MERCER

Coordinated Care Initiative Dual-Eligible Model

Capitation Rate Development and Certification

January 1, 2021–December 31, 2021

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

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 capitation rates for use during the Coordinated Care Initiative (CCI) program calendar year 2021 (CY 2021) for dual-eligible beneficiaries. The CY 2021 period encompasses the time period of January 1, 2021 through December 31, 2021. The CCI dual-eligible model rates include rates for Cal MediConnect (CMC), the State's duals demonstration program.

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 Centers for Medicare & Medicaid Services (CMS) rate review process. This report follows the general outline of the CMS July 2020 through June 2021 Medicaid Managed Care Rate Development Guide, which is the applicable version of the guide for the CY 2021 period. The rate development process included the historical practice of developing rate ranges. However, the actuaries are certifying to a final rate within the developed rate ranges.

Multiple attachments are also included as part of this rate certification package. These attachments include summaries of the CY 2021 capitation rates (including the final and certified capitation rates) and capitation rate calculation sheet (CRCS) exhibits that provide more detail around various rate setting components. These attachments are referenced throughout the body of this report. The final capitation rates by managed care organization (MCO), county and population can be found in the attached files, listed below:

- **CMC:** *CA CCI Duals CY 2021 MediConnect Exhibits 2021 01 28.xlsx*.
- **Non-CMC:** *CA CCI Duals CY 2021 Non-MediConnect Exhibits 2021 01 28.xlsx.*

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

One significant change for the CY 2021 rating period is the decision to carve pharmacy out of managed care for non-CMC only (CMC rates continue to have pharmacy carved-in). The initial plan was for this change to be effective January 1, 2021, but a three-month delay was implemented, which resulted in the need to develop a managed care capitation rate add-on for pharmacy for the January 1, 2021–March 31, 2021 period. The development of this pharmacy rate is consistent with other base data and rate development for the CY 2021 period but is handled as a rate add-on for the effective period. As such, there will be two sets of capitation rates applicable for CY 2021 for non-CMC:

- One set of rates applicable for the three-month period of January 1, 2021 to March 31, 2021 inclusive of a pharmacy add-on.
- One set of rates applicable for the final nine-month period of April to December 2021 with no pharmacy add-on.

Across all counties, MCOs and populations within the CCI dual-eligible model, the final CY 2021 capitation rates represent a 2.6% increase when compared to the final CY 2020 capitation rates for CMC. For non-CMC the final CY 2021 capitation rates represent a 0.3% decrease when compared to the final CY 2020 capitation rates for January to March 2021 and a 1.6% decrease for April to December 2021. The rate change is calculated using a constant case mix based on CY 2021 projected member months (MMs) by rate cell (plan and county) and excludes the impact of MCO tax.

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General Information

This section provides a brief overview of California's CCI dual-eligible managed care program 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 CCI dual-eligible managed care delivery model has been in existence since 2014. CCI refers to members enrolled in CMC, members eligible for but not enrolled in CMC and members ineligible for CMC. Members began enrolling into CCI beginning in April 2014, with phase-in varying by county. The last county to begin the CCI transition was Orange County in July 2015.

Within existing Two-Plan counties (Los Angeles, Riverside, San Bernardino and Santa Clara counties), two MCOs operate within each county, one a commercial plan and one a local initiative health plan. The one exception is in Los Angeles County, where given the structure of CMC, there are five MCOs in operation. In San Diego County, a Geographic Managed Care county, there are seven MCOs in operation. In County Organized Health System (COHS) counties, such as Orange and San Mateo counties, there is a single MCO. Mercer has served as California's contracted actuarial firm supporting the Medi-Cal managed care program and rate development since 2005.

For capitation rate payment purposes, different rates are paid to the MCOs for each county in which they operate.

Managed Care Organization Participation

For the CY 2021 rating period, 14 MCOs operate in the CCI dual-eligible managed care program. 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 that can be found in the attached Excel files titled *CA CCI Duals CY 2021 MediConnect Exhibits 2021 01 28.xlsx* for CMC and *CA CCI Duals CY 2021 Non-MediConnect Exhibits 2021 01 28.xlsx* for non-CMC. Capitation rates are shown for each MCO and county/rating region combination.

Covered Services

Generally, services covered through the CCI dual-eligible model include hospital services (including inpatient [IP], outpatient [OP] and emergency room [ER] services), physician services, long-term care (LTC) services, transportation services, laboratory and radiology services, hospice care services, community-based adult services (CBAS), Multipurpose Senior Services Program (MSSP) services, and prescription drugs. Additionally, certain mental health (MH) services for members with mild to moderate MH conditions are covered. Notable services carved out of the managed care programs include the following:

- Specialty MH services (including IP and OP behavioral health services, with exceptions noted below)
- Alcohol and substance use disorder treatment services
- Services for major organ transplants except kidney transplants (non-COHS counties)
- Dental services except medically necessary Federally Required Adult Dental Services and fluoride varnish dental services that may be performed by a medical professional
- Certain pharmaceutical products, including blood factor drugs, erectile dysfunction drugs, HIV/AIDS drugs and psychotherapeutic drugs
- Services covered under the California Children's Services program
- In-Home Supportive Services (IHSS)
- Effective April 1, 2021 for non-CMC only, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim: covered outpatient drugs, including physician administered drugs, medical supplies and enteral nutritional products

Covered Populations

The CCI dual-eligible program currently covers Medi-Cal recipients aged 21 and older that are eligible for full Medicare benefits (defined as having Part A and Part B Medicare coverage). Generally, managed care enrollment is mandatory for the CCI model. An exception to this is

full dual members with an Affordable Care Act (ACA) Expansion aid code. These members are not eligible for the CCI program and are included within the Seniors and Persons with Disabilities (SPD)/Full-Dual category of aid (COA) group for capitation rate payment purposes and are covered under a separate certification. There are no significant changes to covered populations for the CY 2021 rating period.

