Mercer

Government Human Services Consulting

AIDS Healthcare Foundation

Capitation Rate Development and Certification

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

December 24, 2024

Contents

Section 1

Executive Summary

The State of California Department of Healthcare Services (DHCS) contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to develop actuarially sound internal capitation rate ranges, and to certify to final contracted capitation rates for the AIDS Healthcare Foundation (AHF) for rating period of January 1, 2025 through December 31, 2025 (calendar year [CY] 2025).

This report describes the rate development process and provides the certification of actuarial soundness required by 42 CFR §438.4. This report was developed to provide the requisite rate documentation to DHCS and to support the rate review process performed by the Centers for Medicare & Medicaid Services (CMS). This report follows the general outline of the CMS 2024–2025 Medicaid Managed Care Rate Development Guide, published in January 2024, and the CMS Addendum to the 2024–2025 Medicaid Managed Care Rate Development Guide, published in June 2024. The rate development process included the historical practice of developing rate ranges. However, the actuaries are certifying to a final rate within the developed rate ranges as federally required.

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

Multiple attachments are included as part of this rate certification package. These attachments include summaries of the CY 2025 capitation rates (including the final and certified capitation rates), capitation rate calculation sheet (CRCS) exhibits, and stand-alone methodology documents, which provide more detail around various rate setting components. These attachments are referenced throughout the body of this report. The final capitation rates can be found in the attached file titled *CY 2025 AIDS Healthcare Foundation Rates 2024 12.xlsx.*

Mercer has not trended forward the previous year's rates but has done a comprehensive exercise of rebasing using more recent program experience. The rebasing means 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 have occurred. 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. Other changes are also effective during the CY 2025 rating period, all of which are described later in this report.

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

A comparison of the certified CY 2025 capitation rates to the certified CY 2024 capitation rates is also provided in an attachment. Each certified CY 2025 rate (separate for the UIS and SIS populations) is compared to the capitation rates certified within the CY 2024 rating period. Updated AHF base data is driving a majority of the rate changes observed between CY 2024 and CY 2025.

It should also be noted, there may be a future amendment to this certification submitted to CMS. The potential updates include State directed payment refinements and the impacts of Proposition 35.

Section 2
General Information

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

- Program history
- Managed care plan (MCP) 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 MCP contract information for additional detail.

Program History

AHF contracts with DHCS to provide covered health care services for its eligible members who are at least 21 years old and who have ever had a diagnosis of stage three human immunodeficiency virus (HIV) infection, also known as acquired immunodeficiency syndrome (AIDS). AHF receives a capitation payment from DHCS for the services provided.

This document describes the methodology and major steps used in the development of AHF's Medi-Cal capitation rates. Medi-Cal capitation rates for AHF's eligible members were developed in accordance with the rate-setting guidelines established by CMS.

DHCS will offer actuarially sound final payment rates to AHF. AHF 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 development process are described in the following paragraphs.

The rate development examined those enrolled AHF members without full Medicare coverage (AIDS Non-Dual) and those with full Medicare coverage (AIDS Full-Dual). The rate development process reflects the impact of State legislated policy changes

implemented by DHCS and other Medi-Cal benefit changes that are not fully reflected in the base data.

Covered Services

Generally, services covered through the contract with AHF are consistent with those covered within the Mainstream managed care program. As in the Mainstream managed care program, all pharmacy drugs have been carved out to fee-for-service (FFS) including approved AIDS prescription drugs. Notable services carved out of the AHF managed care program include the following:

- Specialty mental health (MH) services (including inpatient [IP] and outpatient [OP] behavioral health [BH] services)
- Alcohol and substance use disorder treatment services.
- Home- and Community-Based Services (HCBS) (with the exception of community-based adult services [CBAS] in Los Angeles County).
- Dental services (except medically necessary Federally Required Adult Dental Services and fluoride varnish dental services that may be performed by a medical professional).
- Administration and ingredient costs of Coronavirus Disease 2019 (COVID-19) vaccines.
- Effective January 1, 2022, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim; covered OP drugs, including physician administered drugs, medical supplies, and enteral nutritional products.

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

- Major Organ Transplant (MOT) services
- Enhanced case management (ECM) services
- 14 Community Supports (CS) services are allowable in the MCP contracts as “in lieu of” services (ILOS) in accordance with 42 CFR §438.3(e) and/or the terms and conditions of California’s 1115 and Section 1915(b) waivers.

