specifically, the Child, Adult, ACA Expansion, and SPD COA groups only. In addition, since a separate maternity payment rate has been developed, maternity costs were excluded from the risk-adjustment process for the Child, Adult, and ACA Expansion COA groups.

Since risk adjustment is applied to distribute funds to MCOs within a region and some regions only have one MCO, capitation rates for MCOs in these regions are not risk-adjusted. The CDPS+Rx risk-adjustment process is also not applied to the LTC and LTC/Full-Dual COA groups. This is because no readily available model exists for the institutionalized population and associated Medi-Cal data elements. Further, for the LTC and LTC/Full-Dual COA groups, the corresponding capitation rate is specific to members residing in an LTC facility, which in itself appropriately matches payment to risk. Similarly, the WCM rates are not risk-adjusted since no readily available model exists for this very specific population and there is only one MCO per region with a credible population size.

Capitation rates for the SPD/Full-Dual COA group are not risk-adjusted using the CDPS+Rx model for two main reasons. First, the CDPS+Rx model utilizes diagnoses and pharmacy data within the process of producing risk scores. When using a diagnosis-based risk adjustment model, much of the claims history is captured through Medicare. This, coupled with Medicare Part D covering the vast majority of a dual member's pharmacy claims, leaving limited pharmacy experience within the Medi-Cal program, further complicates the use of risk adjustment for dual members. Second, for the SPD/Full-Dual COA, the majority of the dollars paid for all medical claims are covered by the Medicare benefit. The capitation rates only represent the costs of the services not already covered through Medicare. The current cost weights developed for the Medi-Cal program assume all managed care covered services are paid by the Medi-Cal MCOs. Creating a risk-adjustment system for the dual population would require a unique set of cost weights that account for services paid through Medicare and a methodology to overcome the data issues mentioned above. This additional level of resources, with potentially limited benefit of better matching payment to the limited remaining risk for these dual eligible members, was not performed.

Within CY 2023, capitation rates for the UIS population were not risk adjusted. For CY 2024, UIS rates will be risk adjusted in certain regions. For this relatively smaller population, some regions and COA groups may have credibility size issues to apply risk adjustment, but there will also be some regions and populations that will have credible population sizes. As a result, risk adjustment will be applied to the UIS population in CY 2024 in some regions.

The individual acuity factors and final plan factors in effect for CY 2024 will be based on claims and encounter data with dates of service June 1, 2022 through May 31, 2023 (referred to as the study period), using encounter data submitted by the MCOs to DHCS by November 30, 2023. After individual acuity factors are calculated using the above study period, these acuity factors will be aggregated by MCO and COA groups using each plan's enrollment snapshot as of the first four months within CY 2024 (January, February, March, and April). The January 2023 through April 2023 snapshots will be used to assign members to an MCO and COA group for these months based on actual MCO enrollment for these months. Further, the April 2023 snapshot will receive eight additional months of weight (for a total of nine months of weight) and will act as the prospective assumption of MCO enrollment for the remainder of the CY 2024 rating period.

To ensure the risk-adjustment process does not increase or decrease the total amount of capitation payments, the MCOs' risk factors will be adjusted for budget neutrality. The intent of this adjustment is to recalibrate all the MCO risk-adjustment factors to yield a region average of 1.0000. Each MCO's own risk-adjustment factors will then be applied to the county/region average base capitation rates (less BHT, CBAS, and LTC long-term stays components) to arrive at each MCO's risk-adjusted rate.

The risk-adjustment process will only include experience data for individuals who have at least six months of total Medi-Cal eligibility within the 12-month study period. Individuals who do not meet the six-month eligibility criterion are assigned the respective MCO's average risk factor associated with that individual's COA group.

The CDPS+Rx risk adjustment model, Version 7.0, updated by the University of California, San Diego, has been further adjusted to more closely align with the risk associated with the Medi-Cal Managed Care covered benefits. For example, the cost weights reflected in the national model were developed assuming standard benefit packages (including options of including or excluding pharmacy and BH services), utilizing multiple states' data. Mercer modified the cost weights to better reflect California Medi-Cal-specific data and services covered under the managed care program (excluding pharmacy, BHT, CBAS, and LTC long-term stays services). For additional details of the risk adjustment methodology, please see the separate document *CY 2024 CA Interim RAR Methodology Letter 2023 12.pdf*. This document describes the process used for the interim risk scores, but the general process described will be the same in the final calculation that will occur in CY 2024.

In an effort to encourage and reward cost efficiencies, and effectiveness, DHCS applying risk-adjustment to region average rates with 100% credibility.

Further, only health plans with sufficient population size will be risk adjusted. For health plans without sufficient population size, a factor of 1.0 will be applied.

## Behavioral Health Treatment Services

For BHT services, the budget neutral risk-adjustment factors will be created by the relative proportion of BHT utilizers to the overall population, or BHT utilizer prevalence (i.e., the ratio of BHT utilizers to total member months). Each MCO's BHT utilizer prevalence will be divided by the region average BHT utilizer 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 is anticipated to use actual MCO enrollment from January, February, March, and April 2024 to evaluate each MCOs BHT utilizer prevalence after the MCO procurement and more is known regarding disenrollments due to the PHE unwinding. Similar to the CDPS+Rx model applied to all other services mentioned above, the BHT risk adjustment will also be applied to the region average rates (specific to other BHT rate component only) with 100% credibility.

Currently, there are interim factors applied to the BHT portion of the capitation rates. To calculate the interim factors, BHT utilizer prevalence was measured based on MCO-reported RDT data, the state's eligibility data, as well as the state's BHT supplemental payment records (available through December 2022, when the BHT supplemental payment was in effect). The RDT data was checked for reasonableness, compared to each MCO's historical BHT experience, and validated with the state's encounter data. However, these interim factors will be overwritten by the final factors that will be calculated in the middle of the CY 2024 time period.

The vast majority of BHT costs occur with the Child, SPD, and WCM COA groups, and specifically only within the SIS population. All other populations did not contain enough BHT service volume to warrant an application of risk adjustment, and therefore it is anticipated they will receive the developed county/region average rate component specific to BHT.

## Community-Based Adult Services

For the CBAS COS, the budget neutral risk-adjustment factors will be created by the relative proportion of CBAS utilizers to the overall population, or CBAS utilizer prevalence (i.e., the ratio of CBAS utilizers to total member months). Each MCO's CBAS utilizer prevalence will be divided by the region average CBAS utilizer 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 is anticipated to use actual MCO enrollment from January, February, March and April 2024 to evaluate each MCO's CBAS utilizer prevalence after the MCO procurement and more is known regarding disenrollments due to the PHE unwinding. Similar to the CDPS+Rx model applied to all other services mentioned above, the CBAS risk adjustment will be applied to the region average rates (specific to the CBAS rate component only) with 100% credibility.

Currently, there are interim factors applied to the CBAS portion of the capitation rates. To calculate the interim factors, CBAS utilizer prevalence was measured based on encounter data for CBAS utilizers, while the state's eligibility data was used for total member months. The encounter data was reviewed at a monthly level and checked for reasonableness against MCO-reported RDT experience. This CBAS encounter data was then utilized to develop projected utilizers to match the risk adjustment snapshot, by MCO and COA group. However, these interim factors will be overwritten by the final factors that will be calculated in the middle of the CY 2024 time period.

The vast majority of CBAS costs occur within the SPD and SPD/Full-Dual COA groups, and primarily within the SIS population, with the exception of the UIS population in Los Angeles County, only. As a result, this risk-adjustment process only applies in these instances. All other populations did not contain enough CBAS service volume to warrant an application of risk adjustment, and therefore will receive the developed county/region average. Further, only health plans with sufficient population size will be risk adjusted. For health plans that do not have sufficient population size, a factor of 1.0 will be applied.

## Long-Term Care Long-Term Stays Services

Budget neutral risk-adjustment factors will be created for the portion of the LTC COS attributable to long-term stays (e.g., 90 consecutive days or more). These LTC long-term stay budget neutral risk-adjustment factors will be developed based on cost weighted LTC long-term stay utilization/1,000 by MCO and COA group for each rating region. Each MCO's cost weighted score will be divided by the region average cost weighed score to arrive at the risk-adjustment factors. Similar to the CDPS+Rx model applied to all other services mentioned above, the LTC long-term stay risk adjustment will be applied to the county/region average rates (specific to the LTC long-term stay rate component only) with 100% credibility.

LTC long-term stay utilization/1,000 will be measured by MCO based on members who utilize long-term LTC services across all member months and their enrollment in the January, February, March, and April 2024 snapshot month. Long-term stay LTC days within the encounter data, by MCO and COA group, will be categorized between three different risk

groups, as follows from highest cost to lowest (on a per diem basis); DP-NF, ICF-DD, and Other (e.g., SNF-B, etc.). Utilizing the Other group as a baseline (e.g., 1.0), relative statewide cost factors will be developed and applied to the DP-NF and ICF-DD utilization/1,000 to create a cost-weighted utilization/1,000, which then formed the basis of the budget-neutral risk adjustment calculation for each rating region. Each MCO's cost-weighted utilization per 1,000 will be divided by the region average to develop the risk-adjustment factors.

Currently, there are interim factors being applied to the LTC long-term stays portion of the capitation rates. For the interim factors, October 2022 through December 2022 encounter data and enrollment was used as the basis for the factors. The cost-weighted LTC utilization per 1,000 scores described previously were calculated based on encounters and enrollment from this October 2022 through December 2022 time period. Further, this only applied to the historical CCI and COHS counties, since the transition of long-term LTC stays was not yet a part of the data for the transitioning non-COHS/non-CCI counties. For the final factors, it is anticipated that the transitioning counties will be included.

This risk-adjustment process for LTC long-term stays applies to the SIS population, specifically, the Adult, ACA Expansion, SPD, SPD/Full-Dual, LTC, and LTC/Full-Dual COA groups. The Child and WCM COA groups did not contain enough LTC long-stay service volume to warrant an application of risk adjustment, and therefore will receive the developed county/region average. For the UIS population, no factors are applied in the draft rates, but this will be reviewed in the final calculation and there is a possibility there could be factors applied for the UIS population at that time. Further, only health plans with sufficient population size will be risk adjusted. For health plans that do not have sufficient population size, a factor of 1.0 will be applied.

## Per Members Per Months Not Subject to Risk Adjustment

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

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

The risk-adjustment process described in this section is budget neutral and is not intended to increase or decrease the total capitation payments made by DHCS to the MCOs.

# Section 7
# Special Contract Provisions Related to Payment

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

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

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

## Incentive Arrangements

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

### Student Behavioral Health Incentive Program

The Student Behavioral Health Incentive Program (SBHIP) was implemented by the state in CY 2022 and will continue through CY 2024 starting CY 2023, which provides incentive payments to MCOs upon successful completion of specified milestones and measures. $389 million is the total maximum incentive funding that may be earned across all participating MCOs over the three-year program period. The SBHIP has no effect on the development of capitation rates.

The purpose of SBHIP is to incentivize MCOs to improve coordination with county BH departments, schools, and other program partners, and, through those collaborations, to create infrastructure; new initiatives, and expand upon existing school-based partnerships that increase students' access to preventive, early intervention and behavioral health services.

The Medi-Cal population that benefits from SBHIP are students who are enrolled in public school grades TK-12. The entities that participate in the delivery of BH services promoted by SBHIP include county BH departments, local schools districts, and school-linked community-based providers.

Further detail regarding the SBHIP is available through the managed care contract, APL or additional guidance issued to MCOs through written communication and on the DHCS website located here: SBHIP.[7]

## CalAIM Incentive Payment Program

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

The state will continue the CalAIM Incentive Payment Program (IPP) through June 30, 2024 which provides incentive payments to MCOs for the achievement of specified metrics and milestones. The total maximum incentive funding that may be earned across all participating MCOs over the full duration of the program is $1.5 billion. The IPP has no effect on the development of capitation rates.

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

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

Additional detail regarding the IPP is available through the managed care contract, APL 23-003[8] and any subsequent revisions, and guidance issued to MCOs through written communication and on the DHCS website located here: CalAIM IPP.