Share of cost members (recipients who establish eligibility for Medicaid by deducting incurred medical expenses) who reside in a nursing facility or on MSSP are part of the CCI managed care population; the rate ranges are developed net of any beneficiary share of cost.

Rate Structure

The base data sets used to develop the CCI dual-eligible CY 2021 capitation rate ranges and rates were divided into cohorts that inherently represent differing levels of risk. These four cohorts are defined as follows:

- Institutionalized: Members with an LTC aid category or residing in a nursing facility for 90 days or more
- CBAS and MSSP: Members who receive CBAS or are clients of MSSP sites
- IHSS (no CBAS, no MSSP): Members who receive IHSS and are classified as "Severely Impaired" or "Not Severely Impaired"
- Community Well/Healthy: All remaining members

In addition, the population was segmented into three separate and distinct populations based on eligibility for rate development purposes. These populations are as follows:

- Beneficiaries enrolled in CMC
- Beneficiaries eligible for but not enrolled in CMC
- Beneficiaries ineligible for CMC (for example, high-risk individuals, such as those with end stage renal disease [with the exception of COHS counties] and the developmentally disabled)

Blended rate ranges are ultimately developed for each participating plan and county combination. Mercer develops final blended rate ranges and rates covering two populations: CMC and non-CMC (which includes both members eligible for but not enrolled in CMC and members ineligible for CMC).

MCOs are compensated through monthly capitation payments for the two populations noted above. The capitation rates for each population include all services under the managed care contract.

Federal Medical Assistance Percentage

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

The rates certified in this report include only populations that receive the regular FMAP. Rates are developed for each population based on expected cost and homogeneity of risk. The FMAP for each population is not taken into account and is not a consideration. Non-benefit costs are developed using a method that does not consider FMAP for different populations. This includes the provision for underwriting gain and return on capital.

The implementation of the Families First Coronavirus Response Act (H.R. 6021) provides a temporary 6.2 percentage point increase for certain populations effective January 1, 2020, and extending through the last day of the calendar quarter in which the public health emergency, declared by the Secretary of Health and Human Services for Coronavirus Disease 2019 (COVID-19), including any extensions, terminates. The increased FMAP percentage applies to all populations in this report.

There are two services for which the State receives a different FMAP than the regular FMAP that applies on a population basis. Those services are family planning, for which the FMAP is 90%, and adult preventive services, which earns an additional 1% pursuant to section 4106(b) of the ACA. Mercer and the State prepare separate memoranda that describe and document the process for estimating the proportion of the capitation rate subject to these different FMAPs.

Rate Methodology Overview

Capitation rates for the CCI dual-eligible model were developed in accordance with rate-setting guidelines established by CMS. As noted previously, the actuaries continued the historical practice of rate range development for the CCI dual-eligible model. However, the actuary is certifying to a rate within the developed rate range.

For rate range development for the CCI dual-eligible model MCO population, Mercer used CY 2018 MCO-reported encounter data, the CY 2018 Rate Development Template (RDT) data (from direct contractors with DHCS and the MCOs' global subcontractors) and other ad hoc claims data reported by DHCS and the CCI dual-eligible model MCOs. The most recently available Medi-Cal-specific financial reports submitted to the California Department of Managed Health Care (DMHC) at the time the rate ranges were determined were also considered in the rate range development process.

The RDT data used in the development of the rate ranges is data collected from each MCO within the Medi-Cal managed care program separately for each county in which each MCO operates. The data requested from each MCO is completed by the MCOs at the level of detail needed for rate development purposes, which includes membership, medical utilization and medical cost data for the most recent calendar year (CY 2018 for the CY 2021 rate ranges) by cohort, population 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 the CY 2021 period. Additional adjustments were then applied to the selected base data to incorporate:

- Prospective and historic (retrospective) program changes not reflected (or not fully reflected) in the base data
- CMC influenced population acuity adjustments in limited counties/cohorts
- Trend factors to forecast the expenditures and utilization to the rating period
- Administration and underwriting gain loading

The above approach has been utilized in the development of the rate ranges for the CY 2021 CCI dual-eligible model. DHCS will offer the final certified rates within the actuarially sound rate ranges of each MCO, as developed by the actuary. 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 that the capitation rate development process and resulting rates, as outlined in this report and supporting documentation, are reasonable, appropriate and attainable and that MCOs are assumed to reasonably achieve Medial Loss Ratios (MLRs) greater than 85%.

The CY 2021 internal rate ranges result in aggregate priced-for effective MLRs greater than 85%.

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

- CMC:
  - Assumed aggregate upper bound MLR: 100% - 9.58% (upper bound non-medical load) = **90.42%** (ranges between 88.84% and 92.07% by county, based on prospective member mix).

  - Assumed aggregate lower bound MLR: 100% - 8.01% (lower bound non-medical load) = **91.99%** (ranges between 90.57% and 93.46% by county, based on prospective member mix).