Covered Populations

AHF contracts with DHCS to provide covered health care services for its eligible members who are at least 21 years old and who have ever had a diagnosis of stage three HIV infection and who voluntarily enroll in the program.

As part of the CalAIM initiative, various additional populations have or will become enrolled in managed care, effective from CY 2022 and through CY 2025. Additional

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

Populations that transitioned after CY 2023 were analyzed to identify potentially transitioning members, and ultimately it was found that the impact of these initiatives would be minimal. Therefore, no rate impact was applied for AHF.

Rate Structure

Due to the inherent risk for all members covered under the program, rate ranges are developed for only two categories of aid (COA) based on Medicare eligibility, AIDS Non-Dual and AIDS Full-Dual.

The capitation rates include all services covered under the managed care contract, with the exception of services specific to those covered under the Maternity supplemental payment. Services specific to the supplemental payments are carved out of the monthly capitation rates and reimbursed to AHF only when applicable members meet the criteria in order for AHF to receive a supplemental payment. More detail on the supplemental payment is provided later in this certification letter.

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 subject to a different FMAP and show this information. If there are proposed differences among the capitation rates to covered populations, CMS requires valid rate development standards are applied and are not based on the rate of FMAP associated with the covered populations. This subsection addresses these FMAP concerns from CMS.

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

Populations that receive a higher FMAP than the regular FMAP include the Breast and Cervical Cancer Treatment Program (BCCTP) population (a subset of the AIDS Non-Dual population) who meet federal standards, and the Affordable Care Act (ACA) Expansion population. For CY 2025, the BCCTP population receives 65% FMAP. For CY 2025, the ACA Expansion population receives 90%.

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

For the federal capitation rates for the UIS population, rate components attributed to emergency services are subject to a 50% FMAP, while rate components attributed to pregnancy-related services are subject to a 65% FMAP. For AHF, 100% of the UIS

federal capitation rates are assumed to be for emergency services and none for pregnancy-related services.

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

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

Rate Methodology Overview

Capitation rates for the AHF managed care program were developed in accordance with rate-setting guidelines established by CMS. As noted previously, Mercer continued the historical practice of rate range development for the AHF program. However, this report certifies to a final rate within the developed rate ranges as federally required.

For rate range development for the AHF population, Mercer utilized various data elements: CY 2021, CY 2022, and CY 2023 rate development template (RDT) data, and other ad hoc claims data reported by DHCS and AHF. The most recently available Medi-Cal specific financial reports submitted to the California Department of Managed Health Care (DMHC) at the time the rate ranges were determined were also considered in the rate range development process.

The RDT data requested from AHF is completed at the level of detail needed for rate setting purposes, which includes AHF membership, medical utilization, and medical cost data for the two most recent base data years by COA group and by category of service (COS).

Adjustments were made to the selected base data to match the covered population risk and the State Plan approved benefit package for CY 2025. 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.
- Trend factors to forecast the expenditures and utilization to the rating period.
- Administration and underwriting gain loading.
- Further, DHCS takes additional steps in the measured matching of payment to risk:

- Application of a maternity supplemental payment.

The above approach has been utilized in the development of the rate range for the CY 2025 AHF program to be consistent, where applicable, with rate setting under other Medi-Cal program models. DHCS will offer the final certified rates within the actuarially sound rate range as developed by the actuary. AHF has the opportunity and responsibility to independently review the rates offered by DHCS and to determine whether the rates are acceptable based on their individual financial requirements.

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

Medical Loss Ratio

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

For CY 2025, the State will impose remittance provisions related to this MLR. Any revenue will need to be remitted to the State up to 85% MLR, if the calculated actual MLR is less than 85% for an MCP.

Rate Ranges

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

The lower and upper bounds of the rate ranges are developed by varying certain assumptions throughout the rate development process. Once the “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 MCP. The total variation produced by the varied assumptions is reviewed for reasonableness to ensure the final rate ranges represent reasonable, appropriate, and attainable rates for the covered populations during the rating period.

Section 3
Data

Base Data

The information used to form the base data for the AHF rate range development was 36-months of requested AHF RDT data and DMHC-required Medi-Cal specific financial reporting.

The base data elements included utilization and unit cost by the following consolidated provider types or COS, including:

- IP Hospital
- OP Facility
- Emergency Room (ER)
- Long-Term Care (LTC)
- Primary Care Physician (PCP)
- Specialty Physician
- Federally Qualified Health Center (FQHC)
- Other Medical Professional
- MH–OP
- Behavioral Health Treatment (BHT) Services
- Laboratory and Radiology
- Transportation
- CBAS
- Hospice
- CS
- ECM
- Other HCBS
- All Other (OTH)

New to the base data are the CS and ECM COSs. Both were CalAIM initiatives effective January 1, 2022 and collected as part of the RDT.

