Mercer

Government Human Services Consulting

Program of All-Inclusive Care for the Elderly

Amount that Would Otherwise be Paid and Capitation Rate Development Certification

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

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Contents

Section 1

Executive Summary

The California Department of Health Care Services (DHCS) contracted with Mercer Government Human Services Consulting (Mercer), as part of Mercer Health & Benefits LLC, to develop actuarially sound[1] capitation rate ranges for the Program of All-Inclusive Care for the Elderly (PACE) and PACE Amount that Would Otherwise be Paid (AWOP), during the calendar year 2024 (CY 2024) rating period. This letter presents an overview of the methodology and analyses used in Mercer's AWOP and experience-based rate range development that complies with the requirements set forth by the Centers for Medicare & Medicaid Services (CMS). The PACE AWOP, as defined by CMS, is "the amount that would otherwise have been paid under the State plan if the participants were not enrolled under the PACE program" and "takes into account the comparative frailty of participants." To meet CMS approval, the PACE capitation rates cannot exceed the AWOP.

[1] Actuarially sound/actuarial soundness — Medicaid capitation rates are "actuarially sound" if, for 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.
Actuarial Standard of Practice 49

Section 2
PACE Program Overview

PACE Eligibility

The PACE program enrolls eligible Medi-Cal members aged 55 and older meeting nursing facility (NF) clinical criteria and living within the PACE service area. PACE AWOPs were developed to be consistent with the counties covered by each participating PACE Organization (PO). Each PO has a corresponding AWOP that was developed using data for the counties covered by that PO. PACE AWOPs were developed covering the following PACE program counties/county combinations.

Counties/County Combinations	
Alameda	Alameda/Santa Clara
Contra Costa	Fresno
Fresno/Kings/Madera/Tulare	Fresno/Madera
Humboldt[2]	Kern/Tulare
Los Angeles	Napa/Solano/Sonoma[3]
Merced/San Joaquin/Stanislaus	Orange
Riverside/San Bernardino	Sacramento
Sacramento/El Dorado/Placer/San Joaquin/Sutter/Yuba	San Bernardino/Los Angeles
San Diego	San Francisco
Santa Clara	

In addition, a PACE experience-based rate range was developed for each PO operating in the above counties/county combinations.

This certification includes rates for 11 new POs, with three expected to be operational on January 1, 2024 servicing the following counties: Alameda, Los Angeles, Riverside, San Bernardino, and Santa Clara. Another eight on July 1, 2024 will be operational in Los Angeles, Riverside, San Bernardino, Tulare, Fresno, Kings,

[2] Due to credibility concerns with the population size in Humboldt County, the AWOP for Humboldt leveraged data from the following counties: Humboldt, Sonoma, Mendocino, Del Norte, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity.

[3] Due to credibility concerns with the population size in Napa, Solano, and Sonoma Counties, the AWOP for Napa/Solano/Sonoma leveraged data from the following counties: Marin, Napa, Solano, Sonoma, Mendocino, Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, Trinity, and Yolo.

Madera, Kern, and Merced counties. AWOPs and experience-based rate ranges developed for these new POs were developed consistent with the methodology described below. Since no current experience exists, the experience-based rates were developed based on cost information submitted by other POs in the same or neighboring counties deemed to be similar in terms of geography or cost of living.

Covered Benefits

The PACE program encompasses a comprehensive benefit package, including NF, long-term services and supports (LTSS) including home- and community-based services (HCBS), inpatient hospital, outpatient hospital, physician services, laboratory and x-ray services, pharmacy, transportation, durable medical equipment (DME), and hospice services. A comprehensive list of covered benefits and coordinated access services can be viewed in the State of California PACE State Plan Amendment.

Section 3

Overview of Medi-Cal PACE Rate Setting

Beginning in CY 2018, per California Welfare & Institutions Code 14301.1, DHCS began setting PACE capitation rate ranges using an experience-based rate approach, in addition to developing the required AWOP as per the CMS PACE Medicaid Capitation Rate Setting Guide released in December 2015 and federal regulation. The PACE capitation rates paid to each PO will be determined by the State, within the experience-based rate range and less than the AWOPs. The separate developments of AWOP and PACE rates are consistent, and not in conflict with, the Medicaid state plan.