- Non-CMC (excluding pharmacy add-on):
  - Assumed aggregate upper bound MLR: 100% - 7.99% (upper bound non-medical load) = **92.01%** (ranges between 91.15% and 93.84% by county, based on prospective member mix).
  - Assumed aggregate lower bound MLR: 100% - 6.61% (lower bound non-medical load) = **93.39%** (ranges between 92.62% and 95.01% by county, based on prospective member mix).
- Non-CMC pharmacy add-on:
  - Assumed aggregate MLR: 100% - 4.32% (non-medical load) = 95.68% (ranges between 95.52% and 95.74% by county, based on prospective member mix).

The State has chosen to not impose remittance provisions related to this MLR for CY 2021.

Rate Ranges

To assist DHCS during its rate discussions with each MCO, Mercer provides DHCS with rate ranges that were developed using an actuarially sound process. The population-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 “best estimate” assumption is determined, the assumption is then varied by an appropriate amount to reflect a degree of uncertainty and the potential for variability in actual results by MCO. The total variation produced by the assumptions is reviewed for reasonableness to ensure that the final rate ranges represent reasonable, appropriate and attainable rates for the covered populations during the rating period.

Please note that for CMC, Mercer is certifying to the contracted rates “absent the demonstration” and before the application of any negotiated savings percentage. Subsequent adjustments to the original contracted rates resulting from the application of the integrated savings factor are described in the CMC three-way contracts between CMS, the State and the MCOs.

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Data

Base Data

The information used to form the base data for the CCI dual-eligible model rate range development was MCO encounter data, requested MCO RDT (including global subcontracting MCO RDTs) and ad hoc claims data and DMHC-required Medi-Cal specific financial reporting. The CY 2018 encounter and CY 2018 RDT claims data included utilization and unit cost detail by cohort, population, by county/region, by MCO and by consolidated provider types or COS, including:

- IP Hospital
- OP Facility
- ER
- LTC
- Physician Primary Care
- Physician Specialty
- Federally Qualified Health Center (FQHC)
- Other Medical Professional
- MH – OP
- Pharmacy
- Laboratory and Radiology
- Transportation
- CBAS
- Hospice
- MSSP
- Other Home- and Community-Based Services

- All Other

Base Data Selection

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. 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 abortion. Mercer has relied on data and other information provided by the MCOs and DHCS in the development of these rate ranges. Mercer has reviewed the data and information for reasonableness and Mercer believes the data and information utilized in the rate development to be free of material error and suitable for rate range development purposes for the populations and services covered under the CCI model contracts. Mercer did not audit the data or information and, if the data or information is materially incomplete or inaccurate, Mercer's conclusions may require revision. However, Mercer did perform alternative procedures and analyses that provide a reasonable assurance as to the data's appropriateness for use in capitation rate development under the State Plan.

Ultimately, the actuaries deemed the RDT data as the most reliable base data source, as the CCI program is still relatively new and encounter data is not yet a reasonable reflection of plan experience. Utilization and unit cost information from the plan-specific encounter and RDT data was reviewed at the cohort, population and COS detail levels for reasonableness. The base RDT data was deemed to be fully credible in all counties.

The data utilized was managed care data that did not include any disproportionate share hospital payments or include any adjustments for FQHCs or Rural Health Clinic 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 this is reviewed and discussed with the MCOs. No adjustments are made to the base data, as all of these amounts are already included.

The RDT submissions already include incurred but not reported adjustments that 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 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.

It should be noted that the process described above was not used for unique situations for certain MCOs or counties. There are some situations where a modified approach was more appropriate to utilize. These instances are described in the following subsections.

Impact of Cal MediConnect and Acuity Adjustments

As described in the three-way contract, to develop the final payment rates for members enrolled in CMC, the State/CMS applies an aggregate savings factor to the starting blended CMC rate ranges, as well as withholds a percentage of the capitation rate. The withheld amounts will be repaid subject to each MCO's performance consistent with established quality thresholds.

The base data was reviewed at a population level, which for the CMC-enrolled population included a split of Medicare and Medi-Cal liabilities. Mercer ensured the CMC data reflected a reasonable Medicare/Medi-Cal split at the MCO level, making MCO-specific adjustments based on each MCO's reporting challenges. The managed care data was compared to prior years in order to establish reasonableness.

The CMC-enrolled data was not included in the base data for any population. The data from the CMC eligible but not enrolled (EBNE) population is the best representative of experience "absent the demonstration" and served as the base data for the CMC-enrolled rate development. However, review of the CMC-enrolled experience indicated that the CMC-enrolled population demonstrated significantly higher risk than the CMC EBNE population for several county/population combinations. In these cases, Mercer compared the experience between the CMC-enrolled population and the EBNE population over multiple years of data and developed acuity adjustments to better reflect the risk differential between the CMC-enrolled and CMC EBNE populations. These adjustments were applied to the rates for CMC-enrolled populations as shown below.

Acuity Adjustments

County	Population	CMC Factor
Santa Clara	IHSS (no CBAS, no MSSP)	2.45
Santa Clara	Healthy	1.65
San Mateo	CBAS and MSSP	1.20
San Mateo	IHSS (no CBAS, no MSSP)	1.80
San Mateo	Healthy	1.60
Riverside	IHSS (no CBAS, no MSSP)	1.50
San Bernardino	IHSS (no CBAS, no MSSP)	1.45

County	Population	CMC Factor
San Bernardino	Healthy	1.10

Small Cell Sizes

Per the population definitions within the CCI contracts, there are fewer restrictions on who can enroll in CMC in COHS counties. In San Mateo County, the result is a very small CMC ineligible population (less than 1,000 MMs in the CY 2018 base period across all four cohorts). Given this small population and the potential for significant variability and credibility issues, Mercer aggregated the CMC ineligible population into the CMC EBNE base data to create one combined base data set. Some program changes do impact the CMC EBNE and CMC ineligible populations differently; therefore, the final cohort-specific rates do end up diverging through the rate-development process.