## Quality Component Incentive Program

The state will implement the Quality Component Incentive Program for the CY 2024 contract period, which is designed to incentivize health plans to reduce racial and ethnic disparities for specified quality measures. The Quality Component Incentive is a hybrid program to be implemented alongside the Quality Withhold Program. Any withhold dollars not earned back by health plans under the Quality Withhold Program will be paid out through the Quality Component Incentive Program. Documentation of the Quality Component Withhold Program is included in the Withhold Arrangements section of this certification.

Any health plans that are new to a county in CY 2024 where health plan specific quality data does not currently exist within the External Quality Review Organization (EQRO) system will be excluded from the Quality Component Incentive Program for CY 2024. The enrollees

[7] https://www.dhcs.ca.gov/services/Pages/studentbehavioralheathincentiveprogram.aspx

[8] APL 23-013 is available at https://www.dhcs ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL21-016.pdf.

covered by the Quality Component Incentive Program include all Medi-Cal populations covered under the health plans that are not excluded from the program for CY 2024.

The Quality Component Incentive Program has no effect on the development of capitation rates.

Further details of the Quality Component Incentive Program are described in the accompanying methodology letter titled *CY 2024 CA Quality Component Methodology Letter 2023 12.pdf.*

# Withhold Arrangements

## Quality Component Withhold Program

The state will implement the Quality Component Withhold Program for the CY 2024 contract period. The purpose of the Quality Component Withhold Program is to allow for the quality payment concept that was introduced in CY 2023 to be expanded beyond Two-Plan counties and applied in all managed care model types and continue to leverage quality measures that align with the state's Quality Strategy goals.

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

The Quality Component Withhold Program will withhold 0.38% from the final certified rates across health plans included in the program for CY 2024. The withhold will apply to both SIS and UIS rates across all COAs.

Similar to the Quality Component Incentive Program, any health plans that are new to a county in CY 2024 where health plan specific quality data does not currently exist within the EQRO system will be excluded from the Quality Component Withhold Program for CY 2024. The enrollees covered by the Quality Component Withhold Program include all Medi-Cal populations covered under the health plans that are not excluded from the program for CY 2024.

The Quality Component Withhold Program has no effect on the development of capitation rates.

Of the total withheld amount, 0% is not reasonably achievable under the Quality Component Withhold Program. Further details on the achievability and reasonableness of the Quality Component Withhold Program are described in the accompanying methodology letter titled *CY 2024 CA Quality Component Methodology Letter 2023 12.pdf.*

# Risk Sharing Mechanisms

## Proposition 56/General Fund

The state is continuing two-sided, risk corridors associated with the Prop 56/General Fund directed payment initiatives which had such mechanisms in the prior rating period (CY 2023). These are financial monitoring mechanisms to ensure the State directed payments are distributed in accordance with the state's contractual terms and terms of the CMS-approved

preprints and are not subject to 42 CFR § 438.6(b)(1). These arrangements are further discussed in the Delivery System and Provider Payment Initiative subsection of this report. No risk-sharing mechanism will be in place for the Prop 56 Dental directed payment.

### Rationale for the Use of the Risk-Sharing Arrangement

Risk corridors are necessary for these programs for multiple reasons. First, for some of the Prop 56 arrangements, there was limited credible and complete claims experience data available in the base period with which to develop capitation rates. Also, the risk corridors support DHCS' policy interest in mitigating potential perverse financial incentives for MCOs to avoid appropriate utilization of services subject to these Prop 56 directed payments by limiting gains and losses associated with these initiatives to a reasonable threshold.

### Description of How the Risk-Sharing Arrangement is Implemented

A two-sided risk corridor shall be in effect for Prop 56 Directed Payments capitation payments to MCOs. The Prop 56 Family Planning directed payment will have a separate and distinct risk corridor. The other programs, Developmental Screening, and ACE Screening will be combined into one risk corridor arrangement. The risk corridors shall be based on the medical expenditure percentage (MEP) achieved by each MCO, as calculated by DHCS. The MEP shall be calculated in aggregate across all applicable categories of aid and rating regions where the MCO operates for dates of service within the program year. DHCS will perform the risk corridor calculation no sooner than 12 months after the end of the rating period.

For each risk corridor, DHCS will calculate the numerator of the MEP using an MCO's submitted encounters that have been accepted by DHCS, in accordance with its policies, for services eligible to receive a Prop 56 Directed Payment add-on amount, multiplied by the applicable directed payment add-on amount for each encounter. The resulting amount will be considered the "actual amount" of Prop 56 Directed Payments expenditures issued by the MCO to its eligible network providers in accordance with this preprint for dates of service within the rating period. For each risk corridor, the denominator of the MEP shall be equal to the total of the medical (i.e., non-administrative and non-underwriting gain) portion of the MCO's applicable Prop 56 Directed Payments capitation payment revenues for the rating period, as calculated by DHCS.

The risk corridor will consist of the following bands:

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

MCO's MEP numerator, plus a proportional amount for the non-medical portion of the capitation payments aligned with the Prop 56 Directed Payments.

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

There is no impact on the CY 2024 capitation rates for the provision of a risk corridor. The CY 2024 capitation rates, outlined in the rate certification, reflect Mercer's best estimate of the anticipated costs associated with the Prop 56 Directed Payments.

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

Mercer confirms the CY 2024 Prop 56 Directed Payment add-on risk sharing mechanism was developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medi-Cal covered populations and services under the managed care contract.

## Enhanced Care Management

DHCS will continue to use a symmetrical, two-sided risk corridor which was originally implemented during CY 2022 as part of the CY 2024 ECM program. This risk mitigation mechanism will be applicable to all MCOs receiving the ECM add-on.

### Rationale for the Use of the Risk-Sharing Arrangement

The potential variability associated with the implementation and ramp up of ECM supports the benefits of utilizing two-sided risk corridors. While there is expected to be a level of consistency with unit costs, utilization of ECM services could vary significantly by health plan and county depending on the effectiveness of their roll out of the ECM program. MCO-submitted encounters and plan reported supplemental data submitted in a DHCS created template will be utilized in the risk corridor calculations. The use of a risk corridor helps promote accurate encounter submissions from providers and MCOs. Therefore, the use of this risk corridor is an excellent approach to better match the payments to the overall risk and will help ensure complete and accurate data.

### Description of How the Risk-Sharing Arrangement is Implemented

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

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

- Approved ECM services for individuals enrolled in ECM

- Outreach efforts performed by an ECM provider on individuals targeted for ECM enrollment

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

The risk corridor will consist of the following bands:

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

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

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

- Non-medical expenses (e.g., non-service investments for infrastructure and capacity).
- Incurred but not reported expenses that cannot be adequately supported.
- Medical expenses for non-ECM services and populations (e.g., expenses for Community Supports services), expenses for members who do not meet ECM population or phase-in criteria.
- Unreasonable outlier medical expense levels for which the MCO does not provide satisfactory justification based on member mix, utilizer acuity, unique network considerations, and/or other factors. As experience may be inherently more volatile in the first years of the ECM benefit, DHCS will ensure the review process includes discussion with MCOs in advance of any adjustments to provide an opportunity to support outlier cost levels.
- Related party expense levels in excess of unrelated party expense levels.
- Separate and distinct payments exclusively for administrative costs as defined in Title 28, California Code of Regulations, § 1300.78, such as but not limited to network development and claims processing.
- An assumed non-medical component of global subcapitation payments made by MCOs to global subcontractors that aligns with assumptions used in the CY 2024 rate

development (see Base Data Adjustments related to Global Non-Medical Expense Adjustment). Reductions will be applied in a manner that ensures alignment between allowable medical expenses and medical costs considered in the rate development process.

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

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

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

There is no impact on the CY 2024 capitation rates for the provision of a risk corridor. The CY 2024 capitation rates, outlined in this rate certification, reflects Mercer's best estimate of the anticipated costs associated with ECM.

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

Mercer confirms the CY 2024 ECM add-on risk sharing mechanism was developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medi-Cal covered populations and services under the managed care contract.

## Major Organ Transplant

DHCS will continue the use of a risk corridor originally implemented in CY 2022 for the portion of the CY 2024 MOT PMPM add-on associated with the directed payment that directs MCOs to pay for the transplant event itself at Medi-Cal FFS-equivalent rates. This is a financial monitoring mechanism to ensure the State directed payments are distributed in accordance with the state's contractual terms and terms of the CMS-approved preprints and is not subject to 42 CFR § 438.6(b)(1). The risk corridor will not apply to plans in COHS counties.

### Rationale for the Use of the Risk-Sharing Arrangement

Due to the initial roll-out of the MOT benefit in GMC, Regional, Single-Plan and Two-Plan counties effective January 1, 2022 and potential differences in observed MCO costs versus the capitation rates, DHCS is implementing a two-sided risk corridor for the MOT benefit. Since MOT is a low volume event with large associated costs, there is potential for variation in rate setting assumptions for MOT compared to capitation rates developed for these events. As a result, DHCS is imposing a risk corridor.

### Description of How the Risk-Sharing Arrangement is Implemented

The risk-sharing arrangement will be a two-sided risk corridor utilizing actual MOT expenditures experienced by the MCOs relative to MOT services subject to the directed payment requirements funded within the capitation rates. The risk corridor shall be based on a calculated MEP achieved by each MCO. The MEP shall be calculated in aggregate across

all applicable COAs and rating regions where the MCO operates for dates of service within the rating period. The risk corridor calculations shall be performed no sooner than 12 months after the end of the rating period.

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

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

The risk corridor will consist of the following bands:

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

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

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

- Non-medical expenses.
- Incurred but not reported expenses that cannot be adequately supported.
- Medical expenses for non-MOT services or MOT services not subject to the directed payment requirements (e.g., costs for kidney and cornea transplants).
- For services subject to the directed payment requirements, costs in excess of the directed payment levels.

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

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

There is no impact on the CY 2024 capitation rates for the provision of this risk corridor. The CY 2024 capitation rates, outlined in this rate certification, reflects Mercer's best estimate of the anticipated costs associated with MOT.

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

Mercer confirms the CY 2024 MOT directed payment risk sharing mechanism was developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medi-Cal covered populations and services under the managed care contract.

## UIS Populations

For the CY 2024 rating period, DHCS will utilize a risk corridor for the capitation rates specific to the UIS population. The risk corridor will apply to the UIS Adult and UIS ACA Expansion COAs in all county/regions within the program with the exception of San Benito County, which has a separate (and broader) risk corridor described later in this document.

### Rationale for the Use of the Risk-Sharing Arrangement

The base data period for the CY 2024 rates is SFY 2021–2022. Effective January 1, 2024, California will expand full scope coverage to all beneficiaries ages 26 to 49, regardless of immigration status. As noted in the Program Changes subsection, this transition is very material to the UIS population, and overwhelmingly to the UIS Adult and UIS ACA Expansion COAs, in terms of membership impact. Furthermore, there is no managed care experience available for this population.

A risk corridor is being implemented due to concerns on potential differences in MCO costs versus the capitation rates, given significant uncertainty around the underlying PMPM costs for the transitioning population as well as the magnitude of membership increases.

### Description of How the Risk-Sharing Arrangement is Implemented

The risk-sharing arrangement will be a two-sided risk corridor utilizing actual expenditures experienced by the MCOs, subject to appropriate adjustments as described below. The risk corridor shall be based on a calculated MEP achieved by the MCO. The MEP shall be calculated at the MCO level (statewide) in aggregate across all applicable COAs. The risk corridor calculations shall be performed no sooner than 12 months after the end of the rating period.

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

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

The risk corridor will consist of the following bands:

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

Once the MEP is calculated, the percentage may be increased by an appropriate credibility adjustment for MCOs with low member months. The State anticipates leveraging the methodology described at 42 CFR § 438.8(h) for federally required MLR calculations.

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

- Non-medical expenses.
- Incurred but not reported expenses that cannot be adequately supported.
- Outlier medical expense levels—in comparison to other MCOs in the county or other counties—for which the MCO does not provide satisfactory justification based on member mix or risk, network considerations, and/or other factors.
- Related party expense levels more than unrelated party expense levels for the same or similar services.