Utilization and unit cost information from the appropriate base data elements, as referenced above, was reviewed at the COS detail level for reasonability.

CY 2021, CY 2022, and CY 2023 served as the 36-month base data period. For all COS' except CS and ECM, weightings of 10%, 30%, and 60% were applied to each CY data period, respectively. For CS and ECM COS, 40% weighting was applied to CY 2022 and 60% weighting was applied to CY 2023 data. All selected base data was adjusted (as appropriate) to reflect the impact of historical program changes within this period. This is discussed further in the program changes section.

The data utilized was AHF data that did not include any disproportionate share hospital payments or any adjustments for FQHC or rural health clinic (RHC) reimbursements. FQHC costs considered in rate development are the costs incurred by AHF, net of any wrap-around payment by DHCS to reimburse the FQHC at their prospective payment system rate. AHF reported this information as part of the RDT data and it was included in the aggregate base data development. Information on catastrophic claims was reported separately within the RDT submission, then it was reviewed, and discussed with the plan. No adjustments were made to the base data for catastrophic claims, as all these amounts are already included. The RDT submission already included incurred but not reported (IBNR), adjustments that were reviewed for appropriateness. No further IBNR adjustments were applied.

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, AHF RDT data served as the starting base data for rate setting. The RDT data submissions are thoroughly reviewed, vetted, and discussed with AHF during the rate setting process. Encounter data is also used as a supplementary data source for rate setting, primarily for analyses of program change impacts. Encounter data undergoes considerable edits within DHCS to ensure quality and appropriateness of the data for rate setting purposes. Base period AHF COA eligibility (described below) and encounter data were pulled consistent with service code mappings from DHCS, including lists of excluded services, such as State-only Funded abortion services. Mercer has relied on data and other information provided by AHF 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 contract. 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 performed alternative procedures and analyses, which provide a reasonable assurance as to the data's appropriateness for use in capitation rate development under the State Plan.

The Excel rate range spreadsheets contain detailed CRCS for the AHF rate development. Base data are presented by COS as annual utilization per 1,000 members, average unit cost and the resulting per member per month (PMPM) calculations and are reflected in columns (A), (B), and (C) of the CRCS, respectively.

Maternity Supplemental Payment

To further enhance the measured matching of payment to risk, DHCS utilizes a maternity supplemental payment for all health plans. Pertaining to gender, the primary issue that could result in significant variance among the AHF's enrolled population and hence their risk, is the event of maternity and its related cost. Costs for pregnant women are on average substantially higher than the average medical cost of care for men and non-pregnant women with similar demographic characteristics. To mitigate the maternity risk issue within the rates, DHCS includes a maternity supplemental payment, which represents costs for the delivery event. Prenatal and postpartum care costs are not part of the supplemental payment but remain within the capitation rates for their respective COA. AHF receives the lump sum maternity supplemental payment when one of its current members gives birth and DHCS is appropriately notified a birth event has occurred. Non-live birth expense data and non-live birth outcomes are excluded from the maternity supplemental payment analysis and the corresponding development of the CY 2025 maternity supplemental payments. This results in non-live birth expenses being included in the base capitation rates rather than being included in the supplemental payment.

For the CY 2021, CY 2022 and CY 2023 base data period, AHF did not experience any maternity events for its members and did not incur any maternity related costs. The process described below is applicable to the maternity supplemental payment development for the MCPs operating in Los Angeles County. The final maternity supplemental payment for AHF is based on the Los Angeles County rate, with some appropriate modifications described below.

Maternity Supplemental — Design

- Payment made on delivery event that generates a state vital record.
- One supplemental payment per delivery regardless of number of births.
- Supplemental payment reflects cost of delivery event only (mother and baby, excluding prenatal, and postpartum care).
- Supplemental payment is for the entire CY 2025 time period.
- Same supplemental payment is utilized for AIDS Non-Dual and AIDS Full-Dual COA groups.
- If costs had existed in the base period for AHF then those costs would have been carved out of the base data. However, AHF had no such maternity experience; therefore, a carve-out was not necessary.

