Mercer

Government Human Services Consulting

Coordinated Care Initiative Dual-Eligible Model

Capitation Rate Development and Certification

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

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Contents

Section 1

Executive Summary

The California Department of Health Care Services (DHCS) contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to develop actuarially sound[1] capitation rates for use during the Coordinated Care Initiative (CCI) program calendar year 2022 (CY 2022) for dual-eligible beneficiaries. The CY 2022 period encompasses the time period of January 1, 2022 through December 31, 2022. The CCI dual-eligible model rates include rates for Cal MediConnect (CMC), the State's duals demonstration program.

Multiple attachments are also included as part of this rate certification package. These attachments include summaries of the CY 2022 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 2022 MediConnect Exhibits 2021 12.xlsx.
- **Non-CMC:** CA CCI Duals CY 2022 Non-MediConnect Exhibits 2021 12.xlsx.

Per Section 4.2 of ASOP 49, capitation rates for the CCI managed care program were developed in accordance with Centers for Medicare & Medicaid Services (CMS) requirements and this document provides the certification of actuarial soundness required by 42 CFR § 438.4. CMS defines actuarially sound rates as meeting the following criteria:

- Have been developed in accordance with generally accepted actuarial principles and practices. Proposed differences among capitation rates according to covered populations are based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.
- Are appropriate for the populations to be covered and the services to be furnished under the contract.
- Payments from each rate cell do not cross-subsidize payments for any other rate cell.
- Have been certified by actuaries who meet qualification standards established by the American Academy of Actuaries and the Actuarial Standards Board.

[1] Actuarially sound/actuarial soundness – Medicaid capitation rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For the purposes of this definition, other revenue sources include, but are not limited to, 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.

Any proposed differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations comply with 42 CFR § 438.4(b)(1). Any differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations are based on valid rate development standards that represent actual cost differences to the covered populations, and these differences do not vary with the rate of Federal Financial Participation associated with the covered populations in a manner that increases federal costs.

This report describes the rate development process and provides the certification of actuarial soundness required by 42 CFR §438.4. This report was developed to provide the requisite rate documentation to DHCS and to support the rate review process performed by CMS. This report follows the general outline of the CMS July 2021 through June 2022 Medicaid Managed Care Rate Development Guide (RDG), which is the applicable version of the guide for the CY 2022 period. A copy of the RDG with documentation references is also attached with this report. The rate development process included the historical practice of developing rate ranges. However, the actuaries are certifying to final capitation rates within the developed rate ranges.

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

Mercer expressly disclaims responsibility, liability, or both for any reliance on this communication by third parties or the consequences of any unauthorized use.

Mercer has done a comprehensive exercise of rebasing the capitation rates 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.

Beginning with the CY 2022 rating period, some significant changes within the Medi-Cal program will occur. Highlights of these changes include the implementation of multiple aspects of the California Advancing and Innovating Medi-Cal (CalAIM) proposal, which is a multi-year initiative by DHCS to improve the quality of life and health outcomes for the Medi-Cal population. Multiple components of this initiative are addressed throughout the body of this report.

One specific change associated with CalAIM for the CY 2022 rating period is the decision to carve Multipurpose Senior Services Program (MSSP) services out of managed care. To implement this carve-out, cost and utilization experience for the MSSP category of service (COS) has been removed from the base data. Additionally, given that MSSP utilization drove a portion of population identification in historical rating periods, it was necessary for Mercer to adjust the rate development cohort structure from the prior year. Data for MSSP-only members (members who utilized MSSP services but not community-based adult services [CBAS]), as reported by the MCOs, was utilized to adjust the cohort structure of the base data to match the cohort structure of the CY 2022 rate period. The following table displays the new cohort rate development structure for CY 2022 as compared to CY 2021, along with a brief explanation of the changes. Other changes related to CalAIM are also

effective during the CY 2022 rating period, all of which are described later in this report.

CY 2021 Cohort Structure	Explanation of Changes	CY 2022 Cohort Structure
Institutional	No changes to Institutional	Institutional
CBAS and MSSP	MSSP-Only (no CBAS) has been separated from CBAS	CBAS
IHSS (no CBAS, no MSSP) **Healthy**	IHSS (no CBAS, no MSSP) and Healthy have been combined, along with the MSSP-Only group carved out of CBAS and MSSP, to create a new category: Other Community (no CBAS)	Other Community (no CBAS)

Another significant change is the decision to carve pharmacy out of managed care for the non-CMC population (CMC continues to have pharmacy as a managed care benefit), effective January 1, 2022. As such, pharmacy data and costs have been removed from the non-CMC base data.

Within the rate summary exhibits in the files listed above, there are specific capitation rates at the MCO and county/rating region level which had large positive or negative changes when compared to the prior capitation rates (CY 2021). The majority of these changes are decreases from the prior year primarily attributable to decreases in Institutional membership as a proportion of the total population for most MCOs, the presence of a public health emergency (PHE) related 10% increase to long term care (LTC) services for the CY 2021 rating period that was not applied for CY 2022, and the carve-out of MSSP for the CY 2022 rating period. The rate cells with large increases were either driven by increases in the base data cost on a PMPM basis by county and cohort, or increases in Institutional membership as a proportion of the total population for specific MCOs (e.g., Community Health Group).

Across all counties, MCOs, and populations within the CCI dual-eligible model, compared to the final CY 2021 capitation rates certified on December 1, 2021, the CY 2022 capitation rates represent a 2.5% decrease for CMC and a 5.8% decrease for non-CMC. The rate change is calculated using a constant case mix based on CY 2022 projected member months (MMs) by rate cell (plan and county).

Future amendments to this certification may be submitted to CMS. Certain assumptions material to the rates in this certification depend on the status of the Coronavirus Disease 2019 (COVID-19) PHE. This rate certification assumes the PHE will conclude on December 31, 2021. A future amendment may be submitted to CMS if there are material impacts to the program due to the length of the PHE.

In addition, California provides full scope coverage to beneficiaries with unsatisfactory immigration status (UIS), referred to as the UIS population. UIS members are eligible to receive the same State Plan services as members with satisfactory immigration status (SIS). These UIS members are federally eligible to receive pregnancy and emergency related services. Capitation rates within this certification are set across the entire enrolled population, within which the UIS and SIS members are embedded together. Through communications with CMS, it has come to DHCS and Mercer's attention that these members should be separated from the population with SIS for capitation rate development purposes. If the removal of members and/or services ineligible for full scope federal funding has a material impact on these capitation rates, an amendment will be submitted accordingly.