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

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

There is no impact on the CY 2024 capitation rates for the provision of this risk corridor. The CY 2024 capitation rates, outlined in this rate certification, reflect Mercer's best estimate of the anticipated costs.

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

Mercer confirms the CY 2024 UIS population risk sharing mechanism was developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medi-Cal covered populations and services under the managed care contract.

## San Benito County

DHCS will implement a risk corridor for the San Benito County capitation rates to coincide with the transition of this county from being partially voluntary managed care to mandatory managed care.

### Rationale for the Use of the Risk-Sharing Arrangement

The transition of voluntary members to mandatory managed care has created a level of uncertainty within the rate setting process. As a result, DHCS is imposing a risk corridor.

### Description of How the Risk-Sharing Arrangement is Implemented

The risk-sharing arrangement will be a two-sided risk corridor utilizing actual expenditures experienced by the MCO, subject to appropriate adjustments as described below. The risk corridor shall be based on a calculated MEP achieved by the MCO. The MEP shall be calculated in aggregate across all applicable COAs. The risk corridor calculations shall be performed no sooner than 12 months after the end of the rating period.

The numerator of the MEP will be calculated utilizing plan reported supplemental data reported in a DHCS created template.

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

The risk corridor will consist of the following bands:

- If the aggregate MEP is less than 96%, the MCO will remit to the state within 90 days of notice the difference between 96% of the medical portion of the MCO's applicable capitation payment revenues and the aggregate amount of the MCO's MEP numerator.
- If the aggregate MEP is greater than or equal to 96%, but less than or equal to 104%, the MCO will retain all gains or losses, with no reconciliation payments from the state to the MCO, or vice versa.
- If the aggregate MEP is greater than 104%, the state will remit to the MCO the difference between 104% of the medical portion of the MCO's applicable capitation payment revenues and the aggregate amount of the MCO's MEP numerator.

Once the MEP is calculated, the percentage may be increased by an appropriate credibility adjustment for low member months. The State anticipates leveraging the methodology described in 42 CFR § 438.8(h) for federally required MLR calculations.

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

- Non-medical expenses.
- Incurred but not reported expenses that cannot be adequately supported.
- Outlier medical expense levels—in comparison to other MCOs in the county or other counties—for which the MCO does not provide satisfactory justification based on member mix or risk, network considerations, and/or other factors.
- Related party expense levels more than unrelated party expense levels for the same or similar services.

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

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

There is no impact on the CY 2024 capitation rates for the provision of this risk corridor. The CY 2024 capitation rates, outlined in this rate certification, reflects Mercer's best estimate of the anticipated costs.

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

Mercer confirms the CY 2024 San Benito County risk sharing mechanism was developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medi-Cal covered populations and services under the managed care contract.

## Federally Qualified Health Centers Alternative Payment Model

DHCS will plan to use a symmetrical, two-sided risk corridor with the FQHC APM. This risk mitigation mechanism will be applicable to all MCOs involved with the FQHC APM.

### Rationale for the Use of the Risk-Sharing Arrangement

The FQHC APM is a new structure with limited prior experience and as a result, DHCS is imposing a risk corridor.

### Description of How the Risk-Sharing Arrangement is Implemented

To be determined

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

There is no impact on the CY 2024 capitation rates for the provision of this risk corridor. The CY 2024 capitation rates, outlined in this rate certification, reflects Mercer's best estimate of the anticipated costs associated with MOT.

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

Mercer confirms the CY 2024 FQHC APM risk sharing mechanism will be developed in accordance with generally accepted actuarial practices and principles and will be appropriate for the Medi-Cal covered populations and services under the managed care contract.

## MLR Remittance

The State will impose an 85% minimum MLR for CY 2024. The formula for calculating the Contractor's MLR is a/b, where a is the total covered benefit and service costs of the MCO, including incurred but not reported claim completion in accordance with 42 CFR 438.8(e) and b is the total capitation payments received the MCO, including any withhold payments minus taxes, licensing, and regulatory fees, in accordance with 42 CFR 438.8(f). Remittance takes place when the Contractor's MLR is below the 85% minimum requirement and is the

difference (excess) between the two percentages. Further details of the MLR can be found in the MCO contracts.

Although capitation rates are not directly affected by the minimum MLR requirement, the rates were developed in such a way that the MCOs are reasonably expected to achieve an MLR of at least 85% for CY 2024. This risk mitigation mechanism has been developed in accordance with generally accepted actuarial principles and practices.

## State Directed Payments

There are several State directed payments applicable to the COHS, GMC, Regional, Single-Plan, and Two-Plan model CY 2024 capitation rates. All applicable directed payments are summarized in the table below. The following subsections provide more detail around each initiative.

| Control Name of the State Directed Payment | Type of Payment | Brief Description | Is the Payment Included as a Rate Adjustment or Separate Payment Term? |
|---|---|---|---|
| **Control Name TBD — Prop 56 Family Planning** | Uniform dollar increase | Uniform dollar increases for specific Family Planning services | Rate adjustment |
| **Control Name TBD — Prop 56 Dental** | Uniform dollar and percentage increases | Uniform percentage and dollar increases for specific dental services | Rate adjustment |
| **ACE Screening** | Minimum fee schedule using State Plan approved rates | Minimum fee schedule for specific ACEs Screening services | Rate adjustment |
| **Control Name TBD — Developmental Screenings** | Uniform dollar increase | Uniform dollar increase for specific Developmental Screening services | Rate adjustment |
| **CA_VBP_IPH.Oth_New 20230101-20241231 — MOT** | Delivery system reform | FFS-equivalent payment requirement for network and non-network providers for newly transitioning organ and bone marrow transplant surgeries | Rate adjustment |
| **Control Name TBD — Private** | Uniform dollar increase | Uniform dollar increases for services limited to | 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? |
|---|---|---|---|
| **Hospital Directed Payment (PHDP)** | | predetermined pool amounts for IP and OP/ER | |
| **Control Name TBD — 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 IP/non-IP service sub-pools | Separate payment term |
| **Control Name TBD — District and Municipal Public Hospital Directed Payment (DHDP)** | Uniform dollar increase | Uniform dollar increases for services limited to predetermined pool amounts for IP/non-IP service sub-pools | Separate payment term |
| **Control Name TBD — Designated Public Hospital (DPH) Quality Incentive Program (QIP)** | Quality/performance payments | Payments based on performance on designated measures with specified maximum allowable payments for each DPH | Separate payment term |
| **Control Name TBD —2022 District and Municipal Public Hospital (DMPH) QIP** | Quality/performance payments | Payments based on performance on designated measures with specified maximum allowable payments for each DMPH | Separate payment term |
| **Control Name TBD — SNF Workforce and Quality Incentive Program (WQIP)** | Quality-adjusted uniform dollar increase | Uniform dollar increase for contracted services modified by quality based scores at the provider level | Separate payment term |
| **CA VBP NF.Oth New_20230101-** | Delivery system reform | FFS-equivalent payment requirement | Rate adjustment |

| Control Name of the State Directed Payment | Type of Payment | Brief Description | Is the Payment Included as a Rate Adjustment or Separate Payment Term? |
|---|---|---|---|
| **20251231 — LTC FFS Equivalent** | | for network providers for qualifying LTC services in transitioning counties; at-least FFS-equivalent requirement for qualifying LTC services in non-transitioning counties | |
| **TRI** | Minimum fee schedule using State Plan approved rates | Minimum fee schedule for professional, obstetric, and non-specialty mental health services. | Rate adjustment |
| **Control Name TBD — Children and Youth Behavioral Health Initiative (CYBHI)** | Delivery system reform. | A minimum/maximum fee schedule for school-linked | Rate adjustment |
| **Control Name TBD — 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 |
| **CalAIM Dental Preventive Services** | Minimum fee schedule using State Plan approved rates | Minimum fee schedule for specified preventive service codes at the equivalent of 75% above the State's Schedule of Maximum Allowances | Rate adjustment |

There are no additional directed payments in the program for CY 2024 unaddressed in this rate certification. There are no requirements regarding the reimbursement rates the health plans must pay to any providers unless specified in the certification as a directed payment or pass-through payment or authorized under applicable law, regulation, or waiver.

## Proposition 56/General Fund Directed Payments

Consistent with 42 CFR § 438.6(c), DHCS is utilizing the following provider directed payment initiatives. Two of these share the same designation of "Prop 56" as these payment initiatives are or were funded for their State shares through a ballot proposition to increase the excise tax rate on cigarettes and other tobacco products under the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Prop 56) and two are funded using State General Funds and are listed as follows:

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

Prop 56 add-ons are contingent on appropriations of funds being approved by the California Legislature. Currently, all components are effective for the entire CY 2024 period (January 1, 2024 through December 31, 2024). To the extent the California Legislatures does not appropriate Prop 56 funds for the State share for one or more of these payment initiatives for any portion of the CY 2024 period, the state will either discontinue the program(s) as of that date (and submit a rate certification amendment) or continue the program(s) using State General Fund for the State share. The ACE Screening and Developmental Screening initiatives, listed above with no reference of "Prop 56", will be funded by State General Fund for the State share in CY 2024.

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

| Control Name of the Directed Payment | Rate Cells Affected | Impact | Description of the Adjustment | Confirmation the Rates are Consistent with the Preprint | For Maximum Fee Schedules, Provide the Information Requested |
|---|---|---|---|---|---|
| **CalAIM Dental Preventive Services** | HPSM only — All COAs | Adjustment is included in the CY 2022 base data | Minimum fee schedule for specified preventive service codes at the equivalent of 75% above the State's Schedule of maximum Allowances. | No preprint required (minimum fee schedule). | Not applicable |

| Control Name of the Directed Payment | Rate Cells Affected | Impact | Description of the Adjustment | Confirmation the Rates are Consistent with the Preprint | For Maximum Fee Schedules, Provide the Information Requested |
|---|---|---|---|---|---|
| **Control Name TBD — Prop 56 Family Planning** | All except SPD/Full-Dual and LTC/Full-Dual | See "Sum – Add-Ons Details" tabs in the file titled *CY 2024 Medi-Cal Rate Summaries 2023 12.xlsx* | Adjustment is applied as a PMPM add on to the rates. A description of the data, assumptions and methodology is provided in the narrative below. | Confirmed. The preprint is anticipated to be submitted to CMS in December 2023. | Not applicable |
| **Control Name TBD — Prop 56 Dental** | HPSM only All COAs | See exhibit referenced above | See prior description | Confirmed. The preprint will be submitted to CMS in December 2023. | Not applicable |
| **ACE Screening** | All except SPD/Full-Dual and LTC/Full-Dual | See exhibit referenced above | See prior description | No preprint required (minimum fee schedule). | Not applicable |
| **Control Name TBD — Developmental Screenings** | Child, Adult, ACA Expansion, SPD, and WCM | See exhibit referenced above | See prior description | Confirmed. The preprint will be submitted to CMS in December 2023. | Not applicable |

### Dental Preventive Services

Consistent with 42 CFR §438.6(c)(1)(iii)(A), DHCS implemented a directed provider payment initiative that imposes a minimum fee schedule for network providers that provide certain dental services under the contract using State plan approved rates. The minimum fee schedule for these dental procedure codes applies to all eligible providers who perform these

services. These payments are included in the CY 2022 dental base data described previously.

### Prop 56 Family Planning

The Family Planning Prop 56 directed payment is a payment arrangement, which directs MCOs to pay a uniform and fixed dollar amount add-on payment for specific family planning services to eligible network and non-network providers based on the utilization and delivery of qualifying services for eligible enrollees covered under the contract. The preprints for this payment initiative have been approved for three prior rating periods and the renewal version applicable to the current rating period is anticipated to be submitted to CMS for approval no later than December 31, 2023, with no changes to major terms and conditions.