AWOP Methodology

The PACE AWOP for CY 2024 was developed in accordance with the CMS PACE Medicaid Capitation Rate Setting Guide. Historically, under the context of the Medi-Cal program, in a non-County Organized Health System (COHS) and non-Coordinated Care Initiative (CCI) county, institutionalized members received services almost exclusively through fee-for-service (FFS). Dual members in the community in a non-CCI, non-COHS county had the option to enroll in managed care, though most members still received services through FFS. With limited exceptions, Non-Dual members in the community now participate in mandatory managed care. In a CCI county, where the State has expanded managed care to cover a wider range of LTSS, and in a COHS county, the alternative to PACE is primarily managed care; that is, Duals and Non-Duals participate in mandatory managed care programs that include many LTSS.

While institutionalized FFS members and Dual FFS members in non-COHS and non-CCI counties mandatorily enrolled in managed care in CY 2023, there was no explicit adjustment to the FFS base data to account for this transition to managed care as these members have already been appropriately captured in FFS.

To develop the CY 2024 AWOP, Mercer utilized state fiscal year (SFY) 2021–2022 managed care and FFS data, adjusted for the populations and services covered by the PACE program.

Experienced-Based Rate Ranges Methodology

Actuarially sound PACE experience-based rate ranges for CY 2024 were developed in accordance with generally accepted actuarial principles and practices, consistent with the approach utilized by DHCS in developing reasonable, appropriate, and attainable capitation rates under Medi-Cal. To develop the rate ranges, Mercer collected claims and other data using a Rate Development Template (RDT) at the

category of aid (COA) and category of service (COS) level. The final rate ranges were developed separately for each PO and county/county combination. Adjustments and credibility blending were applied as appropriate.

Separation of Capitation Rates into Federally Eligible UIS and SIS Populations

For CY 2024, separate PACE capitation rates were developed for beneficiaries with satisfactory immigration status (referred to as the SIS population) and beneficiaries with unsatisfactory immigration status (referred to as the UIS population). Additionally, for the UIS population, the capitation payment rates have been further split into the rates applicable for services eligible for federal match (namely, pregnancy-related and emergency services) and into rates applicable for services not eligible for federal match (non-pregnancy-related and non-emergency services).

For each rate cell, UIS acuity factors compared to the SIS population and a percentage of dollars for UIS members for pregnancy-related and emergency services were developed to separate capitation rates for the UIS and SIS populations, and further break the UIS population rates into federal and state-only components. Additional information regarding the factor and percentage development is detailed in section 5 below.

It should also be noted that there will be a future amendment to this certification that will be submitted to CMS. This amendment may include Senate Bill (SB) 525 (Minimum Wage Increase), Targeted Provider Rate Increases as legislated in Assembly Bill (AB) 118, add-on updates associated with AB 1705 GEMT, AB 2511 (Skilled Nursing Facility [SNF] Generators), and adjustments to account for pharmacy rebates on the FFS portion of the AWOP base data.

The following sections describe the program, base data, and adjustments used to develop the AWOP and experience-based rate ranges.

Section 4
AWOP Development

Identification of PACE Eligible Population

The population meeting the PACE eligibility criteria emerged from the institutional and
non-institutional populations who are nursing facility certifiable and aged 55 and older. These two broader groups (institutional and non-institutional) were further classified into Dual and Non-Dual, based on Medicare eligibility, for a total of four groups used to develop the CY 2024 AWOPs.

For the purpose of the AWOP development, the institutional members are defined as members with a long-term care (LTC) aid code or enrolled in a CCI plan with an institutional indicator in the eligibility file during the base data period.

The non-institutional or HCBS members retained for the AWOP development met at least one of the following conditions:

- Members enrolled in CCI and considered HCBS High
- In-Home Supportive Services (IHSS) users with a severely impaired designation
- Users of Community-Based Adult Services (CBAS)
- Members enrolled in the Multipurpose Senior Services Program (MSSP) waiver
- Members enrolled in the Assisted Living Waiver
- Members enrolled in the HCBS waiver

These populations serve as the basis for the PACE AWOP development.