Section 2

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 2022 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 2022 MediConnect Exhibits 2021 12.xlsx* for CMC and *CA CCI Duals CY 2022 Non-MediConnect Exhibits 2021 12.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, CBAS, and prescription drugs (for CMC only). 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)
- Alcohol and substance use disorder treatment services
- Dental services, except medically necessary Federally Required Adult Dental Services and fluoride varnish dental services that may be performed by a medical professional, are carved out, with the exception of members covered by the Health Plan of San Mateo under their new Dental pilot program
- 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
- IHSS
- COVID-19 vaccines, including the cost to administer the vaccine
- Effective January 1, 2022, MSSP
- Effective January 1, 2022 for non-CMC only, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim: covered OP drugs, including physician administered drugs, medical supplies, and enteral nutritional products

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

As part of the aforementioned CalAIM initiative, there are three major benefit/service changes effective January 1, 2022. These include the following:

- Major organ transplants (MOT) in Two-Plan, GMC, and Regional counties (these are already covered in COHS counties, and currently only kidney and corneal transplants are covered in non-COHS counties)
- Enhanced Care Management (ECM) services for non-CMC members
- 14 Community Supports services are now allowable in the managed care contracts as “in-lieu-of” services (ILOS) in accordance with 42 CFR §438.3(e)

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. Through the CalAIM initiative, members with share of cost (excluding LTC aid code members) will be dis-enrolled from managed care. These beneficiaries will receive coverage through the fee-for-service (FFS) delivery system. There are no other significant changes to covered populations for the CY 2022 rating period.

Share of cost members (recipients who establish eligibility for Medicaid by deducting incurred medical expenses) who reside in a nursing facility 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 three cohorts are defined as follows:

- Institutionalized: Members with an LTC aid category or residing in a nursing facility for 90 days or more
- CBAS: Members who receive CBAS
- Other Community (no CBAS): 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 contracts: 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 contracts noted above. The capitation rates for each contract include all services under the specific 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, except for individuals who do not have SIS for whom federal financial participation is available for emergency and pregnancy related services only. 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.

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 PHE, declared by the Secretary of Health and Human Services for 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 2019 MCO-reported encounter data, the CY 2019 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 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 2019 for the CY 2022 rate ranges) by cohort (or cohort subset), population, and by COS.

MSSP-only data (data for members who utilized MSSP services but not CBAS), as reported in the CY 2019 RDT, was utilized to adjust the cohort structure of the base data to match the cohort structure of the CY 2022 rate period. Adjustments were made to the selected base data to match the covered population risk and the State Plan approved benefit package for the CY 2022 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 2022 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 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 medical loss ratios (MLRs) greater than 85%. For each capitation rate, the aggregated load for administration and underwriting gain falls under 10%; therefore, with 42 CFR §438.8 MLR reporting rules, the aggregated priced-for effective MLR is expected to be at least 90%:

- CMC (excluding add-ons): Assumed aggregate MLR: 100% - 8.72% (lower bound non-medical load) = **91.28%** (ranges between 90.35% and 92.50% by plan/county, based on prospective member mix).
- Non-CMC (excluding add-ons): Assumed aggregate MLR: 100% - 7.20% (lower bound non-medical load) = **92.80%** (ranges between 91.94% and 94.26% by plan/county, based on prospective member mix).

The State has chosen to not impose remittance provisions related to this MLR for CY 2022.

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” assumptions are determined, the assumptions are then varied by an appropriate amount to reflect a degree of uncertainty and the potential for variability in actual results by MCO. The total variation produced by the varied assumptions is reviewed for reasonableness to ensure the final rate ranges represent reasonable, appropriate, and attainable rates for the covered populations during the rating period.

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.

Section 3
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), ad hoc claims data, and California Department of Managed Health Care-required Medi-Cal specific financial reporting. The CY 2019 encounter and CY 2019 RDT claims data included utilization and unit cost detail by county/region, population, cohort, MCO, and 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. 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
Riverside	Institutional	1.20
Riverside	CBAS	1.20
Riverside	Other Community (no CBAS)	1.15
San Bernardino	Institutional	1.20
San Bernardino	CBAS	1.20
Santa Clara	Other Community (no CBAS)	1.60
San Diego	Other Community (no CBAS)	1.25
San Mateo	CBAS	1.20
San Mateo	Other Community (no CBAS)	1.80

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 2019 base period across all three 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.

Base Data Adjustments

The MCO-reported RDT experience was adjusted with a number of utilization and unit cost base data adjustments. As detailed below, many of these adjustments align the base data with the varying payment structures for CY 2022. The adjustments are as follows:

- MSSP Carve-Out
- Pharmacy Carve-Out (non-CMC)
- Global Non-Medical Expense Adjustment
- Value-Added Services Adjustment
- Molina Transportation
- Blue Shield of California Systems Conversion

MSSP Carve-Out

Effective January 1, 2022, MSSP services will be carved out of managed care and covered by the State through the FFS delivery system. Accordingly, Mercer excluded MSSP costs reported in the CY 2019 base experience from the base data, as these service costs will not be covered under the capitation rates. To remove the costs associated with these services, the RDT-reported amounts for this COS line were zeroed out within the base data.

Pharmacy Carve-Out (non-CMC)

Effective January 1, 2022, retail pharmacy services will be carved out of managed care for the non-CMC populations and covered by the State through the FFS delivery system. Specifically, the following pharmacy benefits, when billed by a pharmacy and on a pharmacy claim, will be carved out of managed care: covered OP drugs, including physician administered drugs, medical supplies, and enteral nutritional products. To remove pharmacy costs from the capitation rates, the pharmacy COS line was zeroed out within the base data for non-CMC populations, based on MCO

RDT reporting. The RDT data source was reviewed and validated against encounter data for reasonableness.

Global Non-Medical Expense Adjustment

Some MCOs choose to enter into global subcapitation arrangements (defined here as delegating the entire or vast majority of the risk of a beneficiary to another health plan) to administer managed care coverage for some of their Medi-Cal population. The MMs capitated and the capitation amounts paid in these arrangements are reported within the RDT by rate cell and included in the base data. Mercer reviews this data and information (in conjunction with global subcontractor RDT submissions and encounter data) as part of the base data development process. As these global arrangements and capitation payments include considerations for administrative duties and underwriting gain, it is necessary to remove these non-medical expenses from the base data. After removal from the medical portion of the CY 2019 base data, these non-medical data elements are considered when developing the broader non-medical capitation rate loads.