Maternity Supplemental — Modifications for AIDS Healthcare Foundation

As mentioned above, the maternity supplemental rate for the MCPs in Los Angeles was leveraged for AHF. Additionally, clinical guidance indicates members diagnosed with AIDS are automatically considered to have high-risk pregnancies and therefore have a significantly higher prevalence of caesarean deliveries. A 100% caesarean delivery assumption was utilized to create the maternity supplemental payment applicable to AHF. Exhibits showing the final capitation rate and CRCS can be found in the Excel file titled *CY 2025 AIDS Healthcare Foundation Maternity Rates 2024 12.xlsx.*

Satisfactory Immigration Status/Unsatisfactory Immigration Status Considerations

Up to this point in the base data development process, all data processing and adjustments were done using SIS data. Encounter data for the AHF population is available but not deemed sufficiently credible to use for this analysis. However, the AHF population is very specialized in that all members have AIDS, and Mercer has no reason to believe experience for the UIS population would be materially different than the SIS population. Given the relatively small population counts for the AHF population in addition to the small percentage of UIS beneficiaries in this time period, we do not expect the UIS population to have materially different costs from the SIS population.

As previously noted, only pregnancy-related and emergency services are eligible for federal match for the UIS population. As a result, it was necessary to estimate the percentage of PMPM spend for services that are pregnancy-related or emergency specific to the UIS population. For AHF it was assumed that 100% of the federal match for the UIS population is attributable to emergency services. In the development of the emergency services percentage of the UIS rates that are for federally eligible services, state fiscal year (SFY) 2022–23 encounter data for the Los Angeles County UIS population was utilized by analyzing emergency services PMPM spend as a percentage of total UIS PMPM spend. Within the coding logic, various flags in the data were derived and services were flagged as either pregnancy-related or emergency using a hierarchy logic so each encounter or FFS claim only flagged once as either pregnancy-related or emergency. No encounters or FFS claims were flagged twice in the event a service was flagged as both pregnancy-related and emergency related. The coding logic used to derive the federal percentages (both emergency and pregnancy-related services) can be found in Appendix A.

In terms of the hierarchy used for the federal percentages, the first service flagged in the hierarchy was labor and delivery services; these services were identified as emergency related services. Then, pregnancy-related services were identified next in the hierarchy and the remaining emergency services were last in the hierarchy. Using

this hierarchy logic, emergency services were grouped and separated in the analysis to derive the applicable emergency percentages.

The result of this was PMPM amounts by region, COA, and COS for the UIS population for pregnancy-related and emergency services, as a percentage of the total UIS PMPMs, separately. In the development of the percentages utilized for the federal capitation rate development, smoothing ranges were developed at the COA and COS level separately for pregnancy-related and emergency services. The smoothing ranges were developed based on a review of each region's data points for the same COA and COS combination. In the smoothing process, if a region-specific percentage fell within the smoothing range, this value was accepted and used in the calculation of a statewide average percentage of total UIS dollars. This was done separately for pregnancy-related and emergency percentages. The result of this was a statewide average percentage of total UIS PMPM spend for pregnancy-related and emergency services, by COA and COS. These statewide federal percentages (the sum of pregnancy-related and emergency percentages) were then blended with the region-specific federal percentages to derive the federal percentages applied for each region, by COA and COS. A 50% factor was used for the region percentages and the remaining 50% factor was used for the statewide average percentages. This blend was done to introduce variation seen in the percentages by region. These final blended percentages for Los Angeles County were then applied to the AHF UIS rates by COA and COS to derive the certified rates for federal services only. Remaining services for the UIS population are included in the state-only rates that are not part of this certification.

Effective January 1, 2025, DHCS changed the federal services definition specific to post stabilization services provided during IP hospital stays that originated through the emergency department. Under the new definition, only services and associated costs up to the stabilization of the patient are considered an emergency, while all other services and costs are considered non-emergency within the IP hospital stay. The prior logic considered the entire IP stay to be an emergency. Note, any post stabilization services provided to a member after discharge have never been considered emergency within the logic (such as chemotherapy for a cancer patient, for example), unless the service meets the emergency criteria. This change only applies to hospital stays that originated through the emergency department.

To derive the adjustment to the federal percentages as a result of this change, only IP records that originated through the emergency department or had an IP admission code indicating an emergency were reviewed. IP days from these records were then grouped as emergency and non-emergency on a statewide basis based on the updated definition of an emergency as defined in Appendix A (days when the member is in the intensive care unit [ICU] plus the first two days outside the ICU, for IP admissions that originated through the emergency department). Based on this review of ICU days to non-ICU days, an assumed cost associated with emergency days and non-emergency days was developed on a statewide basis. The final federal percentage for the IP COS is the emergency IP percentage before this adjustment

multiplied by the percentage of IP dollars assumed to be for IP days defined as an emergency based on this analysis.