Category Groupings

The base data sets used to develop the PACE AWOP were divided into initial population groups, which have inherently different levels of risk. The initial population groups for the CY 2024 AWOP are as follows:

- Institutional — Dual
- HCBS — Dual
- Institutional — Non-Dual
- HCBS — Non-Dual

Non-Dual members are defined as individuals with Medicare Part A Only or Part B Only or Medi-Cal Only coverage. Dual eligible members are individuals with Medicare Part A and Part B coverage.

AWOP Methodology

County level SFY 2021–2022 (July 2021–June 2022) FFS claims and managed care encounters were used to develop the base data for the CY 2024 AWOP. The FFS and managed care data sets are constructed and adjusted in parallel due to the varying considerations and resulting adjustments needed for each population, as described below. The resulting AWOP rate displayed and detailed in the CRCS is a member-weighted mix of the FFS and managed care data sources; the resulting administrative and underwriting gain load assumptions shown in the CRCS are a product of this, using the non-benefit load assumptions summarized below. A sample calculation using Los Angeles County as an example can be found on the [FFS and MC GME Data – LAN] tab of the accompanying spreadsheet *"CY 2024 PACE Additional Exhibits 2023 12.xlsx"*. When necessary, adjustments were made to the base data to match the covered population risk and benefit package for the CY 2024 period. These adjustments included the following:

- Completing encounters to account for:
  - Missing encounters
  - Zero-pay claims resulting from capitated payment arrangements
  - Incurred but not reported (IBNR)
  - Costs such as utilization management, incentives, and reinsurance that would not be captured in encounter reporting
- Smoothing to correct for utilization and unit cost outliers

Additionally, the following adjustments were applied to the base data to obtain the final AWOPs:

- UIS acuity factors
- Prospective program changes
- Trend factors to project the expenditures and utilization to the contract period
- Acuity adjustment to HCBS members to reflect the frailty difference between the PACE population and the PACE-like population used to develop the AWOP
- Administration and underwriting gain loads

The projected base data was summarized to obtain the CY 2024 utilization per 1,000, unit cost, and per member per month (PMPM) by initial population group and COS. Lastly, for the Dual and Non-Dual populations, the resulting PMPMs for the institutional and HCBS populations were blended at 35% and 65%, respectively, to arrive at the CY 2024 AWOP. A breakout of SFY 2021–2022 member months by county and rate cell for the population covered by managed care versus FFS in the base data period can be found on the [Enrollment] tab of the accompanying spreadsheet "*CY 2024 PACE Additional Exhibits 2023 12.xlsx*". Further,

corresponding with the HCBS Acuity adjustment detailed below, Mercer's analysis has shown that not all members meeting criteria to qualify for programs used in AWOP base data, such as IHSS, MSSP and CBAS, will meet PACE level of care (LOC) criteria. There is no standard NF LOC definition that spans across the various programs; therefore, the mix within the base data used for rate setting purposes is likely skewed towards a higher mix of community members. Mercer has leveraged this, along with available historical experience, and actuarial judgement to arrive at a 35%/65% institutional/community assumption. As in prior years, this standard statewide assumption, across all rate cells, minimizes volatility, especially in smaller counties where the mix can vary materially year-to-year. A potential variation by region/area may be considered in the future.

AWOP Base Data Sources and Analysis

The SFY 2021–2022 Medi-Cal FFS claims and managed care encounters for the four initial population groups were collected and segmented into the 18 COS shown in the table below. In addition to the Medicaid paid amount, the coinsurance amount, patient liability, and copayment amount were included in the base data such that the AWOP would include the full cost of providing State Plan services.

COS				
Inpatient Hospital	Physician Primary Care	Mental Health Outpatient	CBAS	HCBS Other
Outpatient Facility	Physician Specialty	Pharmacy	Hospice	All Other
Emergency Room	FQHC	Laboratory and Radiology	MSSP	
LTC	Other Medical Professional	Transportation	IHSS	

These COS are consistent with the grouping used to develop the capitation rates for other Medi-Cal programs. Additional Medicaid covered services (such as dental) covered under FFS primarily were added to ensure the base data was complete and reflective of the services otherwise covered for a PACE member in the CY 2024 rating period.