For CY 2019, the following factors were used to remove non-medical loads from reported global subcapitation payments in the RDT data: 4% for instances where the global subcontractor is Kaiser, 7% otherwise. Further, Santa Clara Family Health Plan delegates a large portion of medical services to Valley Health Plan in Santa Clara County (not reported by Santa Clara Family Health Plan as a global subcontractor within the RDT). In this instance, a 4% adjustment factor was used to remove the non-medical loads from the payments made to Valley Health Plan within the base data development. Mercer arrived at these factors after a review of global subcontractor and direct contractor experience, including historical administrative costs and MCO-reported financials. Across all CCI dual-eligible MCOs, this adjustment removed approximately $29 million from the CY 2019 base data.

Value-Added Services Adjustment

As part of the CY 2019 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 2019), but were provided as value-added services. Based on this data reported by the MCOs, ten of the plan/counties reported costs for value-added services within this section of the RDT, totaling approximately 0.10% of total medical expenditures across all health plans. This reporting was reviewed and discussed with the MCOs during base data development and an adjustment was deemed necessary to remove a majority of these non-State Plan service expenditures. With this adjustment, approximately $3.5 million was removed from the CY 2019 base data.

As part of CalAIM, certain ILOS (known as Community Supports) will be allowable and specified in the managed care contract effective in CY 2022. Some of the services removed through the base adjustment process aligned with one of the 14 approved ILOS and was considered in an ILOS program change adjustment. The adjustment described here is the base data adjustment that removes all reported value-added services; however, some of the services removed through this

adjustment were added back in through a program change adjustment, described later in this report.

Molina Transportation

Contrary to appropriate practice where transportation to and from a CBAS facility should be billed to the CBAS facility by the transportation provider and incorporated into the CBAS facility daily rate paid by MCOs to the CBAS facility, Molina was directly paying transportation providers for trips to and from CBAS facilities. This is in addition to paying a daily rate to the CBAS facilities, which already included a transportation component. These trips were therefore double-counted in the CY 2019 RDT. Effective October 2019, CBAS trips are no longer paid for by Molina separately. As such, while these CBAS trips were reported in the CY 2019 RDT, they have been removed from the base data as they would reflect transportation costs that would not be incurred in CY 2022. This adjustment resulted in an approximately $815,000 decrease to the CY 2019 base data across all Molina counties.

Blue Shield of California Systems Conversion

Through RDT discussions with Blue Shield of California it was identified that a system conversion in CY 2019 caused additional and/or incorrect payments to be made to providers. The cost impact of this was quantified for each population and cohort on a COS basis and an adjustment was applied to remove these costs from the RDT experience. To inform the adjustment, Blue Shield provided supplemental data and information related to the incorrect payments made to providers. In total, approximately $29 million was removed from the base data across all counties for Blue Shield of California.

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 and CY 2019. Due to this, and the continued expected ramp up for these two plans during CY 2022, base data for these two plans was excluded from the county average base data, consistent with previous rating periods.

Given data inconsistencies observed each year from CY 2016 through CY 2018 in Kaiser's RDT reporting, Kaiser’s RDT-reported information was not deemed appropriate to use in the development of the base data in the prior rate cycle. Mercer has continued to observe anomalies, including very high professional figures, reported in Kaiser’s CY 2019 RDT information. As a result, this information was not deemed appropriate to use in the development of the CY 2019 base data for CY 2022 rate development purposes; Kaiser base data was excluded from the county average base data.

The Excel 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 per member per month

(PMPM) calculations, and are reflected in columns (A), (B), and (C) of the CRCS, respectively. The various cohort groupings are each represented by their own separate CRCS.

Section 4

Projected Benefit Costs and Trends

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

- Trend from CY 2019 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 2022 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 2022 rating period, the CY 2019 base data used was trended forward 36 months to the midpoint of CY 2022.

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[2]. 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

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

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.

There are six COS where significant changes in annual claim cost trends took place to reflect the more recent trend experience. In these instances the annual lower bound PMPM trend factors changed more than 0.50% and at least one of the incremental changes to utilization and/or unit cost trend factors changed more than 0.25% from CY 2021 to CY 2022. These large changes from the prior year are a result of reviewing newer and emerging information (as described above) to appropriately align prospective payment levels, with additional detail regarding CBAS provided following the tables. Please see the table below for detailed changes of trend assumptions by COS.

Annual Trend Factors — All Populations

COS	CY 2021	CY 2022	Change
IP Hospital	0.27%	2.98%	2.71%
Laboratory and Radiology	3.26%	4.03%	0.78%
CBAS	2.52%	5.01%	2.49%
Hospice	0.25%	2.25%	2.00%
Other HCBS	2.00%	4.03%	2.03%
All Other	2.00%	4.03%	2.03%

One of the larger of the changes in trend assumptions year-over-year listed above is for the CBAS COS. Emerging experience displayed a large increase after the start of the PHE in the utilization of CBAS on a services per utilizer basis. After further review, including discussions with MCOs, Mercer concluded this increase in CBAS utilization was mostly tied to the Temporary Alternative Services (TAS) flexibilities for delivery of CBAS services granted by DHCS in tandem with the PHE. Through the TAS, CBAS facilities (which traditionally meet in congregate settings) were granted the authority to provide services remotely in order to enhance patient safety; with this flexibility, members that utilize CBAS have been receiving these services more frequently than in the pre-pandemic base period. The most recent information from the California Department of Aging indicates that the TAS flexibility continues to remain in effect, with an end date tied to a point in time beyond the ending of the PHE (timing to be determined). As a result, Mercer increased the utilization trend

assumption for CBAS from the prior rating period for consideration of the impacts from the TAS flexibility.

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 2019 base period to the midpoint of CY 2022, across all service categories, this contributes approximately +/- 1.0% to the upper and lower bounds of the rate ranges.

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 2021 and CY 2022 as well as the year-over-year change in this trend.

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

CMC	Metric	2021	2022	Change
CMC	Utilization	0.02%	0.82%	0.80%
CMC	Unit Cost	1.38%	1.16%	-0.22%
CMC	PMPM	1.40%	1.99%	0.59%
EBNE	Utilization	0.21%	1.24%	1.03%
EBNE	Unit Cost	0.78%	0.32%	-0.46%
EBNE	PMPM	1.00%	1.57%	0.57%
Ineligible	Utilization	0.19%	0.88%	0.69%
Ineligible	Unit Cost	1.34%	1.06%	-0.28%
Ineligible	PMPM	1.53%	1.95%	0.42%

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 rate development were based on information provided by DHCS staff as of November 17, 2021. 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 2022 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 2022 Program Change Chart 2021 12.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

Unit cost changes for LTC services are largely handled through a program change adjustment and are based on legislatively mandated annual 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 as the fee schedule changes produce corresponding pricing pressures in the managed care delivery system; therefore, it was deemed reasonable and appropriate to use the FFS rate increases in the managed care rate-setting process. Historically, rate increases for all LTC facilities typically occurred August 1 of each year. Beginning in CY 2021, rate increases for Assembly Bill (AB) 1629 LTC facilities occur January 1 of each year, while rate increases for non-AB 1629 LTC facilities continue to occur on August 1 of each year.