The following provides a brief description of this payment initiative:

- This type of 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[9] | Description | Uniform Dollar Amount |
|---|---|---|
| J7294 | Contraceptive Vaginal Ring: Segesterone Acetate and Ethinyl Estradiol | $301.00 |
| J7295 | Contraceptive Vaginal Ring: Ethinyl Estradio and Etonogestrel | $301.00 |
| J7296 | Levonorgestrel — Releasing Iu Coc Sys 19.5 Mg | $2,727.00 |
| J7297 | Levonorgestrel — Rls Intrauterine Coc Sys 52 Mg | $2,053.00 |
| J7298 | Levonorgestrel — Rls Intrauterine Coc Sys 52 Mg | $2,727.00 |
| J7300 | Intrauterine Copper Contraceptive | $2,426.00 |
| J7301 | Levonorgestrel — Rls Intrauterine Coc Sys 13.5 Mg | $2,271.00 |
| J7307 | Etonogestrel Cntracpt Impl Sys Incl Impl & Spl | $2,671.00 |
| J3490U8 | Depo — Provera | $340.00 |
| J7304U1 | Contraceptive Patch: Norelgestromin and Ethinyl Estradiol | $110.00 |
| J7304U2 | Contraceptive Patch: Levonorgestrel and Ethinyl Estradiol | $110.00 |
| J3490U5 | Emerg Contraception: Ulipristal Acetate 30 Mg | $72.00 |
| J3490U6 | Emerg Contraception: Levonorgestrel 0.75 Mg (2) & 1.5 Mg (1) | $50.00 |
| 11976 | Remove Contraceptive Capsule | $399.00 |
| 11981 | Insert Drug Implant Device | $835.00 |

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

| | | |
|---|---|---|
| 58300 | Insert Intrauterine Device | $673.00 |
| 58301 | Remove Intrauterine Device | $195.00 |
| 81025 | Urine Pregnancy Test | $6.00 |
| 55250 | Removal Of Sperm Duct(S) | $521.00 |
| 58340 | Catheter For Hysterography | $371.00 |
| 58600 | Division Of Fallopian Tube | $1,515.00 |
| 58615 | Occlude Fallopian Tube(S) | $1,115.00 |
| 58661 | Laparoscopy Remove Adnexa | $978.00 |
| 58670 | Laparoscopy Tubal Cautery | $843.00 |
| 58671 | Laparoscopy Tubal Block | $892.00 |
| 58700 | Removal Of Fallopian Tube | $1,216.00 |

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

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

There were relatively complete and credible claims experience data available in the base period, though it is subject to encounter under-reporting and other data issues. Similar to the rate development approach used for the prior period, Mercer leveraged the SFY 2021–2022 base period encounter data of the listed procedure codes to develop the base utilization by COA for each procedure code across all model types. Mercer adjusted the base utilization for estimated encounter under-reporting and anticipated ramp-up due to the enhanced payment under this payment initiative based on literature review of expected national utilization levels of family planning services by the following major service types among childbearing age females:

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

Given the assumed utilizations for each code by COA and the known additional unit cost (uniform dollar increase schedule), Mercer then calculated the expected claims PMPM on a statewide basis as the benefit cost component of the add-on rate. Services provided within FQHC/RHC facilities are also excluded from the add-on payments due to the wrap-around payment structure associated with these types of facilities. Additional payments to American Indian Health Services 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 FQHC/RHC provider exclusion factors to develop the final claims PMPM, which vary by MCO and rating region. This benefit cost PMPM is developed on a combined

basis for all SIS and UIS populations. Acuity factors as well as percentages of pregnancy-related and emergency services for the UIS population were developed using code level SFY 2021–2022 base period encounter data by COA on a statewide basis. UIS and SIS PMPM add-on rates were then calculated in a "budget-neutral" manner from the combined add-on rate PMPM and the projected CY 2024 SIS and UIS enrollment. Note, 0% of the Family Planning services was found to meet the criteria as a pregnancy-related or emergency service. As a result, no portion of the UIS rates specific to this directed payment are part of this certification. Lastly, the PMPM amount of each rate component was adjusted to include half of the plan-specific administrative load, which provides for the variable component of the administrative costs of the program while the fixed administrative costs are covered in the base capitation rates, and an underwriting gain of 2.0%. Further detail of these components, including MCO-specific amounts are provided in the accompanying rate development exhibits in Excel format.

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

| Family Planning (January 2024–December 2024) | | | | | |
|---|---|---|---|---|---|
| **Population** | **COA** | **Projected Member Months** | **Prop 56 Add-on Projected Units** | **Total PMPM** | **Total Dollars** |
| SIS | Child | 51,859,900 | 179,000 | $0.75 | $38,664,585 |
| SIS | Adult | 17,357,131 | 516,273 | $8.06 | $139,917,335 |
| SIS | ACA Expansion | 39,761,722 | 545,321 | $2.80 | $111,214,289 |
| SIS | SPD | 8,654,492 | 63,832 | $1.10 | $9,544,839 |
| SIS | LTC | 30,108 | 15 | $0.04 | $1,189 |
| SIS | WCM | 340,559 | 1,166 | $0.74 | $250,605 |
| **SIS** | **All COAs** | **118,003,912** | **1,305,609** | **$2.54** | **$299,592,842** |

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

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

### Prop 56 Dental

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

### Adverse Childhood Experiences Screening

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

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

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

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

The service was added in CY 2021, and Mercer was able to rely on experience data available in the SFY 2021–2022 base period to help inform the take-up assumptions for the CY 2024 contract period. Similar to the rate development approach used for the prior period, Mercer identified eligible enrollees in the base period eligibility data based on their Medicare coverage status and specific age groups (age group 0–18 and age group 19–64) by COA across all model types. Mercer also relied on actual experience data for these codes within the SFY 2021–2022 base period to inform the take-up assumptions used for the CY 2024 contract period. Note, this service is primarily intended for children, but adults under 65 are also eligible to receive this service if deemed medically necessary. Therefore, the assumed take-up assumptions are much lower for adults compared to children. Given the assumed utilizations for each group, the age group mix for each COA, and the known unit cost (minimum fee schedule), Mercer then calculated the expected claims PMPM as the benefit cost component of the add-on rate s to calculate the percentage of members eligible for this service within each COA. Note, enrollees above age 65 or with Medicare Part B coverage are not eligible for this service. Mercer worked together with the State to develop age group specific take-up assumptions around the percentages of eligible members within each age group who will receive this service within the contract period for the CY 2024 rating period. This benefit cost PMPM is developed on a combined basis for all SIS and UIS populations. Acuity factors, as well as percentages of pregnancy-related and emergency services for the UIS population, were developed using code level SFY 2021–2022 base period encounter data by COA on a statewide basis. UIS and SIS PMPM add-on rates were then calculated in a “budget-neutral” manner from the combined add-on rate PMPM and the projected CY 2024 SIS and UIS enrollment. Note, 0% of the ACE Screening services was found to meet the criteria as a pregnancy-related or emergency service. As a result, no portion of the UIS rates specific to this directed payment is part of this certification. Lastly, the PMPM amount of each

add-on rate component was adjusted to include half of the plan-specific administrative load, which provides for the variable component of the administrative costs of the program while the fixed administrative costs are covered in the base capitation rates, and an underwriting gain of 2.0%. Further detail of these components including MCO-specific amounts are provided in the accompanying rate development exhibits in Excel format.

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

| ACEs Screening (January 2024–December 2024) | | | | | |
|---|---|---|---|---|---|
| **Population** | **COA** | **Projected Member Months** | **Prop 56 Add-on Projected Units** | **Total PMPM** | **Total Dollars** |
| SIS | Child | 51,859,900 | 894,330 | $0.53 | $27,432,045 |
| SIS | Adult | 17,357,131 | 52,099 | $0.09 | $1,597,995 |
| SIS | ACA Expansion | 39,761,722 | 89,733 | $0.07 | $2,751,937 |
| SIS | SPD | 8,654,492 | 41,156 | $0.15 | $1,262,459 |
| SIS | LTC | 30,108 | 36 | $0.04 | $1,091 |
| SIS | WCM | 340,559 | 5,844 | $0.52 | $178,287 |
| **SIS** | **All COAs** | **118,003,912** | **1,083,198** | **$0.28** | **$33,223,813** |

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

Per the preprint and as described earlier in the certification, the add-on rate payment for this payment initiative will be subject to a two-sided risk corridor together with the Developmental Screening add-on rate payment.

### Developmental Screening

The Developmental Screening directed payment is a payment arrangement, which directs MCOs to pay a uniform and fixed dollar amount add-on payment for specific developmental screening services to eligible network providers based on the utilization and delivery of qualifying services for eligible enrollees covered under the contract. The preprints for this payment initiative have been approved for three prior rating periods and the renewal version applicable to the current rating period will be submitted to CMS for approval no later than December 31, 2023, 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 for qualifying covered services provided to eligible managed care enrollees up through age 20.

| Procedure Code | Description | Uniform Dollar Amount |
|---|---|---|
| 96110 | Developmental Screening (absent modifier "KX") | $59.90 |

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

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

Mercer was able to rely on experience data available in the SFY 2021–2022 base period to help inform the take-up assumptions for the CY 2024 contract period. Similar to the rate development approach used for the prior period, Mercer identified eligible enrollees in the base period eligibility data based on their Medicare coverage status and specific age groups (age group 0–2 and age group 3–20) by COA across all model types to calculate the percentage of members eligible for this service within each COA. Note, only children under age 20 and without Medicare Part B coverage are eligible for this service. Mercer developed age group specific take-up assumptions around the percentage of eligible members who will receive this service within the contract period. In conjunction with prior take-up assumptions used for historical rating periods, Mercer also relied on actual experience data for the Developmental Screening code within the SFY 2021–2022 base period to inform the take-up assumptions used for the CY 2024 contract period. This service is primarily intended for younger children under age three, though older children ages three through 20 are also eligible to receive this service if deemed medically necessary. Given the assumed utilizations for each group, the age group mix for each COA, and the known additional unit cost (uniform dollar increase), Mercer then calculated the expected claims PMPM as the benefit cost component of the add-on rate. This benefit cost PMPM is developed on a combined basis for all SIS and UIS populations. Acuity factors as well as percentages of pregnancy-related and emergency services for the UIS population were developed using code level SFY 2021–2022 base period encounter data by COA on a statewide basis. UIS and SIS PMPM add-on rates were then calculated in a "budget-neutral" manner from the combined add-on rate PMPM and the projected CY 2024 SIS and UIS enrollment. Note, 0% of the Developmental Screening services was found to meet the criteria as a pregnancy-related or emergency service. As a result, no portion of the UIS rates specific to this directed payment is part of this certification. Lastly, the PMPM amount of each rate component was adjusted to include half of the plan-specific administrative load, which provides for the variable component of the administrative costs of the program while the fixed administrative costs are covered in the base capitation rates, and an underwriting gain of 2.0%. Further detail of these components, including MCO-specific amounts are provided in the accompanying rate development exhibits in Excel format.

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

| Developmental Screening (January 2024–December 2024) | | | | | |
|---|---|---|---|---|---|
| Population | COA | Projected Member Months | Prop 56 Add-on Projected Units | Total PMPM | Total Dollars |

| | | | | | |
|---|---|---|---|---|---|
| SIS | Child | 51,859,900 | 625,854 | $0.76 | $39,651,761 |
| SIS | Adult | 17,357,131 | 0 | $0.00 | $0 |
| SIS | ACA Expansion | 39,761,722 | 3,353 | $0.01 | $212,414 |
| SIS | SPD | 8,654,492 | 9,834 | $0.07 | $623,047 |
| SIS | LTC | 30,108 | 0 | $0.00 | $0 |
| SIS | WCM | 340,559 | 4,075 | $0.75 | $256,810 |
| **SIS** | **All COAs** | **118,003,912** | **643,117** | **$0.35** | **$40,744,032** |

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

Per the preprint and as described earlier in this certification, the add-on rate payment for this payment initiative will be subject to a two-sided risk corridor together with the ACE Screening add-on rate payment.