Base Data Completion

The SFY 2021–2022 time period was used in the development of the CY 2024 AWOP PACE base data. Base data utilization levels were compared to reasonable rate setting benchmarks to estimate missing encounters and adjusted accordingly. Zero-pay claims resulting from capitated payment arrangements were identified and adjusted to reflect the true costs of providing those services.

IBNR was estimated and added to the base to reflect the fully incurred services and payments. The IBNR factors, provided on the [IBNR] tab of the accompanying spreadsheet "*CY 2024 PACE Additional Exhibits 2023 12.xlsx*", were built from the claims triangle reported by the Managed Care Organizations (MCOs) as part of the data collected for managed care rate development. The factors were applied to the managed care experience used in AWOP development. As the pure FFS data used in AWOP development is assumed to be more complete than the managed care data, it received 75% of the managed care adjustment.

Finally, managed care reported data was leveraged to determine a reasonable estimate of costs for utilization management, provider incentives, and reinsurance not included in encounter reporting and subsequently included in the AWOP base data. The cost reports submitted by MCOs in the development of the managed care rates include separately identified costs associated with utilization management, provider incentives, Third Party Liability (TPL), and reinsurance. This data was leveraged to determine proportionally how much of the managed care costs are represented by these categories. That proportion was then summarized and applied to the managed care encounter data on a statewide basis by Dual status, Institutional/HCBS status, and COS.

Non-Federal Share Costs in Designated Public Hospitals

The FFS claims for designated public hospitals (DPHs) in California are processed through a Certified Public Expenditures methodology in which the federal government covers the Federal share, and the county covers the non-federal share of costs. The FFS hospital claims in the base data contained only Federal share costs for DPHs, so adjustments to account for the non-federal share of costs for DPHs were included in the CY 2024 AWOP development. This impacts the FFS Non-Dual population only.

Data Smoothing

In certain situations, unit cost, or utilization data for certain counties and COS was deemed to be an outlier. In those situations, the unit cost or utilization was smoothed to be more reasonable. Reasonableness was based on comparison to other surrounding counties' data and actuarial judgement.

Pharmacy Rebates

For the first half of CY 2021, managed care pharmacy encounters were adjusted downward between 1.2%-26.2%, varying by county/plan based on pharmacy rebates as reported by the MCO. Managed care rebates are reflective of the costs to MCOs if a PACE member were in managed care rather than PACE. An adjustment to account for pharmacy rebates on the FFS portion of the AWOP base data was not applied – this will be updated as part of a future rate amendment.

Third Party Liability (TPL)

The base data was net of TPL; therefore, TPL amounts were excluded from the base data pull.

Patient Liability/Share of Cost

The amount of patient liability was identified in the data and incorporated into the development of the AWOP base data. This was done to ensure that program change and trend adjustments were applied to the total costs of services. The last step of the AWOP development process included removing the patient liability from the final gross AWOP.

Adjustments to Develop the AWOP

Once the base data was adjusted, the CY 2024 AWOP was obtained by applying the following components to the adjusted base data:

- Program changes (covered below with the experience-based rates methodology).
- Trend factors to project the expenditures and utilization to the contract period (covered below with the experience-based rates methodology).
- A 1.45 acuity adjustment factor was applied to the HCBS population to reflect the assumed frailty difference between the actual PACE-eligible population and the PACE-like population used to develop the AWOPs. As most HCBS programs under Medi-Cal used in the AWOP development do not require a member to meet NF LOC criteria (for example, IHSS is a personal care-like service, but is available through the State plan), the only services whereby a member is required to be NF LOC in the same way as PACE are waiver programs. Further, not all MSSP members meet the same LOC criteria as PACE necessitating the application of the 1.45 acuity adjustment factor to bring the overall costs of the base population up to the levels of an HCBS population that better represent true NF LOC members eligible for PACE. Mercer intends to revisit this assumption, leveraging available data, and evaluate reasonableness on an ongoing basis.
- Administration and underwriting gain (not applied to FFS portion of the AWOP) loads (covered below with the experience-based rates narrative).