The LTC rate increase factors are developed separately for each county 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. Further, MCOs provided commentary on their expectations of NMT utilization into the future. This data was also 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 2022

To project the total NMT PMPMs for the rating period, each plan's NMT PMPMs, reported by quarter, were reviewed over time. Based on the ramp up seen through the latest quarters of 2019, NMT PMPMs were trended from the latest quarter in CY 2019 to the CY 2022 period. A 5% ramp-up assumption was utilized in this trend application. This value was averaged with the projected NMT PMPM assumption used in the CY 2021 rate setting process, trended to CY 2022 using the same 5% assumption. This averaged value was used as the projected CY 2022 NMT for each plan/county combination.

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

NMT data was reported by the MCOs in the CY 2019 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 2022 (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, population, and cohort.

Ground Emergency Medical Transportation Fee Increase

Pursuant to approved State Plan Amendment (SPA) 18-004 and subsequent continuances in approved SPAs 19-0020, 20-0009, and 21-0017, and anticipated future continuances, DHCS makes add-on payments to ground emergency medical transportation (GEMT) providers in the State's FFS program that meet specified requirements using proceeds from a GEMT provider quality assurance fee. Both State law (Welfare & Institutions Code § 14129.3(b)) and the approved SPAs establish that the combination of the State's FFS base and add-on payments constitutes the Rogers rates that MCOs must pay to non-contracted GEMT providers serving Medi-Cal managed care enrollees for those 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 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 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 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 approximately 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.

Community-Based Adult Services AB 97 Buyback

Effective July 1, 2019, Medi-Cal restored CBAS facility payment rates in the FFS delivery system 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 program change adjustment was applied to the CBAS COS line to account for this. This program change adjustment was developed by reviewing CY 2019 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:

- 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.
- Separately provided data from certain MCOs in the Medi-Cal program that already cover these benefits on their own. Note 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 2022 (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 judgment; 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 2022, 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.[3] Using this estimate as a benchmark, an assumption was then made about the number of those who need eyeglasses would actually get them in CY 2022. The ramp up assumption used was 50%, and was based on actuarial judgement.

COVID-19 Adjustment

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 2022 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 Federal Government's involvement in COVID-19-related funding (e.g., HHS and FEMA), COVID-19 vaccine take-up rates, Medi-Cal as a secondary payer for certain services, and the impact of the pandemic on the rate of institutionalization in CCI.

Given the limited experience resulting from the COVID-19 pandemic, Mercer evaluated several data sources in considering impacts to the CY 2022 capitation rates, including Mercer and Oliver Wyman internal modeling, and national and state data sources. For the CCI dual-eligible program, an adjustment was applied for MH – OP services acuity as outlined below. Recent enrollment and population mix information was reviewed in development of the prospective member mix as described later in this certification. No other explicit adjustments were applied specific to the COVID-19 pandemic.

Mental Health Outpatient Services Acuity

Acuity changes may occur as new needs develop and treatment becomes warranted. Based on national evidence that the pandemic is having a material impact on MH needs, Mercer is forecasting an uptick in the mild to moderate MH conditions covered by managed care. The COVID-19 add-on includes additional costs for this increase, modeled as a 5% increase in the projected MH – OP services.

CalAIM Community Supports

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

1. Housing Transition/Navigation Services

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

2. Housing Deposits
3. Housing Tenancy and Sustaining Services
4. Short-Term Post-Hospitalization Housing
5. Recuperative Care (Medical Respite)
6. Respite Services
7. Day Habilitation Program
8. Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities
9. Community Transition Services/Nursing Facility Transition to a Home
10. Personal Care and Homemaker Services
11. Environmental Accessibility Adaptations
12. Meals/Medically Tailored Meals
13. Sobering Centers
14. Asthma Remediation Services

MCO Voluntarily Covered ILOS Adjustment

ILOS are medically appropriate and cost-effective alternatives to State plan services or settings that will be authorized in the MCO contracts effective January 1, 2022. The “MCO Voluntarily Covered ILOS Adjustment” specifically adjusts for value-added dollars reported in the RDT that align with one of the newly covered Community Supports services. These were services voluntarily provided by the MCOs within the CY 2019 base data period that were removed within the “Value-Added Services Adjustment” base data adjustment. If a value-added service reported in the CY 2019 RDT was deemed by DHCS and Mercer to align with one of the 14 Community Support services, then those dollars were carved into the rates in the form of a program change adjustment. As these services were reported by county, cohort, and population by each MCO, this adjustment is COS-, cohort-, and population-specific. The data used to apply the adjustment was based on the RDT data reported by the MCOs.

WPC Adjustment

This adjustment specifically adjusts for expenses for services that were provided under the WPC entities that align with one of the newly covered Community Support services. Because these services were provided within the WPC program, anticipated managed care experience was not appropriately reflected in our base data. This adjustment corrects for this understatement. To develop the WPC adjustment, two data sources were utilized:

1. Costs reported by the WPC entities, reported at the county level for CY 2019
2. List of WPC utilizers for CY 2020, provided by DHCS

Costs for any WPC services deemed to align with any of the 14 Community Supports services were assigned to MCOs according to each MCO's share of the WPC membership within a given county/region. Similarly, each MCO's costs were assigned to cohorts and populations based on the cohorts/populations of the MCO's WPC members. These costs were further assigned to COS based on a Community Support/COS allocation developed by DHCS and Mercer.

Community Health Worker

Effective July 1, 2022, community health workers (CHW) will be seen as an addition to the group of skilled and trained individuals who are currently able to provide clinically appropriate Medi-Cal covered benefits and services to Medi-Cal beneficiaries. While this benefit is also available through ECM, this program change as described below is separate from the ECM add-on detailed later in this certification letter.

Leveraging research on CHW staffing and using a build-up similar to the ECM model in identifying potential CHW utilizers, approximately 2.4% of the Medi-Cal Managed Care population were identified to be potential utilizers of CHW services. Assuming a 50% uptake (higher than the uptake assumption used for ECM given the lower acuity of these members and an easier enrollment process), 1.2% of the Managed Care population would ultimately make use of this benefit.

An average number of service hours per month was then developed, taking into account elements such as contact types (i.e., face-to-face, telephonic, etc.), frequency and duration of contacts, CHW enrollee program tenure, and level of need for members receiving CHW services. Program enrollees are then separated into three intensity levels – Low (0.72 average service hours/month), Medium (1.26 average service hours/month), and High (1.86 average service hours/month), with the distribution of members amongst the intensity levels varying by cohort. This is then multiplied by a California-specific CHW provider cost per hour to price this adjustment. Given the emphasis on ECM for the CY 2022 rating period and the mid-year rollout of this benefit, a 5% ramp-up during the first six months of this program benefit is assumed.