## Hospital Directed Payments

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

| Control Name of the State Directed Payment | Aggregate Amount Included in the Certification | Statement that the Actuary is Certifying the Separate Payment Term | The Magnitude on a PMPM Basis | Confirmation the Rate Development is Consistent with the Preprint | Confirmation that the State and Actuary will Submit Required Documentation at the End of the Rating Period (as applicable) |
|---|---|---|---|---|---|
| **Control Name TBD — PHDP** | $7,187.257 million | The actuary certifies the incorporation of the separate payment term | See pink labeled columns in file titled *CY 2024 Medi-Cal Hospital Directed Payment Summary 2023 12.xlsx* for the PMPM estimates | Confirmed. The preprint will be submitted to CMS in December 2023. | Confirmed |

| | | | | | |
|---|---|---|---|---|---|
| **Control Name TBD — EPP** | $2,269.46 million | The actuary certifies the incorporation of the separate payment term | See exhibit referenced above | Confirmed. The preprint will be submitted to CMS in December 2023. | Confirmed |
| **Control Name TBD — DHDP** | $207.29 million | The actuary certifies the incorporation of the separate payment term | See exhibit referenced above | Confirmed. The preprint will be submitted to CMS in December 2023. | Confirmed. |
| **Control Name TBD — DPH QIP** | $2,037.47 million | The actuary certifies the incorporation of the separate payment term | See exhibit referenced above | Confirmed. The preprint is approved. | Confirmed |
| **Control Name TBD — DMPH QIP** | $172.10 million | The actuary certifies the incorporation of the separate payment term | See exhibit referenced above | Confirmed. The preprint is approved. | Confirmed |

Information included in the attached spreadsheet *(CY 2024 Medi-Cal Hospital Directed Payment Summary 2023 12.xlsx)* includes the estimated PMPM impacts associated with each of these separate payment term directed payments by rate cell.

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

### Private Hospital Directed Payment Uniform Dollar Increase

The PHDP preprint will be submitted to CMS for approval no later than December 31, 2023. The PHDP is a uniform dollar add-on payment for services provided by the class of network private hospitals, limited to a pre-determined pool amount, with 70% designated to IP services, and 30% to OP/ER services. The PHDP is a separate payment term; the actual

uniform dollar increase will be calculated after the end of each half of the CY 2024 period based on actual contracted IP and OP/ER services utilized within the class.

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

The directed payment target for PHDP is $7,187.257 million for the entire 12-month rating period. The IP uniform dollar add-on payment estimate of $2,007 and the OP/ER estimate of $256 produced impacts of $5,031.08 million and $2,156.18 million for the respective COS. The attached exhibit (*Exhibit I CY 2024 Directed Payments PHDP 2023 12.pdf*) contains the full detail of these calculations for each COS. The resulting estimates on a PMPM basis by rate cell are provided in the attached spreadsheet (*CY 2024 Medi-Cal Hospital Directed Payment Summary 2023 12.xlsx*) as noted previously.

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

The directed payment target of $7,187.257 million is a draft amount based on information provided by DHCS staff as of November 3, 2023, after which Mercer was not able to incorporate further information as part of this certification. Mercer is aware the final amount may be different as DHCS had not finalized the directed payment target at that time. The final amount will be incorporated through a rate amendment, if necessary.

### Enhanced Payment Program

The EPP directed payment preprint will be submitted to CMS for approval no later than December 31, 2023. The EPP consists of two parts; first, uniform dollar add-on payment for services provided by the four classes of DPHs and second, uniform percentage increase to subcapitation (capitation) payments made to Class A and Class B DPHs. Payments are limited to predetermined pool amounts by DPH provider class. The pool amounts are split into capitation and FFS service sub-pools for applicable DPH classes, and non-capitation pool amounts are further split into IP and non-IP sub-pools. The EPP is a separate payment term; the actual uniform dollar add-on payments and uniform percentage increases will be calculated after the end of each half of the CY 2024 period based on actual contracted services utilized within the applicable provider classes and COS.

Classes A through D are outlined below:

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

### Fee-For-Service Uniform Dollar Increase

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

The methodology that will be used to allocate actual payments associated with these directed payments will be consistent with the methods discussed in this certification and the 42 CFR § 438.6(c) preprint. As described in the EPP preprint, acuity factors will be applied within the final calculations. The application of the acuity factors will be done in a budget neutral fashion whereby the pooled amounts will still be distributed in total. The exclusion of an adjustment for acuity within these current calculations was driven by the insufficient level of detail within the base data and supplemental data utilized in this estimated impact development. However, the resulting estimates produced are considered appropriate for this process.

### Capitation Uniform Percentage Increase

The approach for producing the estimated uniform percentage increase to capitation is similar to prior years. Mercer collected supplemental data from each health plan participating in Class A and Class B counties on historical capitation payments to DPHs and volume of DPH-assigned members. Based on a review of this supplemental data, Mercer estimated the capitation payments for DPH-assigned members anticipated during the rating period and the projected member months for the DPH assigned members by class and rate cell. These calculations produced estimated DPH capitation expenditures, by rate cell and in total, that formed the basis for creating estimated uniform percentage increases that would total the intended directed payment target for the given provider class. The methodology used to allocate actual payments associated with these directed payments will be consistent with the methods discussed in this certification and the 42 CFR § 438.6(c) preprint.

The total impact of the EPP directed payment across the classes is targeted to be approximately $2,269.46 million. The attached exhibits (*Exhibit II CY 2024 Directed Payments EPP 2023 12.pdf*) contain the full detail of these calculations by Class, sub-pool, and impacted COS. The resulting estimates on a PMPM basis by rate cell are provided in the attached spreadsheet (*CY 2024 Medi-Cal Hospital Directed Payment Summary 2023 12.xlsx*).

## District and Municipal Public Hospital Directed Payment Uniform Dollar Increase

The DHDP preprint will be submitted to CMS for approval no later than December 31, 2023. The DHDP is a uniform dollar add-on payment for services provided by the class of network DMPHs, limited to a predetermined pool amount, with 70% designated to IP (IP/LTC) services, and 30% to non-IP (OP/ER) services. The DHDP is a separate payment term; the actual uniform dollar increase will be calculated after the end of each half of the CY 2024 period based on actual contracted IP and non-IP services utilized within the class.

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

The directed payment target for DHDP was $207.291 million for the entire 12-month rating period. The uniform dollar add-on payment estimates of $909 for IP and $201 for LTC produced the IP/LTC impact of $145.10 million, while the OP/ER estimate of $98 produced the OP/ER impact of $62.19 million. The attached exhibit (*Exhibit III CY 2024 Directed Payments DHDP 2023 12.pdf*) contains the full detail of these calculations for each COS. The resulting estimates on a PMPM basis by rate cell are provided in the attached spreadsheet (*CY 2024 Medi-Cal Hospital Directed Payment Summary 2023 12.xlsx*) as noted previously.

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

### Designated Public Hospital Quality Incentive Pool

The QIP DPH directed payment preprint will be submitted to CMS for approval no later than December 31, 2023. The DPH QIP directed payment provides value-based payments to DPHs for meeting specified performance measures linked to the utilization and delivery of services under the managed care contracts. Each county with an applicable non-UC DPH is designated a specified maximum allowable pool payment amount, and the UC facilities statewide are designated a maximum allowable pool payment amount.

The approach for producing the estimated impact is similar to prior years. The QIP DPH directed payment estimates are calculated as a uniform percentage increase to anticipated DPH expenditures in CY 2024 by rate cell; the uniform percentage estimate is modeled on a county-specific basis for the counties with non-UC DPHs and a statewide basis for the UC facilities. Each county/region and UC facilities are allocated a portion of the total respective QIPs. The estimated contracted share of revenue was applied to the capitation GME PMPM by rate cell for the non-UC DPHs and the UC DPHs. These calculations produced estimated DPH capitation expenditures, by rate cell and in total, which formed the basis for creating uniform percentage increases that would total the intended directed payment maximum allowable payment target for each non-UC county and for the UC facilities.

The total impact of the QIP DPH directed payment is targeted to be approximately $2,037.47 million. The attached exhibits (*Exhibit IV CY 2024 Directed Payments DPH QIP 2023 12.pdf*) contain the full detail of these calculations. The resulting estimates on a PMPM basis by rate cell are provided in the attached spreadsheet (*CY 2024 Medi-Cal Hospital Directed Payment Summary 2023 12.xlsx*).

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

### District and Municipal Public Hospital Quality Incentive Pool

The DMPH QIP directed payment preprint will be submitted to CMS for approval no later than December 31, 2023. The DMPH QIP directed payment provides value-based payments to DMPHs for meeting specified performance measures linked to the utilization and delivery of services under the managed care contracts. Each county with an applicable DMPH is designated a specified maximum allowable pool payment amount.

The approach for producing the estimated impact is similar to prior years and similar to the calculation of the non-UC QIP DPH estimates. The QIP DMPH directed payment estimates are calculated as a uniform percentage increase to anticipated DMPH expenditures in CY 2024 by rate cell; the uniform percentage estimate is modeled on a county-specific basis for the counties with DMPHs. Each county/region is allocated a portion of the total respective QIP. The estimated DMPH contracted share of revenue was applied to the capitation GME PMPM by rate cell. These calculations produced estimated DMPH capitation expenditures, by rate cell and by county, which formed the basis for creating uniform percentage increases that would total the intended directed payment maximum allowable payment target for each DMPH county.

The total impact of the DMPH QIP directed payment is targeted to be approximately $172.10 million. The attached exhibits (*Exhibit V CY 2024 Directed Payments DMPH QIP 2023 12.pdf*) contain the full detail of these calculations. The resulting estimates on a PMPM basis by rate cell are provided in the second tab of the attached spreadsheet (*CY 2024 Medi-Cal Hospital Directed Payment Summary 2023 12.xlsx*).

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

### Major Organ Transplant Hospital Directed Payment

The MOT directed payment preprint encompassing the CY 2024 rating period was approved by CMS on April 25, 2023. This directed payment is specific to hospital stays incorporating the MOT event and only applies to transplants transitioning from FFS to managed care. This directed payment directs MCOs to pay hospitals at levels that would be paid in the Medi-Cal FFS delivery system.

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

| Control Name of the Directed Payment | Rate Cells Affected | Impact | Description of the Adjustment | Confirmation the Rates are Consistent with the Preprint | For Maximum Fee Schedules, Provide the Information Requested |
|---|---|---|---|---|---|
| **CA VBP IP H.Oth_New_ 20220101-20241231 — MOT** | Child, Adult, ACA Expansion, SPD, | $0 | Adjustment is applied in the base and is a part of the MOT | Confirmed. | Not applicable |

| | | | | | |
|---|---|---|---|---|---|
| | SPD/Full-Dual | | PMPM add-on. | | |

## Skilled Nursing Facility and Workforce and Quality Incentive Program

The SNF WQIP preprint will be submitted to CMS for approval no later than December 31, 2023. The SNF WQIP is a quality-adjusted uniform dollar add-on payment for services provided by the class of network SNFs for which Medi-Cal is the primary payer, limited to a predetermined pool amount. The SNF WQIP 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 LTC services utilized within the class and actual quality scores.

The approach for developing the estimated SNF WQIP uniform dollar increases and PMPM impacts is similar to the approach utilized for the hospital directed payments. The estimated contracted share of LTC days and unit cost differentials for the SNF WQIP class were applied to the GME PMPM component of the capitation rate by rate cell for the LTC COS. These calculations produced estimated SNF WQIP 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 directed payment target. For this estimate, Mercer assumed uniform quality performance measures across all eligible days.

The directed payment target for WQIP was $295.3 million for the entire 12-month rating period. The uniform dollar add-on payment estimate of $17.27 for LTC produced this impact of $295.3 million. The estimates on a PMPM basis by rate cell are provided in the attached spreadsheet (*CY 2024 Medi-Cal WQIP Directed Payment Summary 2023 12.xlsx*).