Section 5

Development of Experience-Based Rate Ranges

Base Data

The data and information used to form the base data for the PACE experience-based rate ranges was CY 2021 and CY 2022 PO-submitted RDT data and financial reporting. The CY 2021 and CY 2022 RDT data includes utilization and unit cost detail by rating group, county, and 19 consolidated provider types or COS, including:

- Inpatient Hospital
- Emergency Room
- Rehab Post-Acute Care Skilled Nursing Facility
- Outpatient Facility
- Laboratory, Radiology and Diagnostics
- Pharmacy
- DME
- Physician Specialty Services
- Psychiatric and Behavioral Health Services
- Primary Care Services
- Other Medical Professional (Non-Physician)
- PACE Center Services
- Transportation
- Home Health
- In-home Services
- Residential Care Services
- LTC (Custodial Skilled Nursing Facility)
- Dialysis
- All Other

Claims/expense experience for PACE Center Services was collected in the RDT separately, with additional detailed breakouts for Social Services, Routine Nursing, Recreational Therapy, Personal Care/Chore Services, Meals, Escort and Transportation, Nutritional Counseling, and Physical/Occupational/Speech Therapy. This data was reviewed for reasonableness and to provide confirmation that PACE Center Services were not included with other medical services/COS. For final base data development and all adjustments, PACE Center Services were consolidated into one COS.

The experience-based rates utilized a CY 2021 and CY 2022 base data period, applying a 50%/50% even weighting to either year. Credibility, as described below, was developed based on 24 months.

Where provided, utilization and unit cost information from the PO-specific RDT data was reviewed at the rating group and COS detail levels for reasonableness. Ranges of reasonable and appropriate levels of utilization and unit cost were then established for each COS within each rating group. Data reporting for utilization at the COS level continues to be challenging for the newer POs. In these cases, cost information at the total cost level was deemed more reliable than at the unit cost level.

Rate Category Groupings

The base data used to develop the PACE capitation rate ranges were divided into cohorts that represent consolidated rate groupings, which inherently represent differing levels of risk due to payment for Medicare covered services. Rate ranges are developed for two different cohorts:

- Non-Duals (includes Medicare Part A Only, Medicare Part B Only, and Medi-Cal Only members)
- Duals (members covered by Medicare Parts A and B)

Medi-Cal versus Medicare Cost Distribution

Each PO was asked to provide an actual distribution, or an allocation estimate of the percentage of costs, by COS and rating category, that were the responsibility of Medi-Cal. It was assumed that Medicare would be responsible for the remainder of the cost and the provided Medi-Cal cost distribution percentages can therefore be applied to the total reported costs for dual eligible members' experience.

The reported Medi-Cal allocations were reviewed for reasonableness and consistency across POs. Where necessary, a reasonable estimation of Medi-Cal's percentage of costs was developed based on reporting by other POs.

Credibility Blending and Data Smoothing

POs vary in size, as well as in years of operation. Due to this, a credibility blending methodology was used for those POs that were not deemed fully credible. Full credibility was defined to be 18,000 member months. For each PO with less than

18,000 member months for the two-year base period (CY 2021 and CY 2022), cost data from POs in the same or nearby counties were blended.

When POs from different counties were used in the credibility blending, a cost-of-living factor was applied to the external county to account for any cost of living/cost of health care differences. Credibility was adjusted in certain instances where the underlying cost structure of the POs being blended was deemed inconsistent, such as where a relatively small PO is being blended with a much larger PO.

New PO Adjustment

To account for the assumed somewhat relatively higher acuity and operational costs in a new PACE center, Mercer applied a “New PO factor” to POs in operation for less than two years. This factor begins at 3.0% for PACE organizations starting in CY 2024 and decreases to 1.5% at the start of the second year of operation, prorated as necessary. For example, POs beginning July 1, 2023, received a 2.25% increase, the average of the first and second year factors, 3.0% and 1.5%. This adjustment factor was applied to the final rate, after credibility blending and across all COS. Mercer developed this factor by comparing available PO encounter data and PO-submitted RDT data for plans that became effective within the past three years.