Populations Transitioning from Managed Care to FFS

Certain Medi-Cal populations designated by CalAIM within Managed Care will transition to FFS effective January 1, 2022. The non-Institutional share of cost population was the only population that was found to be applicable for the CCI Dual-Eligible program.

Share of cost members were identified in the CY 2019 managed care data by aid code. LTC utilizers were identified using a 90 day look back logic to identify members

utilizing LTC services that were not in a LTC aid code. These members, along with members having a LTC aid code, were excluded from the analysis.

It was ultimately determined that the removal of the Share of Cost population had minimal impact on the acuity for applicable cohort groups or the final prospective member mix assumption, and as such no program change was applied. Overall projected enrollment volume, however, was adjusted to reflect the transition to FFS of this Share of Cost population, resulting in approximately 0.4% fewer projected MMs for CY 2022.

Program Changes Applied as Add-ons to the Rate

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

Enhanced Care Management

The ECM program, effective January 1, 2022 is part of the CalAIM proposal developed by DHCS. The ECM benefit will replace elements of the Health Homes Program (HHP) and the care management services provided by the WPC pilots, and ensure that the state's most vulnerable, high needs Medi-Cal beneficiaries can receive WPC that addresses both clinical and non-clinical needs through intensive and comprehensive care management support.

The impact of the program to the CY 2022 capitated rates was developed at a statewide level, with county-specific adjustments, for a health plan and county specific PMPM add-on to the capitation rates. Without any prior claims experience, the development of this adjustment focuses on the needs of the ECM-eligible population — specifically who meets the criteria and the amount of care management utilized.

Statewide Build-up of ECM Per Enrollee Per Month (PEPM) Rate Development

The following flow charts detail the caseload and provider hour breakdown for varying severity levels of ECM members. These charts, built at a statewide level, detail the hours spent by provider (CM and CHW) at varying severity levels, the distribution of these severity levels over the course of the rating period, as well as the distinction between "new" ECM enrollees and "grandfathered" ECM enrollees (individuals transitioning from WPC and HHP, labeled "WPC/HHP ECM Members"). The first pair of charts is specific to the Institutional cohort while the second pair covers the CBAS and Other Community (no CBAS) cohorts.

Medi-Cal Enhanced Care Management
ECM Monthly Service Hours Per Institutional Enrollee Development

"New" ECM Members	Months 1-6 for Enrolled Members				Months 7-12 for Enrolled Members			
Severity Level	Percent Distribution	Hours per ECM Enrollee per Month			Percent Distribution	Hours per ECM Enrollee per Month		
		CM	CHW	Combined		CM	CHW	Combined
Level 1	0%	3.0	7.4	10.5	0%	3.0	7.4	10.5
Level 2	20%	2.3	4.6	6.9	20%	2.3	4.6	6.9
Level 3	80%	1.2	2.2	3.5	80%	1.2	2.2	3.5
Level 4	0%	0.9	1.2	2.1	0%	0.9	1.2	2.1
	100%	1.4	2.7	4.1	100%	1.4	2.7	4.1
	% of "New" ECM Member Enrollment			27%	% of "New" ECM Member Enrollment			73%

4.1

CY22 Average Monthly Service Hours Per "New" ECM Enrollee

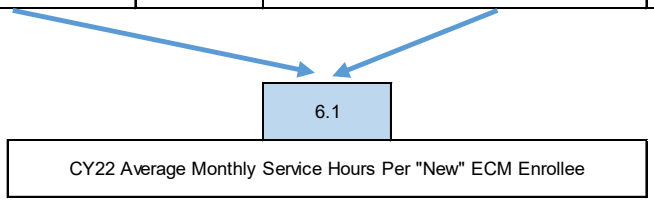
WPC/HHP ECM Members	Months 1-6 for Enrolled Members				Months 7-12 for Enrolled Members			
Severity Level	Percent Distribution	Hours per ECM Enrollee per Month			Percent Distribution	Hours per ECM Enrollee per Month		
		CM	CHW	Combined		CM	CHW	Combined
Level 1	0%	3.0	7.4	10.5	0%	3.0	7.4	10.5
Level 2	20%	2.3	4.6	6.9	20%	2.3	4.6	6.9
Level 3	80%	1.2	2.2	3.5	80%	1.2	2.2	3.5
Level 4	0%	0.9	1.2	2.1	0%	0.9	1.2	2.1
	100%	1.4	2.7	4.1	100%	1.4	2.7	4.1
	% of WPC/HHP ECM Member Enrollment			59%	% of WPC/HHP ECM Member Enrollment			41%

4.1

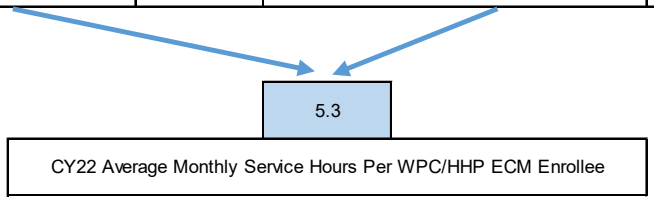
CY22 Average Monthly Service Hours Per WPC/HHP ECM Enrollee

Medi-Cal Enhanced Care Management
ECM Monthly Service Hours Per Community Enrollee Development

"New" ECM Members	Months 1-6 for Enrolled Members				Months 7-12 for Enrolled Members			
Severity Level	Percent Distribution	Hours per ECM Enrollee per Month			Percent Distribution	Hours per ECM Enrollee per Month		
		CM	CHW	Combined		CM	CHW	Combined
Level 1	35%	3.0	7.4	10.5	20%	3.0	7.4	10.5
Level 2	30%	2.3	4.6	6.9	35%	2.3	4.6	6.9
Level 3	20%	1.2	2.2	3.5	35%	1.2	2.2	3.5
Level 4	15%	0.9	1.2	2.1	10%	0.9	1.2	2.1
	100%	2.1	4.6	6.7	100%	1.9	4.0	5.9
	% of "New" ECM Member Enrollment			27%	% of "New" ECM Member Enrollment			73%