The methodology that will be used to allocate actual payments associated with this directed payment will be consistent with the methods discussed in this certification and the 42 CFR § 438.6(c) preprint. The final actual add-on payment will be adjusted based on facility-specific, curved WQIP performance measure scores. To facilitate CMS rate review for the SNF WQIP directed payment, the table below summarizes the directed payment.

| Control Name of the State Directed Payment | Aggregate Amount Included in the Certification | Statement that the Actuary is Certifying the Separate Payment Term | The Magnitude on a PMPM Basis | Confirmation the Rate Development is Consistent with the Preprint | Confirmation that the State and Actuary will Submit Required Documentation at the End of the Rating Period (as applicable) |
|---|---|---|---|---|---|
| Control Name TBD — SNF WQIP | $295.3 million | The actuary certifies the incorporation of the separate payment term | See file titled *2024 Medi-Cal WQIP Directed Payment Summary 2023 12.xlsx* for the PMPM estimates | Confirmed. | Confirmed |

## Long-Term Care Directed Payment

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

- Effective January 1, 2023 for SNF services, and effective January 1, 2024 for ICF-DD and SA services, MCOs operating in non-COHS and non-CCI regions are required to reimburse network LTC providers at, and those providers are required to accept, the payment rate that would otherwise have been paid in the FFS delivery system (i.e., Medi-Cal FFS per diem rate). This requirement applies to all LTC services, both for services transitioning from FFS and all LTC services previously covered by MCOs in these counties.
- Effective January 1, 2023 for SNF services, and effective January 1, 2024 for ICF-DD and SA services, MCOs operating in COHS and CCI counties are required to reimburse network LTC providers at no less than the payment rate that would otherwise have been paid in the FFS delivery system (i.e., Medi-Cal FFS per diem rate).

This directed payment is incorporated into the capitation rates as a rate adjustment, and further described in Section 4, under LTC FFS Equivalent Directed Payment Adjustment.

This delivery system reform arrangement includes an effective maximum on the rate of reimbursement in certain counties. There were instances in the base data where the MCO paid above the maximum for the month of admission and subsequent month. MCOs currently paying above the maximum are expected to lower their reimbursement rates consistent with requirement in State law for MCOs to pay, and providers to accept, the Medi-Cal FFS per-diem rate. There are no exemptions to allow MCOs to pay above the maximum; however, MCOs can enter into alternative arrangements with their network providers that

result in payments beyond the per-diem reimbursement, such as provider incentive payments.

| Control Name of the Directed Payment | Rate Cells Affected | Impact | Description of the Adjustment | Confirmation the Rates are Consistent with the Preprint | For Maximum Fee Schedules, Provide the Information Requested |
|---|---|---|---|---|---|
| **CA_VBP_NF. Oth New 20230101-20251231 — LTC Directed Payment** | All | See Program Change charts referenced in Section 4 | Adjustment is applied in the base capitation rates and is a portion of the LTC COS. | Confirmed. | See description above. |

## Children and Youth Behavioral Health Initiative

DHCS is implementing a delivery system reform State directed payment under 42 CFR § 438.6(c) for the reimbursement applicable behavioral health services included in the CYBHI fee schedule.

The rate impacts associated with this program will be captured in a future rate amendment.

## Equity and Practice Transformation Directed Payment

The Equity and Practice Transformation state directed payment will require MCOs to reimburse selected network providers uniform dollar increases, modified based on performance on designated measures, for the first contracted service for each assigned member seen in the rating period. The state directed payment is pending finalization of the program parameters and is not included in this rate certification. The preprint will be submitted to CMS for approval no later than December 31, 2023.

The rate impacts associated with this program will be captured in a future rate amendment.

## Targeted Provider Rate Increase

The Targeted Provide Rate Increase directed payment is a payment arrangement, which directs MCOs to pay no less than a minimum fee schedule payment for specific services to eligible network providers based on the utilization and delivery of qualifying services for eligible enrollees covered under the contract. As this is a minimum fee schedule using State plan approved rates, there will be no preprint submitted per 42 CFR § 438.6(c)(2)(ii). The TRI directed payment is described further within Section 4 of this report.

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

| Control Name of the Directed Payment | Rate Cells Affected | Impact | Description of the Adjustment | Confirmation the Rates are Consistent with the Preprint | For Maximum Fee Schedules, Provide the Information Requested |
|---|---|---|---|---|---|
| **TRI** | All | See Program Change charts referenced in Section 4 | Adjustment is applied in the base capitation rate and is a portion of various COS as detailed in the Program Changes chart referenced in Section 4 | Not Applicable. | Not Applicable. |

# Pass-Through Payments

Pass-through payments, as described below, are applied in the COHS, GMC, Regional, Single-Plan, and Two-Plan Model CY 2024 capitation rates.

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

A new pass-through payment for public distinct part NF services transitioning from an FFS delivery system to a managed care delivery system under 42 CFR § 438.6(d)(6) is pending finalization of the program parameters and is not included in this rate certification. The pass-through payment transitions existing State Plan-approved supplemental payments for DP/NF services that will be covered for the first time under a managed care contract following the carve-in of LTC services. The pass-through payment program parameters will be incorporated through a rate amendment.

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

Historical adjustments associated with the private hospital quality assurance fee (HQAF) and DMPHs are continuing for CY 2024. The approach for making these adjustments within the capitation rates are being addressed through two paths; first, Pass-through Payments as defined by 42 CFR § 438.6(d), and 2) Directed Payments as defined by 42 CFR § 438.6(c).

The directed payment approach is described earlier within this certification report and is paid through a separate payment term. The pass-through components of the HQAF/DMPH adjustments are paid as a PMPM add-on amount by rate cell, included within the certified rates. These have been developed in a fashion similar to historical approaches.

The estimated share of revenue for the private hospitals and DMPHs was applied to the capitation GME PMPM by rate cell for each impacted COS (IP and OP/ER for private hospitals, and only IP for DMPHs). These calculations produced estimated private and DMPH PMPMs, by rate cell and in total. It should be noted the GME amounts utilized to produce the baseline amounts are inclusive of projected maternity costs. This approach was taken so these adjustments did not impact the maternity supplemental payments (this is consistent with historical practice). The DMPH components of the capitation rates were increased by a uniform percentage increase to the IP component (19.32%). The private hospital components of the capitation rates were increased by a uniform percentage increase to the IP component (9.75%) and a uniform percentage increase to the OP/ER component (11.68%). The total target impact of $1,297.4 million is projected across all the California managed care models (COHS, GMC, Regional, Single-Plan, and Two-Plan models) for the 12-month rating period. The development of these add-on amounts did not impact the underlying data or assumptions associated with the regular development of the capitation rates. Consistent with historical approaches, no additional administrative load or underwriting gain is included within these add-on amounts for HQAF/DMPH. The DMPH targeted expenditure is approximately $97.4 million across the 12-month period and the DMPH targeted expenditure of $97.4 million is part of the $1,297.4 million total impact.

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

Included attachments labeled *Exhibit A CY 2024 DMPH IP Pass-Through 2023 12.pdf*, *Exhibit B CY 2024 Private Hospital IP HQAF Pass-Through 2023 12.pdf*, and *Exhibit C CY 2024 Private Hospital OP ER HQAF Pass-Through 2023 12.pdf* contain the detailed components behind these calculations. The resulting PMPM add-on rates by rate cell are provided in the “Sum – Region Add-Ons” tabs within the attached spreadsheet *CY 2024 Medi-Cal Rate Summaries 2023 12.xlsx*.

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

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

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

For the DMPH pass-through, the non-federal share of this payment arrangement will consist of voluntary IGTs from eligible public entities. The entities transferring funds are DMPHs — public hospitals as defined by Welfare & Institutions Code §14105.98(a)(25)

excluding DPHs as defined by Welfare & Institutions Code §14184.10(f)(1). The expected transferring entities will consist of cities, counties, and special health care districts; in general, the funding entities have general taxing authority, either directly or through receipt of property taxes from counties. The IGTs for the non-federal share of the payments are voluntary, and the State solicits letters of intent from eligible transferring entities that will identify the approximate amount of IGTs they plan to provide. As the non-federal share of the final payments will be based upon actual member months realized by the MCOs, the total amount of IGTs ultimately necessary for the payments will not be known until after the rating period has ended. To the best of our knowledge, the entities have not received State appropriations specific to this program at this time. As stated above, the non-federal share of this payment will consist of voluntary IGTs for which the transferring entity will certify the transferred funds qualify for federal financial participation. The State has yet to enter into any written agreements with the funding entities relating to the non-federal share of this payment arrangement. The State is not aware of any additional written agreements currently existing between healthcare providers and/or related entities to finance the non-federal share specific to this payment arrangement. If approved, the State intends to enter into separate agreements with the transferring entities regarding the provision of IGTs for this purpose, including a mechanism whereby the transferring entities certify that the funds transferred are public funds and eligible for federal financial participation pursuant to applicable federal regulations.

## Martin Luther King Jr. Community Hospital in Los Angeles Region

Historical program change adjustments for the Martin Luther King Jr. Community Hospital (MLK) IP component of the LA Region SPD and ACA Expansion rate cells are being presented as pass-through payments based upon the definition of a pass-through within 42 CFR § 438.6(d). In alignment with the prior program change adjustment, additional costs not included within the base data are added to the IP COS to meet the requirements of SB 857 that establishes IP payment levels for MLK.

The estimated share of IP revenue for MLK was applied to the capitation IP GME PMPM by rate cell. These calculations produced estimated MLK PMPMs by rate cell and in total. It should be noted, the GME amounts utilized to produce the baseline amounts are inclusive of projected maternity costs. This approach was taken so these adjustments did not impact the maternity supplemental payments (this is consistent with historical practice). A uniform percentage increase for the MLK component of the IP COS was established to provide the needed adjustments to reflect the required costs. The development of these adjustments also includes a 3.550% administrative load, which aligns with administrative costs assigned to the maternity supplemental payment as well as the administrative load included with the Prop 56 directed payment add-on payments. An underwriting gain of 2.0%, also consistent with the other payment mechanisms previously mentioned, is included as part of the add-on payment. The total adjustment including administrative load and underwriting gain is estimated to be $47.42 million across CY 2024 based upon enrollment projections.

Included attachment labeled *Exhibit D CY 2024 MLK IP Pass-Through 2023 12.pdf* contains the detailed components behind these calculations. The resulting PMPM add-on rates by rate cell are provided in the “Sum – Region Add-Ons” tabs within the attached spreadsheet *CY 2024 Medi-Cal Rate Summaries 2023 12.xlsx*.

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

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

## Benioff Children's Hospital Oakland in Alameda Region

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

The estimated share of revenue for BCHO was applied to the capitation GME PMPM by rate cell and applicable COS. These calculations produced estimated BCHO PMPMs by rate cell and in total. It should be noted the GME amounts utilized to produce the baseline amounts are inclusive of projected maternity costs. This approach was taken so these adjustments did not impact the maternity supplemental payments (this is consistent with historical practice). A uniform percentage increase across all applicable COS was established to reflect the needed adjustments to reflect total costs. The development of these adjustments also includes a 3.550% administrative load that aligns with administrative costs assigned to the maternity supplemental payment as well as the administrative load included with the Prop 56 directed payment add-on payments. An underwriting gain of 2.0%, also consistent with the other payment mechanisms previously mentioned, is included as part of the add-on payment. The total adjustment including administrative load and underwriting gain is estimated to be $22.00 million across CY 2024 based upon enrollment projections.

The detailed build-up of these adjustments is included in the attachment labeled *Exhibit E CY 2024 BCHO Pass-Through 2023 12.pdf*. The resulting PMPM add-on rates by rate cell are provided in the "Sum – Region Add-Ons" tabs within the attached spreadsheet *CY 2024 Medi-Cal Rate Summaries 2023 12.xlsx*.