Further, to acknowledge cost information provided by the new POs starting on or after January 1, 2020, Mercer leveraged the credibility formula and heavily blended their reported base expenses with cost data from POs in the same or nearby counties until full credibility was reached. This adjustment, similar to the new PO adjustment mentioned above, was applied as a factor to the final rate, after credibility blending and across all COS.

Section 6

Components of Development that Apply to Both AWOPs and Experience-Based Rate Ranges

UIS Acuity Factor and Federal Percentage Development

As briefly described in Section 2, separate PACE capitation rates were developed for the SIS and UIS populations. To establish separate payment rates, SIS and UIS-specific experience-based rates as well as AWOPs were developed. The acuity factors and percentages of pregnancy-related and emergency services applied do not vary in the experience-based and AWOP development process.

UIS Acuity Factor Compared to the SIS Population

This factor represents the expected PMPM cost relativity of the UIS population compared to the SIS population. This statewide factor was developed from RDT information specific to the UIS population for the entire base data period and was calculated separately for each rate cell (1.15 for the Dual population; 1.10 for the Non-Dual population). To derive an aggregate UIS base (across federally eligible and state only services), these UIS acuity factors were applied to the SIS base, creating a UIS-specific base data set for PACE capitation rate development.

Percentage of Dollars for UIS Members for Pregnancy-Related and Emergency Services

As noted previously, only pregnancy-related and emergency services have been confirmed eligible for federal match for the UIS population. As a result, it was necessary to estimate the percentage of PMPM spend for services that are pregnancy-related or emergency specific to the UIS population. Given the age demographic of the PACE population, it was assumed that little to no pregnancy-related services would be rendered by PACE members. As such, the UIS Federal percentage applied to the UIS population only represents emergency services. Leveraging COA and COS-specific managed care emergency percentages, the resulting Federal share (4.0% for the Dual population; 21.0% for the Non-Dual population) was aggregated by PACE-specific COS mix and applied uniformly across all COS.

Trend

Trend is an estimate of the change in the overall cost of medical services over a finite period of time. Trend factors are necessary to estimate the expenses of providing health care services in a future period. As part of the CY 2024 AWOP and rate range

development for the PACE program, Mercer developed trend rates for each provider type or COS separately by utilization and unit cost components. For experience-based rate development, trend rates for the different populations (Institutional, HCBS) were also blended at 35% and 65%, respectively, to be consistent with the underlying base data.

Trend information and data were gathered from multiple sources, including RDT data, PO financial statements, Medi-Cal MCO trend data, Medi-Cal FFS experience, Consumer Price Index, National Health Expenditures updates and multiple industry trend reports such as the CMS Medicaid actuarial report. Mercer also relied on professional judgment based upon experience in working with the majority of the largest Medicaid programs in the country.

For the experience-based rate ranges, the CY 2021 and CY 2022 base data was trended forward 30 months to the mid-point of CY 2024 with POs starting July 1, 2024 receiving an additional three months of trend. The SFY 2021–2022 AWOP base was membership-weighted and trended 30 months to the mid-point of CY 2024.

The claim cost trend range component is +/- 0.25% per year for each of the utilization and unit cost components. The upper bound trend was applied in the development of the AWOPs.

The specific lower bound trend levels by utilization and unit cost for the 19 COS are displayed in columns (G) and (H) of the experience-based CRCS, respectively. These annual trend figures are applied for the number of months represented in the time periods section in the upper right corner of the CRCS. The number of trend months is determined by comparing the mid-point of the modeled CY 2021 to CY 2022 base period to the mid-point of the rating period, CY 2024.

Annual lower bound claim cost trends, across all COS range (varying by PO) from 2.2% to 3.5% for Duals and 3.2% to 3.9% for Non-Duals on a PMPM basis. For the AWOPs, upper bound claim cost trends were used and across all COS range (varying by AWOP) from 0.5% to 1.4% for Duals and 2.4% to 3.6% for Non-Duals on a PMPM basis (Institutional and HCBS combined). Note the trend figures exclude unit cost changes associated with the program changes listed below.