WPC/HHP ECM Members	Months 1-6 for Enrolled Members				Months 7-12 for Enrolled Members			
Severity Level	Percent Distribution	Hours per ECM Enrollee per Month			Percent Distribution	Hours per ECM Enrollee per Month		
		CM	CHW	Combined		CM	CHW	Combined
Level 1	15%	3.0	7.4	10.5	20%	3.0	7.4	10.5
Level 2	30%	2.3	4.6	6.9	30%	2.3	4.6	6.9
Level 3	30%	1.2	2.2	3.5	30%	1.2	2.2	3.5
Level 4	25%	0.9	1.2	2.1	20%	0.9	1.2	2.1
	100%	1.7	3.5	5.2	100%	1.8	3.8	5.6
	% of WPC/HHP ECM Member Enrollment			62%	% of WPC/HHP ECM Member Enrollment			38%



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

County-specific Adjustments for PEPM and Outreach

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

- Provider Cost Trend (applied to unit cost) — Since the base PEPM was developed using CY 2020 salary information, 24 months of 5.0% annual trend is applied to project costs to the CY 2022 contract period.
- County Wage Adjustment (applied to unit cost) — Similar to HHP, an adjustment is applied to factor in wage differences for ECM providers between counties in California.
- Medicare Part B Chronic Care Management (CCM)/Behavioral Health Integration Services Adjustment (applied to utilization) – this adjustment accounts for Part B eligible ECM enrollees who are eligible for CMS' CCM or Behavioral Health Integration programs. ECM providers are expected to collaborate with the member's physician in order to pursue the appropriate CCM and Behavioral Health Integration payments from CMS for their ECM enrollees with Part B coverage. As CMS will be covering ECM-like services through the CCM and Behavioral Health Integration programs, a portion of the CMs service hours (utilization) were reduced. The result is a downward rate adjustment applicable to the CBAS and Other Community (no CBAS) cohorts to account for the overlap in services rendered. These services were assumed to not overlap with the ECM for the Institutional cohort and no downward adjustment was applied to this population.
- County-run Targeted Case Management (TCM) Services Adjustment (applied to utilization) — This adjustment accounts for the overlap between TCM and ECM services for ECM enrollees enrolled in both programs. For the first year of ECM, no adjustment will be applied as the state and health plans are navigating through systematic and operational data complications in properly identifying TCM enrollees. This adjustment will be reassessed for year two (CY 2023) of the ECM program.
- County Rural Adjustment (applied to utilization) — Similar to HHP, a 25% upward adjustment factor is applied to account for the additional service hours required to serve ECM enrollees residing in a rural setting.

Converting from a PEPM to PMPM Add-on

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

Identifying ECM "Eligible" Members for Outreach and Enrollment

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

For members transitioning from other sunsetting care management programs such as WPC and HHP, the State and Mercer worked closely with WPC Lead Entities to better understand each county's WPC program and determine WPC and HHP members who would transition to ECM in January 2022. Specifically, the count of WPC and HHP enrollees is based on the most recent member list from these programs available at the time of rate development (4Q 2020 for WPC and 1Q 2021 for HHP) along with appropriate growth assumptions. It is assumed the entire group (after an initial adjustment) will transition into ECM in January 2022. Given this identification criteria for the HHP and WPC programs and the approach in identifying those who are ECM-eligible, 95% of transitioning WPC members and 65% of transitioning HHP members are assumed to remain in ECM after six months.

As for the "New" ECM Enrollees (counts and MMs), ECM-eligible individual counts (excluding HHP/WPC transitioning individuals) by health plan and population were projected based on guidance provided by the ECM policies from DHCS regarding identifying ECM-eligible "populations of focus". In the development of these projections, it was assumed that health plans will outreach to approximately 75% of the ECM-eligible population during the first 12 months and that approximately 70% of the Institutional cohort and approximately 25% of the CBAS and Other Community (no CBAS) cohorts targeted will enroll in ECM. These ramp up assumptions are the basis for "new" ECM enrollee counts and MMs projections.

Ultimately, accounting for the aforementioned uptake and ramp-up assumptions, the rate development assumes that by the 4th quarter of CY 2022, 1.2% of non-CMC members will be enrolled in ECM.

Consistent with CY 2022 Mainstream rate-setting, full Mainstream lower bound administrative and underwriting gain loads were used for ECM. This is deemed appropriate given the additional burden health plans will experience as they ramp up their ECM program.

Major Organ Transplants

CY 2022 capitation rates include PMPM add-ons to reflect the impact of MOT becoming a managed care covered benefit effective January 1, 2022 in Two-Plan,

GMC, and Regional counties. MOT are already a covered benefit within the COHS model. Add-on rates were developed for the following transplant types: Bone Marrow, Liver, Heart, Lung, Intestine, and Pancreas. Kidney and cornea transplants are already covered in all managed care models.

For the PMPM add-on development, Mercer reviewed historical CY 2018 and CY 2019 FFS data and identified individuals who received a MOT by each transplant type listed above through APR-DRG and/or surgical codes. Mercer then reviewed eligibility to establish, by individual, the pre- and post-transplant periods. The pre-transplant period was identified when an individual dis-enrolled from an MCO to FFS prior to a MOT surgery event. The post-transplant period was identified as the period where, after a MOT surgery, the average number of months before an individual re-enrolled into an MCO. Costs for the transplant event itself were reviewed and defined as costs incurred during the IP stay of the transplant surgery. Average costs for these transplant periods (pre, event, and post) were then converted to per utilizer per month figures.

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

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

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

Adjusted base period unit costs and utilization per 1,000 statistics were trended from the midpoint of the base period (January 1, 2019) to the midpoint of the contract period (July 1, 2022) for a total duration of 42 months. Further, county-specific historical prevalence of transplant events were reviewed to develop PMPM add-ons that vary by county. Annual trends by service category are consistent with lower bound trends used for the broader rates. Add-on rates reflect a full administration load consistent with lower bound assumptions used for the broader capitation rates. The fully loaded rates have an impact of approximately $6.5 million for the CY 2022 rating period.

Health Plan of San Mateo Dental

Effective January 1, 2022, dental services will be covered in San Mateo County. Given this is a new managed care benefit, the data utilized was CY 2019 Medi-Cal Dental FFS (Denti-Cal) data in San Mateo County. The data was then adjusted for the following items:

- Removal of Prop 56 supplemental payments
- Services provided at FQHCs were adjusted to an “arms-length” amount not inclusive of the full Prospective Payment System rate.
- Annualized trend factors were applied for 36 months to the midpoint of the CY 2022 rating period.
- Various managed care adjustments were made to price the benefit consistent with expectations within managed care.
- Items as part of the CalAIM initiative were addressed:
  - DHCS is implementing a State directed payment under 42 CFR §438.6(c) imposing a minimum fee schedule for certain dental services under the contract using State plan approved rates. An additional adjustment was applied to applicable preventive services to increase the unit cost from base expected managed care levels to 75% of the Schedule of Maximum Allowance, consistent with the State directed payment.
  - An adjustment to reflect the Caries Risk Assessment new benefit.
  - An adjustment to reflect the Silver Diamine Fluoride new benefit.
- Lower bound administration and underwriting gain loads consistent with the broader rate development were utilized in the development of the PMPM add-on.