In Lieu of Services

As part of the CY 2018 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 base data year (CY 2018), but were provided as an in-lieu of service. Based on this data reported by the MCOs, four of the MCOs reported costs for in-lieu services within this section of the RDT, totaling approximately 0.14% of total medical expenditures across those health plans. This reporting was reviewed and discussed with the MCOs during base data development and an adjustment was deemed necessary to remove these non-State Plan service expenditures. With this adjustment, approximately $890,000 was removed from the CY 2018 base data. In lieu of services will continue to be monitored in future base data and rate setting periods.

Excluded Health Plans

Aetna entered San Diego County effective January 1, 2018 and United entered San Diego County effective October 1, 2017. Membership for these plans began to slowly ramp up after their entrances into the Medi-Cal program and throughout CY 2018. Due to this and the continued expected ramp up for these two plans during CY 2021, a decision was made to exclude base data for these two plans from the county average base data, consistent with previous rating periods.

Given data inconsistencies observed during prior rate setting processes in the CY 2016 and CY 2017 RDT reporting, Kaiser's RDT-reported information was not deemed appropriate to use in the development of the base data last cycle. Mercer has continued to observe anomalies, including very high professional figures, reported in Kaiser's CY 2018 RDT information. As a result, this information was not deemed appropriate to use in the development of the CY 2018 base data for CY 2021 rate setting purposes and Kaiser base data was excluded from the county average base data.

The Excel rate range spreadsheets contain detailed CRCS for the Two-Plan, GMC, Regional and COHS model rate development. Base data are presented by COS as annual utilization per 1,000 members, average unit cost and the resulting per member per month (PMPM) calculations and are reflected in columns (A), (B) and (C) of the CRCS, respectively. The various COA groupings are each represented by their own separate CRCS.

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Projected Benefit Costs and Trends

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

- Trend from CY 2018 to the rating period
- Program changes

The adjustments listed above are shown within the various columns of the CRCS by county/region, population, cohort and COS. The exact columns are noted within each subsection below.

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 cost of medical services over a finite period of time. Trend factors are necessary to estimate the expenses of providing health care services in a future period. As part of the CY 2021 rate range development for the CCI dual-eligible model program, Mercer developed trend rates for each provider type or COS separately by utilization and unit cost components. For all populations in the CY 2021 rating period, the CY 2018 base data used was trended forward 36 months to the midpoint of CY 2021. The pharmacy benefit was only trended 31.5 months from the midpoint of CY 2018 to the midpoint of the first quarter of 2021 to align with the limited three-month continuation of this benefit in managed care.

Mercer reviewed and utilized multiple sources of data and information for trend development. These include most recent MCO encounter and RDT data, MCO Medi-Cal only financial statements, Medi-Cal-specific hospital IP and OP payment data, Consumer Price Index, National Health Expenditures updates and multiple industry trend reports including the CMS Medicaid actuarial report. Each of these data and information sources has strengths and challenges, and those strengths and challenges may change over time. Hence, no one, or combination of, data and information source(s), was utilized within a prescribed formula. Rather, each was reviewed for its potential applicability and utilized collectively with other data and information via actuarial judgement in order to inform the final trends.

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

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

The report provides the following examples:

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

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

Given the recent financial information available at the time the rate ranges were developed, the range for the claim cost trend component is typically +/- 0.25% per year for each of the utilization and unit cost components, or roughly +/- 0.5% PMPM per year (the +/- 0.25% does not apply to a zero value, such as those for LTC utilization). Over the three-year period from the midpoint of the CY 2018 base period to the midpoint of CY 2021, across all service categories, this contributes approximately +/- 1.0% to the upper and lower bounds of the rate ranges.

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

The specific lower bound trend levels by utilization and unit costs for the 19 COS are displayed in columns (D) and (E) of the CRCS, respectively, for each population group. These annual trend figures are applied for the number of months represented in the time periods section in the upper right hand corner of the CRCS. The number of trend months is determined by comparing the midpoint of the base period to the midpoint of the rating period.

The table below displays the average lower bound claim cost trends for CY 2020 and CY 2021 as well as the year-over-year change in this trend (CY 2021 trends for non-CMC exclude the three months of pharmacy).

Annual Average Lower Bound Claim Cost Trends Across All MCOs, Populations and COS

CMC	Metric	2020	2021	Change
CMC	Utilization	-0.17%	0.02%	0.18%
CMC	Unit Cost	1.62%	1.38%	-0.24%
CMC	PMPM	1.45%	1.40%	-0.05%
EBNE	Utilization	0.01%	0.21%	0.21%
EBNE	Unit Cost	1.02%	0.78%	-0.24%
EBNE	PMPM	1.03%	1.00%	-0.03%
Ineligible	Utilization	0.05%	0.19%	0.14%
Ineligible	Unit Cost	1.53%	1.34%	-0.20%
Ineligible	PMPM	1.58%	1.53%	-0.06%

Program Changes

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

The next several subsections are the program changes adjustments that were explicitly accounted for within the CY 2021 capitation rates. A summary showing the managed care impact by county/region and population/cohort (where applicable) can be found within the program change charts that are provided within the Excel file titled *CA CCI Duals CY 2021 Program Change Chart 2021 01 28.xlsx*. Additionally, the program change adjustments identified below are applied in columns (F) and (G) of the CRCS, unless otherwise indicated.