Category of Aid (Aid Code) Groupings

There are significant differences between groups of individuals for whom rates must be set; therefore, capitation rates are calculated separately for each of the groups. These groups are referred to as rating groups. When an individual becomes eligible for Medi-Cal, they are assigned a specific aid code. AHF's rating groups, which are comprised of several aid codes similar in definition or are comprised of individual beneficiaries with similar demographic characteristics or medical conditions, are as follows:

1. AIDS Non-Dual are members who are at least 21 years old and who have ever had a diagnosis of stage three HIV infection, and who have no Medicare coverage or have partial Medicare coverage, such as Medicare Part A only or Part B only.
2. AIDS Full-Dual are members who are at least 21 years old and who have ever had a diagnosis of stage three HIV infection, with both Medicare Part A and Part B.

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 the midpoint of the CY 2021, CY 2022, and CY 2023 base period (July 2, 2022) to the midpoint of CY 2025 (July 1, 2025)
- Program Changes
- Other Items

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

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

Trend

Trend is an estimate of the change in the overall utilization and cost of medical services over a finite period of time. Trend factors are necessary to estimate the expenses of providing health care services in a future period. As part of the CY 2025 rate range development for the AHF program, Mercer developed trend rates at the COA level for each provider type or COS separately by utilization and unit cost components. Notably, Mercer selected the same trends for the SIS and UIS populations for each COA. This was done, as it is Mercer's expectation that utilization or unit cost trends will not differ substantially between the populations on a service category basis. Though Mercer did not vary trend selections between SIS and UIS, the exhibits contained in this section are created using the aggregated SIS population (without Maternity services), where the large majority of program costs are associated. For all COA group cohorts in the CY 2025 rating period, the base data was trended forward 36 months from the mid-point of CY 2021–2023 to the mid-point of CY 2025.

Mercer reviewed and utilized multiple sources of data and information for trend development. These include recent MCP encounter and RDT data, MCP Medi-Cal-only financial statements, Medi-Cal specific hospital IP and OP payment data, consumer price index, national health expenditures updates, and multiple

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

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

Trends were newly set for ECM services for the CY 2025 rates. For the CY 2024 rates, ECM services were developed separately and included as an add-on PMPM. Therefore, no trend was explicitly displayed on the CRCS for this service to project to the contract period for CY 2024 rates. For CY 2025 rates, unit cost trend was assumed to be 5.0% based on analysis of wage inflation of the providers delivering these services. Utilization trends were backed into to align to the separately developed ECM PMPM for the contract period.

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 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 2024 to CY 2025. These large changes from the prior year are a result of reviewing newer and emerging information (as described above) to appropriately align prospective payment levels. Please see Table 1 below for detailed changes of trend assumptions by COS for the indicated COA groups.

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

Table 1

Annual Trend Factors All COAs — SIS — Non-Maternity			
COS	**CY 2024**	**CY 2025**	**Change**
ER	5.35%	2.11%	-3.24%
PCP	3.11%	4.76%	1.65%
FQHC	3.09%	3.80%	0.71%
Other Medical Professional	4.01%	4.77%	0.76%
MH–OP	3.26%	4.79%	1.53%
Hospice	1.75%	-0.25%	-2.00%
ECM	N/A	18.24%	18.24%

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

Effective October 1, 2024, California Senate Bill (SB) 525 introduced a tiered minimum wage schedule for covered healthcare employees, requiring many employers to pay $25.00 per hour by June 2026. This new schedule builds on the previous minimum wage of $15.00 per hour and aims to ensure fair compensation for healthcare workers while addressing industry-specific needs. Mercer analyzed Bureau of Labor Statistics wage data, focusing on occupations within the Medi-Cal benefit package, and assessed the broader impact of wage increases on total labor costs. Additionally, Mercer gathered survey data from MCPs regarding expected changes in contracted rates due to SB 525, anticipating that increased wage pressures will lead to higher reimbursement demands from providers. The SB 525 adjustment is incorporated into the prospective unit cost trend assumption, varying by service category to reflect the specific workforce composition.

After the mid-point/best estimate trends were determined, a trend range was created by adding 0.25% to each of the utilization and unit cost components as the upper bound, and subtracting 0.25% as the lower bound, with the exception that no unit cost range was created for the LTC COS, where the best estimate trends were determined to be zero and handled through other rate setting components. In aggregate, the annualized lower bound claim cost trends for the SIS population, across all AHF COA groups, and all COS, average 0.9% for utilization and 3.1% for unit cost, or 4.1% PMPM. This represents an increase of 0.7% over the aggregate

trend figures at the lower bound from those developed for the CY 2024 capitation rates.