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

The non-federal share of this payment arrangement will consist of voluntary IGTs from eligible public entities. For this payment, the entity transferring funds is University of California, San Francisco, a state entity that does not have general taxing authority. The IGT for the non-federal share of the payments is voluntary, and the State solicits a letter of intent from University of California, San Francisco that will identify the approximate amount of IGTs they plan to provide. As the non-federal share of the final payments will be based upon actual member months realized by MCOs, the total amount of IGTs that ultimately will be necessary for the payments will not be known until after the rating period has ended. To the best of our knowledge, the entity has not received State appropriations specific to this program at this time. As stated above, the non-federal share of this payment will consist of a voluntary IGT for which the transferring entity will certify the transferred funds qualify for federal financial participation. The State has yet to enter into any written agreement with the

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

## Pass-Through Payments Base Amount Calculation

For the CY 2024 rating period, DHCS has confirmed the projected aggregate amount of pass-through payments to hospitals does not exceed either of:

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

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

### Amount of Historical Pass-Through Payments, 42 CFR § 438.6(d)(3)(ii)

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

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

#### General Methodology

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

1. Forty (40) percent of the base amount defined at 42 CFR § 438.6(d)(2) applicable to the period of January 1, 2024 through June 30, 2024.
2. Thirty (30) percent of the base amount defined at 42 CFR § 438.6(d)(2) applicable to the period of July 1, 2024 through December 31, 2024.

The aggregate amount resulting from this calculation is $2,114,504,118 as displayed in the exhibit *CY 2024 Base Amount Calculation 2023 12.pdf*.

The 42 CFR § 438.6(d)(2)(i) component of the base amount is equal to the aggregate difference between the amounts calculated in accordance with 42 CFR § 438.6(d)(2)(i)(A) and (d)(2)(i)(B). This amount is the differential between the amount paid under Medicaid managed care and the amount Medicare FFS would have paid for IP and OP hospital services provided to eligible populations under the Medicaid managed care contracts for the 12-month period immediately two years prior to the CY 2024 rating period, which corresponds to CY 2022.

The 42 CFR § 438.6(d)(2)(i)(A) calculation includes two elements; unit cost and utilization. All state-only services were excluded in the cost and utilization data for this part of the calculation. Unit costs were based on Department of Health Care Access and Information,

previously the Office of Statewide Health Planning and Development, statewide data for Medicare FFS beneficiaries. CY 2021 data was leveraged to arrive at estimated CY 2022 average unit costs for IP and OP hospital services. To maintain consistency with the approach used for the 42 CFR § 438.6(d)(2)(i)(B) component, unit cost trend was applied to the CY 2021 data in order to determine a reasonable estimate of CY 2022 unit costs. The trend applied was based on the Consumer Price Index for All Urban Consumers for hospital related services over the previous five SFYs (SFY 2017–2018 through SFY 2021–2022). The resulting estimated IP and OP unit costs are 3.43% higher year-over-year compared to the CY 2021 unit costs.

Utilization was calculated based on SFY 2021–2022 base data used in Medi-Cal managed care rate development that was trended forward to CY 2022. Distinct trends were applied for IP and OP hospital services based on the base data utilization change from CY 2018 through SFY 2021–2022. For simplicity, the base period data was not trended to the rating period; however, the state may elect to apply trend adjustments, as appropriate, in the calculation of the base amount applicable to future rating periods.

Unit cost was multiplied by utilization for both IP and OP hospital services, respectively. The resulting amounts were then summed to determine the total amount for the 42 CFR § 438.6(d)(2)(i)(A) component of the calculation.

The 42 CFR § 438.6(d)(2)(i)(B) calculation includes three elements: unit cost, utilization, and directed payments. SFY 2021–2022 data was trended to arrive at estimated CY 2022 average unit costs for IP and OP hospital services. The same trend used for the 42 CFR § 438.6(d)(2)(i)(A) component of the calculation was utilized here. Utilization is identical to that used for the 42 CFR § 438.6(d)(2)(i)(A) component of the calculation. Unit cost was multiplied by utilization for both IP and OP hospital services, respectively. The resulting amounts were then summed and further increased by the amount of applicable directed payments for IP and OP hospital services for the CY 2022 base period to arrive at the total amount for 42 CFR § 438.6(d)(2)(i)(B). The applicable directed payments were made as part of the DPH EPP and PDHP. These directed payments were first implemented beginning on July 1, 2017.

### Aggregate Difference

The aggregate difference between the total amounts of 42 CFR § 438.6(d)(2)(i)(A) and (d)(2)(i)(B) is $6,041,440,337. This amount was multiplied by a factor of 0.35 to account for the 40% and 30% phase-down levels associated with the seventh and eighth fiscal years, respectively, occurring after July 1, 2017.

### Trend Adjustments

At the time of this calculation, SFY 2021–2022 cost and utilization data specific to Medi-Cal managed care was available for use in this calculation and trended forward to determine the reasonable estimates in calculating the Base Amount for the CY 2024 rating period. Both unit cost and utilization trends were applied in the calculation of the amount specified by 42 CFR § 438.6(d)(2)(i). Trends were applied consistently for both 42 CFR § 438.6(d)(2)(i)(A) and (d)(2)(i)(B).

The unit cost trend adjustment is based on the Consumer Price Index for All Urban Consumers, Hospital, and Related Services. The year-over-year growth from July 1, 2017 through July 1, 2022 was used to determine an annual trend percentage of 3.43%. This

source of growth is consistent with the annual growth rate historically approved by CMS in the preprint for the state's QIP. Based on CMS' approval of this data source for determining unit cost growth, DHCS believes this source is reasonable and appropriate. While alternative trends are possible and may be reasonable, that fact does not diminish the reasonableness of the state's approach in utilizing an established cost index to inform the trend assumption.

The utilization trend adjustment is based on the year-over-year growth from CY 2018 through SFY 2021–2022 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 2017–2018 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 = $2,114,504,118

Unit Cost Trend Removed = $1,882,720,532

Utilization Trend Removed = $2,045,637,898

Unit Cost Trend and Utilization Trend Removed = $1,818,205,550

DHCS believes both the unit cost and utilization trends applied in this calculation are reasonable and appropriate. However, 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 2024 rating period.

The 42 CFR § 438.6(d)(2)(ii) component of the base amount is assumed to be equal to $0 at this time, consistent with the approach used for prior rating periods. The amount in accordance with 42 CFR § 438.6(d)(2)(ii) is the differential between the amount paid under Medicaid FFS and the amount Medicare FFS would have paid for IP and OP hospital services provided to eligible populations through the Medicaid FFS delivery system for the 12-month period immediately two years prior to the CY 2024 rating period that have subsequently shifted to the Medicaid managed care delivery system. There were material shifts of IP and OP hospital services, and of eligible populations, from Medicaid FFS to Medicaid managed care for the applicable time periods. However, given the 42 CFR § 438.6(d)(2)(i) component on its own exceeds the projected aggregate amount of pass-through payments for the CY 2024 rating period, DHCS has opted to keep this component of the calculation $0 at the current time. The state reserves the right to utilize this component of the calculation in a future amendment of this certification, particularly in relation to the incorporation of pass-through payments for DP/NF services in accordance with 42 CFR § 438.6(d), or for future rating periods.

# Section 8
# Certification and Final Rates

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

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

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

Mercer certifies that the COHS, GMC, Regional, Single-Plan, and Two-Plan 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,

[redacted]

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

[redacted]

James J. Meulemans, ASA, MAAA, FCA
Partner

## Appendix A

# Pregnancy-related and Emergency Service Identification Logic

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

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

1. Labor and Delivery (Emergency) — Labor and delivery is separated out from other maternity-related services since labor and delivery is considered emergency for claiming purposes.

2. Maternity DHCS (Pregnancy-related) — The State maintains an existing set of business rules or logic/criteria it uses to identify applicable maternity-related services for FFS claiming on the UIS population. This category corresponds to this logic. Mercer reviewed the State's logic to ensure agreement that the services identified by the logic would be related to a maternity-related service. Mercer's assessment was that the logic included was a reasonable basis for the identification of the maternity services.

3. Maternity Mercer (Pregnancy-related) — Mercer maintains a set of codes and coding methodology to identify maternity-related services in encounter data for capitation rate development purposes. Mercer's coding and methodology was developed by and is continually refined by Mercer's team of clinicians and coding and data specialists.

4. Pregnancy-related "Catch All" (Pregnancy-related) — This logic identified live birth or delivery events. Using that birth/delivery event date, all encounters were pulled within SFY 2021–2022 for these members with dates of service 238 days prior to the delivery event (pregnancy-related services). The 238-day threshold (34 weeks) was selected because based on information from the National Center for Health Statistics, only 3% of

babies are born before 34 weeks of pregnancy. That means 97% of all births are at 34 weeks of pregnancy or later. This 238-day threshold is viewed as conservative because it does not account for the first few weeks of pregnancy for most births (90% of births are at 37 weeks or later). The assumption here is that virtually every service delivered during pregnancy is ultimately for the benefit of the unborn child.

5. Emergency Medical Transportation (Emergency)
6. Emergency Facility (Emergency)
7. Emergency Other (Emergency)
8. IP Admissions that Originated Through the ER (Emergency)
9. Dialysis (Emergency)
10. Emergency DHCS (Emergency) — Similar to the Maternity DHCS categorization, the State maintains existing business rules or logic/criteria is uses to identify emergency-related services for FFS claiming on the UIS population. Mercer reviewed the State's logic to ensure agreement that the services identified by the logic would be related to an emergency-related service. Mercer's assessment was that the logic included was a reasonable basis for the identification of the emergency services.

# Detailed Codes and Logic

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

1. **Labor and Delivery Criteria**

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

**Criteria Set 1:**

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

'O6010X0', 'O6010X1', 'O6010X2', 'O6010X3', 'O6010X4', 'O6010X5', 'O6010X9', 'O6012X0', 'O6012X1', 'O6012X2', 'O6012X3', 'O6012X4', 'O6012X5', 'O6012X9', 'O6013X0', 'O6013X1', 'O6013X2', 'O6013X3', 'O6013X4', 'O6013X5', 'O6013X9', 'O6014X0', 'O6014X1', 'O6014X2', 'O6014X3', 'O6014X4', 'O6014X5', 'O6014X9', 'O6020X0', 'O6020X1', 'O6020X2', 'O6020X3', 'O6020X4', 'O6020X5', 'O6020X9', 'O6022X0', 'O6022X1', 'O6022X2', 'O6022X3', 'O6022X4', 'O6022X5', 'O6022X9', 'O6023X0', 'O6023X1', 'O6023X2', 'O6023X3', 'O6023X4', 'O6023X5', 'O6023X9', 'O670', 'O678', 'O679', 'O68', 'O690XX0', 'O690XX1', 'O690XX2', 'O690XX3', 'O690XX4', 'O690XX5', 'O690XX9', 'O691XX0', 'O691XX1', 'O691XX2', 'O691XX3', 'O691XX4', 'O691XX5', 'O691XX9', 'O692XX0', 'O692XX1', 'O692XX2', 'O692XX3', 'O692XX4', 'O692XX5', 'O692XX9', 'O693XX0', 'O693XX1', 'O693XX2', 'O693XX3', 'O693XX4', 'O693XX5', 'O693XX9', 'O694XX0', 'O694XX1', 'O694XX2', 'O694XX3', 'O694XX4', 'O694XX5', 'O694XX9', 'O695XX0', 'O695XX1', 'O695XX2', 'O695XX3', 'O695XX4', 'O695XX5', 'O695XX9', 'O6981X0', 'O6981X1', 'O6981X2', 'O6981X3',

'O6981X4', 'O6981X5', 'O6981X9', 'O6982X0', 'O6982X1', 'O6982X2', 'O6982X3', 'O6982X4', 'O6982X5', 'O6982X9', 'O6989X0', 'O6989X1', 'O6989X2', 'O6989X3', 'O6989X4', 'O6989X5', 'O6989X9', 'O699XX0', 'O699XX1', 'O699XX2', 'O699XX3', 'O699XX4', 'O699XX5', 'O699XX9', 'O700', 'O701', 'O7020', 'O7021', 'O7022', 'O7023', 'O703', 'O704', 'O709', 'O720', 'O721', 'O722', 'O723', 'O730', 'O731', 'O740', 'O741', 'O742', 'O743', 'O744', 'O745', 'O746', 'O747', 'O748', 'O749', 'O750', 'O751', 'O752', 'O753', 'O754', 'O755', 'O7581', 'O7582', 'O7589', 'O759', 'O76', 'O770', 'O771', 'O778', 'O779', 'O80', 'O82', 'Z370', 'Z371', 'Z372', 'Z373', 'Z374', 'Z3750', 'Z3751', 'Z3752', 'Z3753', 'Z3754', 'Z3759', 'Z3760', 'Z3761', 'Z3762', 'Z3763', 'Z3764', 'Z3769', 'Z377', 'Z379'