Long-Term Care Rate Changes

Rate increases for LTC services are largely handled through a program change adjustment and are based on legislatively mandated annual fee-for-service (FFS) rate increases, resulting in only minor trend adjustments applied to the LTC COS. 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. Rate increases for LTC facilities typically occur August 1 of each year. Beginning in CY 2021, rate increases for AB 1629 LTC facilities occur January 1 of each year, while rate increases for non-AB 1629 LTC facilities will continue to occur on August 1 of each year.

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

The LTC rate increase factors are developed separately for each county within the CCI dual-eligible model program. To calculate the adjustment factors for each county, costs and rate increases by the different LTC facility types are analyzed by county and final adjustment factors are developed using this information.

Hospice Rate Increase

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

Non-Medical Transportation

Non-medical transportation (NMT) became a managed care covered benefit effective July 1, 2017. NMT refers to non-emergent transportation to and from medical appointments for beneficiaries where the mode of transportation has no medical component associated with it. This includes modes of transportation such as taxicabs and public transportation and does not include modes of transportation such as non-emergent ambulance transportation or transportation via a wheelchair van (which are referred to as non-emergent medical modes of transportation). To develop a rate adjustment for this program change, supplemental

transportation data was provided by the MCOs by three grouped modes of transportation (emergent, non-emergent medical and non-medical), by COA and by quarter for CY 2018 and CY 2019. The data was provided by quarter to evaluate the ramp up of the NMT benefit through the most recently available quarter of data prior to the January 1, 2021 rating period start date. Additionally, this data was supplemented with data from other state Medicaid programs to develop a benchmark NMT PMPM by COA. To develop the NMT adjustment PMPMs, the following process was done.

Project Non-Medical Transportation Per Member Per Months for CY 2021

To project the total NMT PMPMs for the rating period, each plan's NMT PMPMs, reported by quarter, were reviewed as a percentage of the NMT PMPM benchmarks in total across all COA groups. Based on the ramp up seen in the third and fourth quarters of 2019, a plan-specific percentage of the NMT benchmark was assumed for each plan and county combination for CY 2021. Each plan's assumed NMT PMPM in the rating period was calculated as the assumed percentage times the NMT benchmark PMPMs. The same percentage was used for each COA. This was done in a consistent manner for each plan county/region combination.

Calculate Non-Medical Transportation Costs Assumed in the CY 2021 Rates

NMT data was reported by the MCOs in the CY 2018 base data time period were used as the basis for the NMT amounts assumed in the rates. These amounts reported by the MCOs were trended to CY 2021 (using the trend factors developed for the Transportation COS line).

Calculate Non-Medical Transportation Adjustment

The final NMT PMPM adjustment was calculated as the difference between the projected NMT PMPMs in the rating period minus the NMT PMPMs assumed in the rates. This was done separately for each county, cohort and population.

Ground Emergency Medical Transportation Fee Increase

Pursuant to approved State Plan Amendment (SPA) 18-004 and subsequent continuances in approved SPAs 19-0020 and 20-0009, DHCS makes add-on payments to Ground Emergency Medical Transportation (GEMT) providers in the State's FFS program that meet specified requirements using proceeds from a GEMT provider qualify assurance fee. Both State law (Welfare & Institutions Code § 14129.3(b)) and the approved SPAs establish that the combination of the State's FFS base and add-on payments constitutes the Rogers rates that MCOs must pay to non-contracted GEMT providers serving Medi-Cal managed care enrollees for those fiscal years in which the GEMT add-on is effective. A program change adjustment has been included in the certified capitation rates to account for this MCO obligation. It should be noted that the impact of this adjustment is very small for the CCI full dual population since Medicare is the primary payer for GEMT services.

The first step was to evaluate each GEMT code after the Medi-Cal fee increase to see if any crossover Medi-Cal liability existed by code. To do this, the Medicare ambulance fee schedule was reviewed for the applicable codes (A0225, A0427, A0429, A0433 and A0434). Based on this review, it was determined that crossover Medi-Cal liability would only exist for code A0429 and only in certain counties, since 80% of the Medicare fee schedule fell below the Medi-Cal fee schedule in certain counties for this code only.

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

This adjustment was developed by county, and due to the very small materiality of this adjustment for the duals populations, the same PMPM adjustment was developed for each cohort and population.

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

Multipurpose Senior Services Program Rate Increase

Unit cost trend factors were not developed for the MSSP COS. Instead, MSSP price increases are handled through a program change adjustment and are based on 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. The State pays a single monthly per user per month for MSSP services, and that monthly rate was increased by 25% effective July 1, 2019. A consistent 25% unit cost adjustment factor was applied to the MSSP COS for all populations.

Community-Based Adult Services AB 97 Buyback

Effective July 1, 2019, Medi-Cal restored CBAS facility payment rates to levels in effect prior to the AB 97 10% rate reduction applied to certain CBAS facilities, which is expected to produce corresponding pricing pressures in managed care. As a result, a unit cost change program change adjustment was applied to the CBAS COS line to account for this. This program change adjustment was developed by reviewing CY 2018 RDT and encounter data specific to CBAS. Based on the review of this data, if it was observed that a plan was paying a CBAS rate less than $76.27 (the state fee schedule CBAS daily rate without the AB 97 10% reduction applied [based on code S5102, which makes up the vast majority of CBAS), an adjustment was made in these instances to raise the unit cost to $76.27. If a plan was paying CBAS daily rates in excess of this amount, no adjustment was made.