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

Program Changes

Program change adjustments recognize the impact of benefit or eligibility changes that took place during or after the base data period. The program changes incorporated in the development of the rates were based on information provided by DHCS staff as of November 1, 2024. The program changes detailed below were viewed to have a material impact on capitation rates and were reviewed, analyzed, and evaluated by Mercer with the assistance of DHCS.

The next several subsections are the program changes adjustments explicitly accounted for within the CY 2025 capitation rates. A summary showing the managed care impact can be found within the program change charts provided within the Excel files titled *CY 2025 AIDS Healthcare Foundation Rates 2024 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

As noted in the Trend subsection, unit cost trend factors were not developed for the LTC COS. In lieu of a trend adjustment, rate increases for LTC services are handled through a program change adjustment and are based on legislatively mandated annual FFS rate increases. In general, managed care payment levels have aligned closely with FFS payment levels for these services and it was deemed reasonable and appropriate to use the FFS rate increases in the managed care rate setting process.

Previously, rate increases for Assembly Bill (AB) 1629 LTC facilities occurred January 1 of each year, and rate increases for non AB 1629 LTC facilities occurred on August 1 of each year. Beginning in CY 2024, rate increases for all LTC facilities will occur on January 1 of each year. The LTC rate increase factors are developed by COA separately for each rating region. To calculate the adjustment factors for each region, costs, and rate increases by the different LTC facility types are analyzed by region and COA, and the final adjustment factor is developed using this information. In addition, SB 525 was considered in the development of the adjustment.

Hospice Rate Increase

Similar to the LTC COS, unit cost trend factors were not developed for the Hospice COS. Instead, Hospice price increases are handled through a program change adjustment and are based on legislatively mandated annual FFS rate increases. In general, managed care payment levels have aligned closely with FFS payment levels for these services and it was deemed reasonable and appropriate to use the FFS rate increases in the managed care rate setting process. There are two components to the Hospice rate increase; the rate increases for Hospice services that occur on October 1 of each year, and the rate increases for Hospice room and board that occur on August 1 of each year. To calculate the adjustment factor applied in the capitation rates, the rate increases for Hospice services are weighted with the rate increases for Hospice room and board. In addition, SB 525 was considered in the development of the adjustment. Two adjustment factors are developed at a statewide level across Non-Dual and Dual populations.

Ground Emergency Medical Transportation Fee Increase

Pursuant to approved State Plan Amendment (SPA) 18-0004, and subsequent continuances in approved SPAs 19-0020, 20-0009, 21-0017, and 22-0040, and anticipated future continuances, DHCS makes add-on payments to ground emergency medical transportation (GEMT) providers in the State's FFS program that meet specified requirements using proceeds from a GEMT provider quality assurance fee (QAF). Both State law (Welfare & Institutions Code § 14129.3[b]) and the approved SPAs establish the combination of the State's FFS base and add-on payments constitute the Rogers rates MCPs must pay to non-contracted GEMT providers serving managed care enrollees for those fiscal years in which the GEMT add-on is effective. Similar to prior years, a program change adjustment has been included in the certified capitation rates to account for this MCP obligation. To develop the program change adjustment, applicable codes were queried in the encounter data, and a per trip add-on of $220.80 was assumed for each applicable trip. In instances where Medicare is anticipated to cover costs for GEMT trips for Full-Dual/Part B eligible members, the total Medi-Cal paid amount was compared to the Medicare fee schedule and smaller add-on amounts were assumed for these trips based on these differences. Further, this add-on only applies to non-contracted trips and non-public GEMT providers. All trips were assumed to be non-contracted in the development of this adjustment since historical reporting by the MCPs on contracts for GEMT services has shown very minimal levels of contracting in the program. Further, DHCS provided a list of public GEMT providers, and the trips within this adjustment were only based on providers not in this public provider list.