Program Changes

Program change adjustments recognize the impact of benefit, eligibility, and/or reimbursement changes that have become effective since the beginning of the base period or will become effective by the end of the contract period. The program changes incorporated in the development of the rates were based on information provided by DHCS staff. The following program changes were accounted for in the development of the CY 2024 AWOP and capitation rates:

- **LTC Rate Increase —** This increase to LTC and NF unit costs accounts for rate increases to AB 1629 facilities and other LTC facilities. LTC program changes are based on the historical increases of LTC daily rates and the projected increase for

CY 2024. The county-specific percentage program change is calculated by comparing the average cost level in the respective experience-based (CY 2021 and CY 2022) and AWOP (SFY 2021–2022) base data periods to the contract period (CY 2024).

- **IHSS Wage Increase —** The IHSS wage increase is an increase to unit costs for the Personal Care COS from the base period to CY 2024 wage levels. The county-specific program change was developed by comparing the average IHSS hourly rate in the respective base data periods to the projected average hourly rate in the contract period. As Medicare does not cover IHSS services, the change in hourly rate affects both the Non-Dual and Full-Dual populations.
- **Hospice Rate Increase —** The hospice adjustment takes into account annual rate increases to hospice services and room and board. An adjustment was applied to all populations, consistent with the managed care rates.

While POs are not required to pay at FFS levels for LTC, hospice, or personal care, Mercer believes the program change adjustments developed for the AWOP are reasonable approximations of upward cost pressures for similar services provided by the POs.

The program changes outlined below apply to one or both the Medi-Cal managed care and FFS programs and therefore were included in the development of the AWOPs:

- **SB 523 and AB 1705 Ground Emergency Medical Transportation (GEMT) —** SB 523 established the GEMT Quality Assurance Fee (QAF) program, which provides for an annual GEMT QAF rate that will be imposed on each emergency medical transport provided by each non-public GEMT provider subject to the QAF. The QAF collected will be used to provide increased reimbursement in the form of an add-on to the FFS fee schedule rate for the appropriate billing codes. AB 1705 established the Public Provider GEMT (PP-GEMT) program resulting in a per trip rate increase for public GEMT providers. Both State law (Welfare & Institutions Code 14129.3[b]) and approved SPAs establish the combination of the State's FFS fee schedule rates and the add-on payments constitutes the Rogers rates MCOs must pay to non-contracted GEMT providers serving Medi-Cal managed care enrollees for those years in which the GEMT add-on is effective. The amount included in the AWOP was consistent with rate setting for other Medi-Cal programs. The state intends on updating the AB 1705 add-on with trend for CY 2024. This adjustment will be captured in a future rate amendment.
- **COVID-19 At-Home Testing —** Effective February 1, 2022, COVID-19 antigen tests can be billed and reimbursed as a pharmacy-billed medical supply benefit through Medi-Cal Rx. Coverage is for over-the-counter (OTC) FDA-authorized COVID-19 antigen test kits, used in accordance with Centers for Disease Control and Prevention (CDC) recommendations.

- **Additional AB 97 Buybacks —** Effective July 1, 2022, to support quality and equity goals, the State eliminated the AB 97 payment reductions for certain providers.
- **Community Health Worker (CHW):** Effective July 1, 2022, CHWs were an addition to the group of skilled and trained individuals who are able to provide clinically appropriate Medi-Cal covered benefits and services to Medi-Cal beneficiaries. Further, effective January 1, 2023, CHWs were also allowed to be reimbursed for asthma remediation services and violence prevention services. This benefit is available in the managed care delivery system and the impact of this program change is quantified by identifying potential CHW utilizers and leveraging research on CHW staffing.

Disproportionate Share Hospital, Graduate Medical Education, and Indirect Medical Education Payments

The expenditure and utilization data did not include Disproportionate Share Hospital (DSH), Graduate Medical Education (GME) or Indirect Medical Education (IME) payments. The State processes DSH, GME, and IME payments outside the PACE contract. Therefore, these payments are not part of the AWOP or capitation rate development process.