Adult Optional Benefits

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

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

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

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

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

For vision services, the PMPM adjustment was developed by estimating the price for frames and lens dispensing fees as well as developing an assumed utilization of the benefit. To estimate the price for frames and lens dispensing fees, encounter data from CY 2017 to CY 2019 was utilized, as this benefit is already covered in Medi-Cal for children under age 21, pregnant women and beneficiaries residing in a nursing facility. From this data, a price per eyeglasses was developed for CY 2021, which includes frames and lens dispensing fees only, as costs for lens fabrication provided by the Prison Industry Authority are not covered in managed care. To develop the utilization assumption, historical figures budgeted by DHCS along with data estimates from the California Optometric Association estimate were reviewed. The California Optometric Association estimated that approximately two million Medi-Cal beneficiaries aged 21–64 need eyeglasses.[2] Using this estimate as a benchmark, an assumption was then made on the number of those who need eyeglasses would actually get them in CY 2021. The ramp up assumption used was 50%, and was based on actuarial judgement.

Other Items

Health Care-Acquired Conditions

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

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

As such, Mercer initially reviewed potential encounter data information for making an appropriate adjustment. Unfortunately, the required information (a present on admission indicator, for example) is not currently part of the encounter data. This is an ongoing process without any current information available for a rate adjustment. Other studies and other state experience have shown limited needed adjustments related to these types of conditions. This issue will continue to be reviewed. No adjustments have been included within these rates.

Graduate Medical Education

With regard to Graduate Medical Education (GMED) costs and along with item AA.3.9 of *Documentation Requirements for Actuarially Sound Capitation Rates, Effective Date:*

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

November 15, 2014, DHCS staff has confirmed that there are no provisions in the CCI dual-eligible model managed care contracts regarding GMED. The CCI dual-eligible model MCOs do not pay specific rates that contain 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 CCI dual-eligible model managed care program are not required to cover retrospective eligibility periods for their enrollees. These periods are covered in the Medi-Cal FFS program. Since MCO data serves as the base data for the rate ranges, retrospective eligibility periods are not part of the capitation rate development process. No adjustments are necessary.

Mental Health Parity and Addiction Equity Act

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

Institution for Mental Disease

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

Provider Overpayments

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

American Indian Health Services Carve-Out

Starting January 1, 2018, MCOs were no longer at risk for all eligible American Indian Health Services (AIHS) and are paid via a separate payment arrangement that is not part of these capitation rates. The MCOs manage these services on an Administrative Services Only contract with DHCS. AIHS costs were excluded from the CY 2018 RDT reporting and are therefore excluded from the rate development base.

Pharmacy Carve-Out

One significant change for the CY 2021 rating period is the decision to carve pharmacy out of managed care for non-CMC only (CMC rates continue to have pharmacy carved-in). The initial plan was for this change to be effective January 1, 2021, but a three-month delay is being implemented, which resulted in the need to develop a managed care capitation rate for pharmacy for the January 1, 2021–March 31, 2021 period. The development of this pharmacy rate is previously described and consistent with other base data and rate development for the CY 2021 period.

COVID-19

The impact of the COVID-19 pandemic on the CY 2021 capitation rates was considered. Significant national uncertainty exists regarding the impact of COVID-19 during CY 2021 due to the ever-changing situation with regionalized infection rates, responses driven by local governments and new treatment protocols, to name a few factors. Many elements were considered, including infection rate and severity mix of cases, the impact of social distancing, the Federal Government's involvement in COVID-19-related funding (e.g., HHS and FEMA), the availability of a vaccine, and Medi-Cal as a secondary payer for certain services.

Given the limited experience resulting from the COVID-19 pandemic, Mercer evaluated several data sources in considering impacts to the CY 2021 capitation rates, including Mercer and Oliver Wyman internal modeling, and national and state data sources. Mercer considered the costs of COVID-19 testing and treatment, deferred and canceled care, and mental health outpatient services acuity. These various components have both upward and downward expected cost impacts. The ultimate impact of COVID-19 is highly dependent on numerous unknown variables and it was determined that no COVID-19 adjustment would be applied to the CY 2021 rates for the CCI dual-eligible program.

In addition, given the uncertainty surrounding the availability and uptake of a vaccine, DHCS carved both the vaccine and vaccine administration out of managed care. In addition, per the CMS vaccine toolkit, there is no assumed Medicaid liability for the cost of the vaccine itself in CY 2021. Consequently, no explicit adjustment was made for these costs.

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, which include the following:

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

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

Administration

The administration loading for the CCI dual-eligible program MCOs was developed by population group and reviewed in aggregate. The administration load factor is expressed as a percentage of the capitation rate (for example, percent of premium). This midpoint percentage was developed from a review of the MCOs' historical reported administrative expenses. The administrative costs are reviewed to ensure that they are appropriate for the approved state plan services and Medicaid eligible members. Mercer also utilized its experience and professional judgment in determining the midpoint, lower bound and upper bound percentages to be reasonable. At the midpoint, the CY 2021 administration load is approximately 6.6% for the CMC-enrolled population and 5.4% for the non-CMC population (excluding the three months of pharmacy). The range for the administration component is between +/- 0.3% and +/- 0.4% from the midpoint value to the upper/lower bounds. The pharmacy add-on for the non-CMC population includes a 2.0% administration load, which is broadly consistent with the assumed administrative cost level that was removed during the main capitation rate development process.

The midpoint aggregate assumptions reflect an increase of less than 0.1% from the prior rating period for the CMC-enrolled population, and reflect a decrease of less than 0.1% for the non-CMC population, as compared to the prior rating period.