Ground Emergency Medical Transportation Rate Increase AB 1705

Effective January 1, 2023, AB 1705 established the Public Provider GEMT program, resulting in a per trip rate increase for GEMT public service providers. Based on the data, assumptions, and methodology used in the previous subsection pertaining to

the GEMT QAF add-on, a separate rate increase of $1,049.98 was applied to the assumed public GEMT provider trips. Specific to the dual population, this per trip add-on puts all GEMT trips for the applicable codes above the Medicare fee schedule. As such, all Full-Dual/Part B only public provider GEMT trips have been adjusted to only reflect Medi-Cal's liability of the total GEMT payment rate inclusive of the AB 1705 add-on. To ensure only non-contracted GEMT provider trips were included in this adjustment, supplemental data requests were collected for transportation information, which included plans indicating levels of contracting with GEMT providers. Based on this historical reporting, a decreasing (and minimal) portion of GEMT trips were reported as contracted and the proportion of contracted trips was very small. Since only non-contracted trips are subject to the GEMT add-on amounts (both QAF and AB 1705), it was assumed no GEMT trips would be contracted in the development of the GEMT adjustment in the CY 2025 rates.

The State intends on submitting an add-on rate increase for CY 2025 to account for trend. Any impacts associated with this increase would be captured in a future rate amendment if deemed necessary.

CalAIM Community Supports

Under the CalAIM initiative, a CS program was implemented effective January 1, 2022. The following 14 pre-approved CS services became available under Medi-Cal managed care, effective January 1, 2022:

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

In Lieu of Services Documentation

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

- For service definitions and a description of each ILOS in the program, please see page 9 of the CA ILOS Policy Guide 2024 12.
- For State Plan services crosswalk, please see page 62 of the DHCS Community Support Policy Guide.
- For target populations, please see page 66 of the DHCS Community Support Policy Guide.
- For the projected ILOS Cost Percentage, please refer to the CY 2025 AHF Prospective ILOS Cost Percentage 2024 12.pdf.
- For a review on cost effectiveness, please refer to the CA ILOS Literature Review 2024 12.

Medi-Cal Targeted Provider Rate Increases

Pursuant to the 2023 Budget Act and AB 118, the State will establish a minimum fee schedule directed payment for select primary care services, obstetrics services, and non-specialty MH services. The State aims to create a new fee schedule that will supersede the current FFS rates for select procedure codes and that will be "87.5% of the lowest maximum allowance established by the federal Medicare Program for the same or similar services or the level of reimbursement, as specified". This program change will be referenced as targeted rate increase (TRI) through the remainder of this document.

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

- Physicians
- Physician Assistants
- Nurse Practitioners
- Podiatrists
- Certified Nurse Midwife
- Licensed Midwives
- Doula Providers

- Psychologists
- Licensed Professional Clinical Counselor
- Licensed Clinical Social Worker
- Marriage and Family Therapist

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

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

Identification of Applicable Data

Utilizing SFY 2022–23 encounter data for AHF, detailed claim lines with the applicable procedure codes are used as the basis of this adjustment. For the select primary care services, the data was limited to the applicable providers subject to the directed payment, as noted above.

General Repricing Methodology

Adjustments were developed by COS and COA. For codes subject to the Prop 56 physician supplemental payment, the minimum TRI is always set to the historical supplemental amounts.

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

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

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

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

- Reduction of the targeted rate by 20% for professional services performed at a facility
- Increase of the targeted rate by 39.7% for physician CCS claims for Whole Child Model (WCM) members
- Increase of the targeted rate by 43.44% for hospital OP services with a currently active hospital OP department provider number
- Application of Family Planning augmented rates per SB 94

- Multiple pricing discounts for surgical cutbacks and evaluation and management codes billed with BH assessment services
- Excluding surgical procedure codes billed by an assistant surgeon

Current managed care payment levels are calculated as the unit cost on each detailed claim line with adjustments for trend on the claim to proxy the expected cost of these claims in CY 2025.

Full-Dual or Part B-Only Claims

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

For claims with codes ineligible for Medicare reimbursement, the TRI is assumed to follow the same methodology as the Non-Dual or Part A-Only non-capitated claims.

Major Organ Transplants

Effective January 1, 2022, in GMC, Regional, Single-Plan, and Two-Plan counties, MOTs became a managed care covered benefit. MOTs were already a covered benefit within the COHS model. Program change adjustments applied to the 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.

Previously funded as an add-on to the rates, MOT expenses are now mostly accounted for in the base data period. For the program change development, Mercer reviewed managed care encounter data for counties where MOT became a covered benefit effective January 1, 2022 and identified individuals who received an MOT by each transplant type listed above through All Patients Refined Diagnosis Related Groups and/or surgical codes. Using this same MOT identification logic, Mercer also leveraged COHS managed care encounter data as a benchmark for expected MOT utilization in GMC, Regional, Single-Plan, and Two-Plan counties. Mercer reviewed and identified outliers in the managed care encounter data and adjusted unit cost pricing to remove outliers. The resulting PMPM program change adjustments developed for CY 2025 rates reflect expected ramp-up costs for MOT beyond what is already reflected in the base data.