The Proposition 56 Dental State directed payment under 42 CFR §438.6(c) is applicable to services covered under this pilot program. The impact of this State directed payment is displayed as an additional PMPM add-on and is described later in this report.

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: November 15, 2014*, DHCS staff has confirmed 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, DHCS staff has confirmed that there are no provisions in the CCI dual-eligible model managed care contract in violation of Mental Health Parity and Addiction Equity Act.

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).

Section 5

Projected Non-Benefit Costs

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

- Administration
- Underwriting gain
- MCO tax

Capitation rates appropriately include provision for the administrative expenses 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 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 2022 administration load is approximately 6.7% for the CMC-enrolled population and 5.5% for the non-CMC population. The range for the administration component is approximately +/- 0.4% from the midpoint value to the upper/lower bounds.

The midpoint aggregate assumptions reflect an increase of approximately 1.4% from the prior rating period for the CMC-enrolled population, and reflect an increase 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 2.8% for the CMC-enrolled population and 2.4% 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 an increase of approximately 0.8% for the CMC-enrolled population and an increase of approximately 0.5% for the non-CMC population.

Managed Care Organization Tax

Effective July 1, 2016, DHCS implemented a CMS-approved[4] 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 only 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

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

submitted tax structure for the applicable two tax years within CY 2022 (state fiscal year [SFY] 2021–2022 and SFY 2022–2023).

SFY 2021–2022 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	$50.00	675,001–4,000,000	$1.50
4,000,001+	$0.00	4,000,001+	$0.00

SFY 2022–2023 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	$55.00	675,001–4,000,000	$1.50
4,000,001+	$0.00	4,000,001+	$0.00

For the CY 2022 calculations, Mercer used projections for July 2021 through December 2021 (informed by enrollment observed through July 2021) to estimate the proportion of the SFY 2021–2022 MCO tax liability that remains for January 2022 through June 2022.

However, with the MCO tax liability being approved through the end of CY 2022, the entirety of the MCO tax liability meant for the first half of SFY 2022–2023 (July 2022 through December 2022) was applied to the CY 2022 MCO tax PMPMs calculations. Using this total tax liability, a singular PMPM was calculated for CY 2022 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 under the approved tax model, Aetna Better Health and UnitedHealthcare are not subject to any MCO tax for Medi-Cal members.

Section 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 three member-mix adjustment population cohorts that align with the population groups described in more detail earlier:

- Institutional
- CBAS
- Other Community (no CBAS)

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 three 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; 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 Aetna Better Health, Kaiser, and UnitedHealthcare cannot have members in CMC in CY 2022.

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

Section 7

Special Contract Provisions Related to Payment

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

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

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

Incentive Arrangements

COVID-19 Vaccination Incentive Program

COVID-19 vaccination incentive payments are being utilized to encourage vaccinations among Medi-Cal's beneficiaries. The new program to boost COVID-19 vaccination rates will allow Medi-Cal MCOs to earn incentive payments for activities that are designed to close vaccination gaps with their enrolled members, based upon lessons learned so far in the pandemic. MCOs provide case and care management services for Medi-Cal members and are well positioned to provide enhanced coordination services, partner with primary care providers, and conduct outreach for vaccine distribution to their members. The vaccination incentive program will also encourage significantly expanded outreach in underserved communities.

Funding will incentivize outreach programs and activities by MCOs and their providers, particularly primary care providers and pharmacies, as well as engagement with trusted community organizations, such as food banks, advocacy groups, and faith-based organizations.

The vaccination incentive program runs from September 2021 through February 2022. The funding for these incentives that will be paid in accordance with 42 CFR §438.6(b) will not exceed $250 million across all applicable managed care contracts and certifications. The total incentive payments under each contract and certification will not exceed 5% of the capitation payments. The vaccination incentive program has no effect on the development of capitation rates.

Additional detail regarding the vaccination incentive program is available through the managed care contract, All Plan Letter 21-010 and any subsequent revisions, and similar instruction issued to MCOs.[5]

Withhold Arrangements

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

The CY 2022 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 2022, 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, separately.

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 2022 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 2022. If the Medi-Cal component of the blended rate re-mixed using the actual population mix for the MCO in CY 2022 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 2022 capitation rates for the provision of a risk corridor. The CY 2022 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.

[5] All Plan Letter 21-010 and supplemental Attachment A are available at https://www.dhcs.ca.gov/Documents/COVID-19/APL-21-010-Vaccine-Incentive.pdf and https://www.dhcs.ca.gov/Documents/COVID-19/APL-21-010-Attachment-A-Vaccination-Incentive-Program-Outcome-Metrics.pdf, respectively.

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

Cal MediConnect Risk Corridor

The CY 2022 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.

Enhanced Care Management Risk Corridor (non-CMC)

Effective for CY 2022, DHCS will use a symmetrical, two-sided risk corridor as part of the ECM program. This risk mitigation mechanism will be applicable to all MCOs receiving the ECM add-on under the non-CMC contract only.

Rationale for the use of the Risk-Sharing Arrangement

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

Description of how the Risk-Sharing Arrangement is implemented

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

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

1. Approved ECM services for individuals enrolled in ECM
2. Outreach efforts performed by an ECM provider on individuals targeted for ECM enrollment

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

The risk corridor will consist of the following bands:

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

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

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

- Non-medical expenses, e.g., non-service investments for infrastructure and capacity.
- Incurred but not reported expenses that cannot be adequately supported.
- Medical expenses for non-ECM services and populations, e.g., expenses for Community Supports services, expenses for members who do not meet ECM population or phase-in criteria.
- Unreasonable outlier medical expense levels for which the MCO does not provide satisfactory justification based on member mix, utilizer acuity, unique network considerations and/or other factors. As experience may be inherently more volatile in the first year of the ECM benefit, DHCS will ensure the review process includes discussion with MCOs in advance of any adjustments to provide an opportunity to support outlier cost levels.
- Related party expense levels in excess of unrelated party expense levels.
- Separate and distinct payments that are exclusively for administrative costs as defined in Title 28, California Code of Regulations, § 1300.78, such as but not limited to network development and claims processing.
- An assumed non-medical component of global sub-capitation payments made by MCOs to global subcontractors that aligns with assumptions used in the CY 2022 rate development (see Base Data Adjustments related to Global Non-Medical

Expense Adjustment). Reductions will be applied in a manner that ensures alignment between allowable medical expenses and medical costs considered in the rate development process.