While the above is the overall targeted aggregate administrative percentage, the administrative expense associated with each population group 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 each of the populations is an appropriate method; however, it does not take into account the differences in fixed versus variable administrative costs for each.

The population categories that make up the CCI program have very different medical expense figures. In these instances, the uniform allocation methodology will produce an administrative component for the more expensive population groups that is much larger than the administrative component for the less expensive population groups. While a more expensive eligible could be more administratively intensive, this relationship in administrative costs is most likely exaggerated.

If the fixed 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 population groups and a smaller percentage of the capitation rate for the more expensive population groups. This concept has generally been applied to the capitation rates, whereby the administrative component will be greater for less expensive population groups than the aggregate administrative percentage over the entire population.

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

Underwriting Gain

At the midpoint, the underwriting gain load is approximately 2.2% for the CMC-enrolled population and 1.9% for the non-CMC population. The range for the underwriting gain component is between +/- 0.3% and +/- 0.4% from the midpoint value to the upper/lower bounds. Mercer has implicitly and broadly considered the cost of capital within Mercer's rating assumptions. Mercer's conclusion is that our 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.

The midpoint aggregate assumptions represent a decrease of approximately 0.6% for both the CMC-enrolled population and the non-CMC population.

Managed Care Organization Tax

Effective July 1, 2016, DHCS implemented a CMS-approved[3] MCO tax for applicable full service health care plans and their various lines of business. This tax approval expired on June 30, 2019. DHCS then submitted another MCO tax proposal for July 1, 2019 through December 31, 2022. In response to this request, CMS approved the tax for January 1, 2020 through December 31, 2022. To calculate the total tax liability for each MCO, DHCS utilized enrollment from CY 2018. Based on this enrollment period, each MCO's MMs were taxed at specific per member rates, categorized by tiers that 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 applicable two tax years within CY 2021 (SFY 20-21 and SFY 21-22).

SFY 20-21 MCO Tax Structure

Medicaid		Non-Medicaid	
Member Range	**Tax Per Member**	**Member Range**	**Tax Per Member**
0–675,000	$0.00	0–675,000	$0.00
675,001–4,000,000	$45.00	675,001–4,000,000	$1.00
4,000,001+	$0.00	4,000,001+	$0.00

SFY 21-22 MCO Tax Structure

Medicaid		Non-Medicaid	
Member Range	**Tax Per Member**	**Member Range**	**Tax Per Ember**
0–675,000	$0.00	0–675,000	$0.00
675,001–4,000,000	$50.00	675,001–4,000,000	$1.50
4,000,001+	$0.00	4,000,001+	$0.00

The first six months of SFY 20-21 (July 2020 through December 2020) was used to develop the MCO Tax PMPM for the prior rating period (CY 2020). Using actual enrollment from July 2020 through September 2020, and projected enrollment from October 2020 through December 2020, Mercer is able to estimate the proportion of the SFY 20-21 MCO Tax liability that remains for January 2021 through June 2021. Additionally, acknowledging the anticipated decline in projected enrollment beyond CY 2021, 52% of the SFY 21-22 MCO Tax liability has been built into the July 2021 through December 2021 time period. Using the estimated tax liability for each six month time period in CY 2021, each MCO's total tax liability is known for

[3] http://www.dhcs.ca.gov/services/medi-cal/Documents/CAMCOTaxlett51716.pdf

the CY 2021 time period. Using this total tax liability, a singular PMPM was calculated for CY 2021 for each MCO across all COA and all counties in which they operate.

To produce the final capitation rates payable to the MCOs, the MCO tax is added to the rate ranges. Please note that for CCI dual-eligible beneficiaries, the MCO tax is only applicable to the non-CMC population, as members enrolled in CMC are exempt from the MCO tax. Please also note that Aetna Better Health and UnitedHealthcare are not subject to any MCO tax effective for the CY 2021 contract period.

Health Insurance Providers Fee

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

6
Member Mix Adjustment

Cal MediConnect

The CMC rate will be paid as a single blended rate that takes into account the relative risk of the population actually enrolled in each contracted plan and is weighted accordingly.

The CMC member mix-adjusted blended rate as described in this section is intended to appropriately give each plan incentives to ensure beneficiaries are served, as appropriate, in the lower cost home- and community-based settings. This incentive grows through all phases of the adjustment by placing plans at risk, for increasingly longer durations of time, for beneficiaries shifting between institutional and home- and community-based settings. In addition, the incentive is provided through all phases of the adjustment, due to the prospective adjustments made to the relative cost factors (RCFs) described below, which reflect an assumption of incremental improvement in population distribution (for example, fewer individuals in institutional settings).

The population is categorized into four member-mix adjustment population categories that align with the population groups described in more detail earlier:

- Institutionalized
- CBAS and MSSP
- IHSS (no CBAS, no MSSP)
- Community Well/Healthy

The Medi-Cal component of the demonstration rate utilizes the member mix adjustment methodology in the contracts that support the 1115(a) demonstration for the eligible population.

- It employs the population categories described above. RCFs are established for each of the four populations based on evaluation of the PMPM for each of the individual population groups, relative to the total Medi-Cal rate. As the total Medi-Cal rate incorporates an incremental improvement in population distribution, the calculation of the RCFs is also impacted by the assumed population distribution.
- Plan-specific relative mix factors (RMF) are computed using RCFs and the proportion of each of the population category enrollees in the plan. The RMFs are computed by

multiplying each MCO's distribution of each of the population categories with the established RCFs to calculate a weighted average plan-specific RMF.