Administration

The administration loads for the POs were developed in aggregate across all rate groupings. This factor is expressed as a percentage of the capitation rate (i.e., percent of premium). For the experience-based rate ranges, this mid-point percentage was developed from a review of the POs' historical reported administrative expenses, which are submitted as part of their attested RDTs on an annual basis. The administrative costs are reviewed to ensure they are appropriate and reasonable for the Medicaid eligible PACE members. Mercer also utilized its experience and professional judgment in determining the mid-point and lower/upper bound percentages to be reasonable. Similar to CY 2023, the mid-point administration load was established at 12% across all POs. The range for the administrative component is +/- 3% at the lower/upper bounds from the mid-point value. This PACE wider range reflects the unique nature of POs in terms of member size and operating model, as well as a wide range of actual PO results.

The AWOPs were developed to include a provision for the State's administrative costs for the FFS portion of the base data. Similarly, an appropriate managed care factor was included for the managed care portion of the base. FFS also includes a 2.0% load factor (as a percent of the total AWOP) to reflect the State's administrative costs. Managed care administrative costs across all counties were assumed to be between 4.3% and 5.1%, consistent with other capitated rate setting assumptions for similar populations under Medi-Cal at the upper bound.

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

Underwriting Gain

For experienced-based rate setting, the underwriting gain range was established across all POs at 2.0% (lower bound), 2.5% (mid-point), and 3.0% (upper bound). For AWOP rate setting, consistent with assumptions implemented in managed care rates, the underwriting gain range is 2.0% (lower bound), 3.0% (mid-point), and 4.0% (upper bound), with the development of the AWOP load using the upper bound. Mercer has implicitly and broadly considered the cost of capital within the rating assumptions. Mercer's conclusion is that assumptions surrounding underwriting gain, as well as the income a PO generates from investments, are sufficient to cover at least minimum cost of capital needs for the typical PO.

A managed care underwriting gain is applied to the AWOP only for the portion of base data derived from managed care data. That is, no underwriting gain was applied to FFS.

Incentive Arrangements

There are no PO incentive arrangements in place.

Rate Ranges

To assist DHCS during its rate discussions with each PO, Mercer provides DHCS rate ranges for the experience-based rates developed using an actuarially sound process. The rate ranges were developed using a combination of a modeling process, which varied the medical expense (i.e., risk) trend, the administration loading percentage and the underwriting gain loading percentage to arrive at both a lower/upper bound capitation rate. The final contracted rates agreed to between DHCS and each PO fall within the rate ranges provided by Mercer and below the AWOP.

Section 7

Rate and Rate Range Certification

In preparing the AWOPs and rate ranges described, Mercer has used and relied upon enrollment, eligibility, claim, reimbursement level benefit design and financial data and information supplied by DHCS, its POs and its vendors. DHCS, its POs 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 PACE model rate ranges for the CY 2024 time period, 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. The undersigned actuaries are members of the American Academy of Actuaries and meet its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

AWOPs and rate ranges 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 PO costs will differ from these projections. Mercer has developed these rates and rate ranges on behalf of DHCS to demonstrate compliance with the CMS requirements identified in the CMS PACE Medicaid Capitation Rate Setting Guide and are appropriate for the populations and services covered under the PACE

program. Use of these rates and rate ranges for any purpose beyond that stated may not be appropriate.

POs are advised that the use of these rates and rate ranges may not be appropriate for their particular circumstance, and Mercer disclaims any responsibility for the use of these rate ranges by POs for any purpose. Mercer recommends that any PO considering contracting with DHCS should analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to these rate ranges 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 certification letter, 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 secures the advice of competent legal and taxation counsel with respect to any legal or taxation matters related to this report or otherwise.

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

DHCS agrees to notify Mercer within 30 days of receipt of this report if it disagrees with anything contained in this report or is aware of any information or data that would affect the results of this report that has not been communicated or provided to Mercer or incorporated herein. The report will be deemed final and acceptable to DHCS if nothing is received by Mercer within such 30-day period. If there are any question regarding this report, please contact Ethel Tan at [redacted].

Sincerely,

[redacted]
Ethel Tan, ASA, MAAA
Senior Associate

Copy:
David Bishop, DHCS
Jesse Delis, DHCS
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