**or**

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

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

**or**

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

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

**Criteria Set 2:**

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

2. **Maternity DHCS**

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

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

**Criteria Set 1:**

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

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

**Criteria Set 2:**

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

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

**Criteria Set 3:**

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

'10900ZA' through '10900ZD', '10903ZA' through '10903ZD', '10904ZA' through '10904ZD', '10907ZA' through '10907ZD', '10908ZA' through '10908ZD', '10D00Z0' through '10D00Z2', '10D07Z3' through '10D07Z8', '10Q00YE' through '10Q00YH', '10Q00YJ' through '10Q00YN', '10Q00YP' through '10Q00YT', '10Q00ZE' through ‘10Q00ZH', '10Q00ZJ' through '10Q00ZN', '10Q00ZP' through '10Q00ZT', '10Q03YE' through '10Q03YH', '10Q03YJ' through '10Q03YN', '10Q03YP' through '10Q03YT', '10Q03ZE' through '10Q03ZH', '10Q03ZJ' through '10Q03ZN', '10Q03ZP' through '10Q03ZT', '10Q04YE' through '10Q04YH', '10Q04YJ' through '10Q04YN', '10Q04YP' through '10Q04YT', '10Q04ZE' through '10Q04ZH', '10Q04ZJ' through '10Q04ZN', '10Q04ZP' through '10Q04ZT', '10Q07YE' through '10Q07YH', '10Q07YJ' through '10Q07YN', '10Q07YP' through '10Q07YT', '10Q07ZE' through '10Q07ZH', '10Q07ZJ' through '10Q07ZN', '10Q07ZP' through '10Q07ZT', '10Q08YE' through '10Q08YH', '10Q08YJ' through '10Q08YN', '10Q08YP' through '10Q08YT', '10Q08ZE' through '10Q08ZH', '10Q08ZJ' through '10Q08ZN', '10Q08ZP' through '10Q08ZT', '10Y03ZJ' through '10Y03ZN', '10Y03ZP' through '10Y03ZT', '10Y04ZE' through '10Y04ZH', '10Y04ZJ' through '10Y04ZN', '10Y04ZP' through '10Y04ZT', '10Y07ZE' through '10Y07ZH', '10Y07ZJ' through '10Y07ZN', '10Y07ZP' through '10Y07ZT', '0W8NXZZ', '0WQNXZZ', '10900Z9', '10900ZU', '10903Z9', '10903ZU', '10904Z9', '10904ZU', '10907Z9', '10907ZU', '10908Z9', '10908ZU', '10D17ZZ', '10D18ZZ', '10E0XZZ', '10H003Z', '10H00YZ', '10H073Z', '10H07YZ', '10J00ZZ', '10J03ZZ', '10J04ZZ', '10J07ZZ', '10J08ZZ', '10J0XZZ', '10J10ZZ', '10J13ZZ', '10J14ZZ', '10J17ZZ', '10J18ZZ', '10J1XZZ', '10J20ZZ', '10J23ZZ', '10J24ZZ', '10J27ZZ', '10J28ZZ', '10J2XZZ', '10P003Z', '10P00YZ', '10P073Z', '10P07YZ', '10Q00YV', '10Q00YY', '10Q00ZV', '10Q00ZY', '10Q03YV', '10Q03YY', '10Q03ZV', '10Q03ZY', '10Q04YV', '10Q04YY', '10Q04ZV', '10Q04ZY', '10Q07YV', '10Q07YY', '10Q07ZV', '10Q07ZY', '10Q08YV', '10Q08YY', '10Q08ZV', '10Q08ZY', '10S07ZZ', '10S0XZZ', '10T20ZZ', '10T23ZZ', '10T24ZZ', '10Y03ZE', '10Y03ZH', '10Y03ZV', '10Y03ZY', '10Y04ZV', '10Y04ZY', '10Y07ZV', '10Y07ZY', '30273H1', '30273J1', '30273K1', '30273L1', '30273M1', '30273N1', '30273P1', '30273Q1', '30273R1', '30273S1', '30273T1', '30273V1', '30273W1', '30277H1', '30277J1', '30277K1', '30277L1', '30277M1', '30277N1', '30277P1', '30277Q1', '30277R1', '30277S1', '30277T1', '30277V1', '30277W1', '3E053VJ', '3E0DXGC', '3E0E305', '3E0E33Z', '3E0E36Z', '3E0E37Z', '3E0E3BZ', '3E0E3GC', '3E0E3HZ', '3E0E3KZ', '3E0E3NZ', '3E0E3SF', '3E0E705', '3E0E73Z', '3E0E76Z', '3E0E77Z', '3E0E7BZ', '3E0E7GC', '3E0E7HZ', '3E0E7KZ',

'3E0E7NZ', '3E0E7SF', '3E0E805', '3E0E83Z', '3E0E86Z', '3E0E87Z', '3E0E8BZ', '3E0E8GC', '3E0E8HZ', '3E0E8KZ', '3E0E8NZ', '3E0E8SF', '4A0H74Z', '4A0H7CZ', '4A0H7FZ', '4A0H7HZ', '4A0H84Z', '4A0H8CZ', '4A0H8FZ', '4A0H8HZ', '4A0HX4Z', '4A0HXCZ', '4A0HXFZ', '4A0HXHZ', '4A0J72Z', '4A0J74Z', '4A0J7BZ', '4A0J82Z', '4A0J84Z', '4A0J8BZ', '4A0JX2Z', '4A0JX4Z', '4A0JXBZ', '4A1H74Z', '4A1H7CZ', '4A1H7FZ', '4A1H7HZ', '4A1H84Z', '4A1H8CZ', '4A1H8FZ', '4A1H8HZ', '4A1HX4Z', '4A1HXCZ', '4A1HXFZ', '4A1HXHZ', '4A1J72Z', '4A1J74Z', '4A1J7BZ', '4A1J82Z', '4A1J84Z', '4A1J8BZ', '4A1JX2Z', '4A1JX4Z', '4A1JXBZ'

**Criteria Set 4:**

A. Claim type is one of the following:

   i. Claim Type 04 = Outpatient

   ii. Claim Type 05 = Medical

**and**

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

**and**

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

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

3. **Maternity Mercer**

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

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

**or**

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

**or**

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

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

**Criteria Set 1:**

A. The encounter has any of the 25 diagnosis codes with the codes '082', '07582'

**or**

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

**Criteria Set 2:**

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

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

**or**

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

'O80'. 'O703', 'O704', 'O709'

**or**

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

'59400' through '59410', '59610' through '59614', '59898' through '59899', '01967', '01960', '57022'

**Criteria Set 3:**

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

'O6010X0', 'O6010X1', 'O6010X2', 'O6010X3', 'O6010X4', 'O6010X5', 'O6010X9', 'O6012X0', 'O6012X1', 'O6012X2', 'O6012X3', 'O6012X4', 'O6012X5', 'O6012X9', 'O6013X0', 'O6013X1', 'O6013X2', 'O6013X3', 'O6013X4', 'O6013X5', 'O6013X9', 'O6014X0', 'O6014X1', 'O6014X2', 'O6014X3', 'O6014X4', 'O6014X5', 'O6014X9', 'O6020X0', 'O6020X1', 'O6020X2', 'O6020X3', 'O6020X4', 'O6020X5', 'O6020X9', 'O6022X0', 'O6022X1', 'O6022X2', 'O6022X3', 'O6022X4', 'O6022X5', 'O6022X9', 'O6023X0', 'O6023X1', 'O6023X2', 'O6023X3', 'O6023X4', 'O6023X5', 'O6023X9', 'O670', 'O678', 'O679', 'O68', 'O690XX0', 'O690XX1', 'O690XX2', 'O690XX3', 'O690XX4', 'O690XX5', 'O690XX9', 'O691XX0', 'O691XX1', 'O691XX2', 'O691XX3', 'O691XX4', 'O691XX5', 'O691XX9', 'O692XX0', 'O692XX1', 'O692XX2', 'O692XX3', 'O692XX4', 'O692XX5', 'O692XX9', 'O693XX0', 'O693XX1', 'O693XX2', 'O693XX3', 'O693XX4', 'O693XX5', 'O693XX9', 'O694XX0', 'O694XX1', 'O694XX2', 'O694XX3', 'O694XX4', 'O694XX5', 'O694XX9', 'O695XX0', 'O695XX1', 'O695XX2', 'O695XX3', 'O695XX4', 'O695XX5', 'O695XX9', 'O6981X0', 'O6981X1', 'O6981X2', 'O6981X3',

'O6981X4', 'O6981X5', 'O6981X9', 'O6982X0', 'O6982X1', 'O6982X2', 'O6982X3', 'O6982X4', 'O6982X5', 'O6982X9', 'O6989X0', 'O6989X1', 'O6989X2', 'O6989X3', 'O6989X4', 'O6989X5', 'O6989X9', 'O699XX0', 'O699XX1', 'O699XX2', 'O699XX3', 'O699XX4', 'O699XX5', 'O699XX9', 'O700', 'O701', 'O7020', 'O7021', 'O7022', 'O7023', 'O740', 'O741', 'O742', 'O743', 'O744', 'O745', 'O746', 'O747', 'O748', 'O749', 'O750', 'O751', 'O752', 'O753', 'O754', 'O755', 'O7581', 'O7589', 'O759', 'Z370', 'Z372', 'Z373', 'Z3750', 'Z3751', 'Z3752', 'Z3753', 'Z3754', 'Z3759', 'Z3760', 'Z3761', 'Z3762', 'Z3763', 'Z3764', 'Z3769', 'Z379', 'O770', 'O771',
'O711', 'O713', 'O714', 'O715', 'O716', 'O717', 'O7181', 'O7182', 'O7189', 'O719', 'O8802', 'O8812', 'O8822', 'O8832', 'O8882', 'O9812', 'O9822', 'O9832', 'O9842', 'O9852', 'O9862', 'O9872', 'O9882', 'O9892', 'O9902', 'O9912', 'O99214', 'O99284', 'O99314', 'O99324', 'O99334', 'O99344', 'O99354', 'O9942', 'O9952', 'O9962', 'O9972', 'O99814', 'O99824', 'O99834', 'O99844', 'O9A12', 'O9A22', 'O9A32', 'O9A42', 'O9A52'

**Criteria Set 4:**

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

**or**

B. The encounter has a revenue code of ‘720’, ‘0720’, ‘721’, ‘0721’, ‘722’, ‘0722’, ‘724’, ‘0724’, ‘729’, ‘0729’, ‘112’, ‘0112’, ‘122’, ‘0122’, ‘132’, ‘0132’, ‘142’, ‘0142’, ‘152’, ‘0152’, ‘232’, ‘0232’.

**or**

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

‘O720','O721','O722'

**or**

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

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

**Criteria Set 5:**

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

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

**Criteria Set 6:**

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

4. **Pregnancy-related “Catch All”**

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

A. Identify deliveries for members using the following criteria:

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

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

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

**or**

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

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

5. **Emergency Medical Transportation**

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

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

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

6. **Emergency Facility**

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

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

**and**

B. Federally Qualified Health Center National Provider Identifier is not equal to 1.

7. **Emergency Other**

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

A. Place of service code is 0 ER.

**or**

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

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

8. **Inpatient Admissions that Originated Through the Emergency Room**

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

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

9. **Dialysis**

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

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

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

B. Any member who had an encounter with one of the above procedure codes must also have been diagnosed with end-stage renal disease, acute kidney failure, or stage 5 chronic kidney disease using the following diagnosis codes: ‘N170’, ‘N171’, ‘N172’, ‘N178’, ‘N179’, ‘N185’, ‘N186’

10. **Emergency DHCS**

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

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

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

**and**

B. The claim type is either 05 or 06

**and**

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

**or**

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

**or**

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

**or**

A. The claim type is 03

**and**

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

**and**

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

**or**

A. The claim type is 03

**and**

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

**and**

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

**or**

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

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

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