- MCO RMFs are multiplied by the established capitation rate to determine the member mix-adjusted demonstration capitation payment rate for each MCO.
- The member mix adjustment process includes three distinct phases to address the stability of enrollment and to establish appropriate financial incentives for MCOs.
- The member mix adjustment process described above is administered by county in three phases during the demonstration period; for the CY 2021 contract period, all counties are in Phase III which is described below:
  - MCO rates are based on a targeted relative mix of the population and are not adjusted during the year. The targeted relative mix of the population for the year is based on a multi-year review of enrollment in the plan through the most recent data available. The mix assumption exercises actuarial judgment to trend forward enrollment patterns and project changes in the population. Based on this review, the assumed mix may include shifts in the population
    year-to-year.
    - The State and its actuaries project a targeted relative mix. This mix is designed to be achievable by the MCO, based on assumptions about the plan's ability to promote community services and prevent or delay institutional placement.
    - If the targeted population mix for the MCO for the year results in a greater than 2.5% impact to the Medi-Cal component of the rate paid as compared to the rate that would have been paid based on the actual mix, then the MCO and Medi-Cal would share equally in any increases or decreases beyond the 2.5%. Actual plan gains or loss does not factor into this calculation.

Please note that Aetna Better Health, Kaiser and UnitedHealthcare cannot have members in CMC in CY 2021.

Non-Cal MediConnect

The non-CMC CCI rate is paid as a single, blended rate that takes into account the relative risk of the population actually enrolled in each contracted plan and is weighted accordingly.

Similar to the CMC member mix-adjustment process described above, the blended rate as described in this section is intended to appropriately give each plan incentives to ensure beneficiaries are served, as appropriate, in the lower cost home- and community-based settings.

The payment process is administered by county and varies over three phases to address the stability of enrollment and to establish appropriate financial incentives for the MCO; all counties are in Phase III, which is described below:

- MCO rates are based on a targeted relative mix of the population and are not adjusted during the year. The targeted relative mix of the population for the year is based on a multi-year review of enrollment in the plan through the most recent data available. The mix assumption exercises actuarial judgment to trend forward enrollment patterns and project changes in the population. Based on this review, the assumed mix may include shifts in the population year-to-year.
  - The State and its actuaries project a targeted relative mix. This mix is designed to be achievable by the MCO, based on assumptions about the plan's ability to promote community services and prevent or delay institutional placement.
  - If the population mix for the MCO for the year results in a greater than 2.5% impact to the Medi-Cal component of the rate paid as compared to the rate that would have been paid based on the actual mix, then the MCO and Medi-Cal would share equally in any increases or decreases beyond the 2.5%. The actual plan gains or loss does not factor into this calculation.

Please note that the non-CMC mix for both Aetna Better Health and UnitedHealthcare was based on the assumed countywide average in San Diego County.

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
- Pass-through payments
- Delivery system and provider payment initiatives

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

Incentive Arrangements

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

Withhold Arrangements

There are no withhold arrangements between DHCS and the MCOs applicable to the non-CMC rates.

The CY 2021 CMC capitation rates are subject to a quality withhold as described in the CMC three-way contracts between CMS, the State and the MCOs. The withheld amounts are repaid separately for each demonstration year, subject to each MCO's performance consistent with established quality thresholds. The quality withhold measures and percentages by demonstration year are dictated in the three-way contract.

Risk-Sharing Mechanisms

Member Mix Risk Corridor

Effective for CY 2021, DHCS will continue to use a symmetrical, two-sided risk corridor on the impact to revenue of assumed member mix as compared to actual member mix. This risk corridor has been in place for a number of years, and has been approved by CMS for prior rating periods. This risk corridor applies to all of the MCOs for both CMC and non-CMC.

MCO rates are a blended rate across underlying population groups based on a targeted relative mix of the population and are not adjusted during the year. Projected costs vary significantly across the underlying population groups; therefore, if there are unexpected shifts in the population and the mix for the MCO in CY 2021 varies significantly from the mix assumed in rate development, the capitation rates may not reflect the risk profile of the population covered.

After the conclusion of the rating period, data will be collected on the actual population mix for each MCO during CY 2021. If the Medi-Cal component of the blended rate re-mixed using the actual population mix for the MCO in CY 2021 varies from the blended rate paid by greater than 2.5%, then the MCO and Medi-Cal will share equally in any increases or decreases beyond the 2.5%. The actual plan gain or loss does not factor into this calculation.

There is no impact on the CY 2021 capitation rates for the provision of a risk corridor. The CY 2021 capitation rates reflect Mercer's best estimate projection of population mix. However, the inclusion of a risk corridor is considered in the risk/contingency component of the non-medical expense loads.

This risk mitigation program has been developed in accordance with generally accepted actuarial principles and practices.

Cal MediConnect Risk Corridor

The CY 2021 CMC capitation rates are subject to a one-sided risk corridor as described in the CMC three-way contracts between CMS, the State and the MCOs.

Besides the aforementioned items, there are no other risk-sharing mechanisms effective for the capitation rates being certified to in this rate certification.

Pass-Through Payments

There are no pass-through payments that impact the CCI dual-eligible CY 2021 capitation rates.

Delivery System and Provider Payment Initiatives

There are no directed payment initiatives applicable to the CCI dual-eligible CY 2021 capitation rates.

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

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, reinsurance, or incentive 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.

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 document, please feel free to contact Katharina Lau at +1 (602) 522-6448 or Gabe Smith at +1 (602) 522-6540.

Sincerely,

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