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

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

Description of any effect that the Risk-Sharing Arrangements have on the development of the Capitation Rates

There is no impact on the CY 2022 capitation rates for the provision of a risk corridor. The CY 2022 capitation rates, outlined in this rate certification, reflects Mercer's best estimate of the anticipated costs associated with ECM.

Documentation demonstrating that the Risk-Sharing Mechanism has been developed in accordance with generally accepted actuarial principles and practices

Mercer confirms that the CY 2022 ECM add-on risk sharing mechanism was developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medi-Cal covered populations and services under the managed care contract.

Major Organ Transplant Risk Corridor (non-CMC)

Effective for CY 2022, DHCS will implement a risk corridor for the portion of the MOT PMPM add-on associated with the directed payment that directs MCOs to pay for the transplant event itself at established Medi-Cal FFS rates. The risk corridor will not apply to plans in COHS counties and CMC duals demonstration plans.

Rationale for the use of the Risk-Sharing Arrangement

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

Description of how the Risk-Sharing Arrangement is implemented

The risk-sharing arrangement will be a two-sided risk corridor that utilizes actual MOT expenditures experienced by the MCOs relative to MOT services subject to the

directed payment requirements funded within the capitation rates. The risk corridor shall be based on a calculated MEP achieved by each MCO. The MEP shall be calculated in aggregate across all applicable categories of aid and rating regions where the MCO operates for dates of service within the rating period. The risk corridor calculations shall be performed no sooner than 12 months after the end of the rating period.

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

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

The risk corridor will consist of the following bands:

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

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

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

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

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

Description of any effect that the Risk-Sharing Arrangements have on the development of the Capitation Rates

There is no impact on the CY 2022 capitation rates for the provision of this risk corridor. The CY 2022 capitation rates, outlined in this rate certification, reflects Mercer's best estimate of the anticipated costs associated with MOT.

Documentation demonstrating that the Risk-Sharing Mechanism has been developed in accordance with generally accepted actuarial principles and practices

Mercer confirms that the CY 2022 MOT directed payment risk sharing mechanism was developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medi-Cal covered populations and services under the managed care contract.

State Directed Payments

There are three State directed payments under 42 CFR §438.6(c) applicable to the CCI dual-eligible CY 2022 capitation rates. All applicable directed payments are summarized in the table below. There are no additional directed payments under these contracts for CY 2022 that are not addressed in this rate certification. There are no requirements regarding the reimbursement rates the MCOs must pay to any providers unless specified in the certification as a directed payment or authorized under applicable law, regulation, or waiver.

Control name of the state directed payment	Type of payment	Brief description	Is the payment included as a rate adjustment or separate payment term?
Dental Preventive Services	Minimum fee schedule using State Plan approved rates	Minimum fee schedule for specific Dental Preventive services.	Rate adjustment
Control Name TBD – Prop 56 Dental	Uniform dollar and percentage increases	Uniform percentage and dollar increases for specific dental services	Rate adjustment
Control Name TBD – MOT	Delivery system reform	FFS-equivalent payment requirement for	Rate adjustment

Control name of the state directed payment	Type of payment	Brief description	Is the payment included as a rate adjustment or separate payment term?
		network and non-network providers for newly transitioning transplant surgeries	

All three applicable State directed payments are incorporated into the capitation rates as a rate adjustment, as summarized in the table below. The following subsections provide more detail around each initiative.

Control name of the state directed payment	Rate cells affected	Impact	Description of the adjustment	Confirmation the rates are consistent with the preprint
Dental Preventive Services	CMC and non-CMC in San Mateo County	Impact to both CMC and non-CMC is 0.001%	Adjustment is described in the Health Plan of San Mateo Dental program change section.	No preprint required.
Control Name TBD – Prop 56 Dental	CMC and non-CMC in San Mateo County	$6.04 PMPM for CMC in San Mateo County and $4.46 PMPM for non-CMC in San Mateo County	Adjustment is applied as a PMPM add-on to the rates. A description of the data, assumptions and methodology is provided in the narrative below.	Confirmed. The preprint is anticipated to be submitted to CMS in December 2021.
Control Name TBD – MOT	All rate cells	$0	FFS data was utilized in the rate development for applicable services; no	Confirmed. The preprint is anticipated to be submitted to CMS in December 2021.

Control name of the state directed payment	Rate cells affected	Impact	Description of the adjustment	Confirmation the rates are consistent with the preprint
			additional was required.	

Major Organ Transplant

The MOT directed payment preprint encompassing the CY 2022 rating period is anticipated to be submitted to CMS for approval no later than December 31, 2021. This directed payment is specific to the hospital stay incorporating the MOT event and only applies to transplants transitioning from FFS to managed care. This directed payment directs MCOs to pay hospitals at levels that would be paid in the Medi-Cal FFS delivery system. As FFS data was utilized to develop the add-on as described, no additional adjustment was required to reflect the State directed payment. See Program Changes above regarding MOT for more details.

Proposition 56 Dental Services

Consistent with 42 CFR §438.6(c), DHCS is implementing a directed provider payment initiative that provides payment increases varying from 20% to 60% of the Schedule of Maximum Allowances, or a fixed dollar amount, for certain dental services. The payment increases for these dental procedure codes will be made to all eligible providers who perform these services for HPSM Dental pilot enrollees. The supplemental payments are included as a percentage increase to HPSM's capitation rates through a prospective program change. See Program Changes above regarding Health Plan of San Mateo Dental for more details.

Dental Preventive Services

Consistent with 42 CFR §438.6(c)(1)(iii)(A), DHCS is implementing a directed provider payment initiative that imposes a minimum fee schedule for network providers that provide certain dental services under the contract using State plan approved rates. The minimum fee schedule for these dental procedure codes applies to all eligible providers who perform these services for HPSM Dental pilot enrollees. These payments are included as a percentage increase to HPSM's capitation rates through a prospective program change. See Program Changes above regarding Health Plan of San Mateo Dental for more details.

Pass-Through Payments

There are no pass-through payments that impact the CCI dual-eligible CY 2022 capitation rates.

Section 8

Certification and Final Rates

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

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

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

Mercer certifies that the CCI dual-eligible model capitation rates for the CY 2022 rating period, January 1, 2022 through December 31, 2022 were developed in accordance with generally accepted actuarial practices and principles, and are appropriate for the Medi-Cal covered populations and services (acknowledging any potential future amendments) 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 or reinsurance arrangements in these rates. Use of these rates for any purpose beyond that stated may not be appropriate.

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

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

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

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

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

If you have any questions on the above or the certification 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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Katharina Lau, ASA, MAAA
Principal

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Gabe Smith, FSA, MAAA
Principal

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