DHCS implemented a delivery system reform State directed payment under 42 CFR § 438.6(c) to providers for transplant surgeries covered under managed care in GMC, Regional, Single-Plan, and Two-Plan counties. The directed payment directs MCPs to pay hospitals at levels consistent with those paid in the Medi-Cal FFS delivery system. Projected unit costs used in development of the MOT PMPM program change adjustments account for this directed payment obligation.

Enhanced Care Management

The ECM program became effective January 1, 2022, and is an important component of the CalAIM initiative developed by DHCS. The ECM benefit replaced elements of the care management services provided by the Whole Person Care (WPC) pilots (services provided 2021 and earlier), and ensures the state's most vulnerable, high-need 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 2025 capitation rates was developed at a statewide level, with region-specific adjustments, to derive health plan and region specific PMPM add-ons to the capitation rates. With limited prior claims experience, the development of this adjustment focuses on the needs of the ECM-eligible population — specifically who meets the criteria, and the assumed amount of care management utilized.

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

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

Continuing for CY 2025 ECM rates, in order to account for the multiple start dates for various ECM groups and counties, caseload assumptions were modified to be based on the length of time an individual is enrolled in ECM (1–6 months, 7–12 months, and greater than one year). This methodology allowed for more flexibility with population changes and provided the ability to reflect caseload assumptions more appropriately as the ECM program ramps up.

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

Region-specific Adjustments for Per Enrollee Per Month and Outreach

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

1. County Wage Adjustment (applied to unit cost) — an adjustment was applied to factor in wage differences for ECM providers between regions in California.
2. Overlapping CM Program Adjustments — an important responsibility of ECM providers is to ensure there are not duplication of services with other CM programs. As such, the ECM rates contain offset adjustments for the portion of the projected population enrolled in multiple CM programs.

    A. Medicare Part B Dual Enrollees — this adjustment accounts for Part B eligible ECM enrollees who are eligible for CMS' Chronic Care Management (CCM), Behavioral Health Integration (BHI), or Medicare Advantage CM programs. ECM providers are expected to collaborate with the member's physician in order to pursue the appropriate CCM and BHI payments from CMS for their ECM enrollees with Part B coverage. Additionally, National Committee for Quality Assurance-accredited Medicare Advantage Plans have CM requirements similar to some ECM services. As CMS will be covering ECM-like services through the CCM, BHI, and Medicare Advantage Plans programs, a portion of the CMs service hours (utilization) were reduced. The result is a downward rate adjustment to the SPD-LTC and SPD-LTC/Full-Dual COAs to account for the overlap in services rendered.

    B. Short Doyle Targeted Case Management (TCM) Services Adjustment (applied to utilization) — this adjustment accounts for the overlap between the county-run Short Doyle MH TCM program and ECM services for ECM enrollees enrolled in both programs.

    C. Existing Care Coordination Adjustments — AHF currently provides some care management services for its members, which necessitates the development of a PMPM carve-out to avoid funding the MCP for existing care management services currently accounted for in the AHF capitation rate. As such, for ECM-eligible and enrolled members only, half of the utilization management/quality assurance/Children's Choice costs built into the CY 2025 capitation rates was carved out. These costs can be thought of to be on a per enrollee per month (PEPM) basis and similar to the ECM COS, are then converted to a PMPM basis and removed from the capitation rate. The following table displays how this PMPM carve-out adjustment is applied as a base data adjustment to the main AHF capitation rates. This is a budget-neutral adjustment for AHF.

Table 2

COA	Existing Care Management Carved from OTH COS
AIDS	$9.79
AIDS/Full-Dual	$1.21

Converting from a Per Enrollee Per Month to Per Member Per Month

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[2]. These PMPM costs were used to calculate the ECM COS utilization trends, as explained above in the Trend section.

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

Medicare Part A Buy-in

Effective January 1, 2025, DHCS will begin paying the Medicare Part A premium for eligible Medi-Cal beneficiaries. Member eligibility for this buy-in program is identified using a combination of both aid codes and Medicare Part A and B indicators available within the Medi-Cal eligibility data. The material impact to member classification is that qualified partial-dual members with only Medicare Part B formerly within the AIDS Non-Dual COA would now receive Medicare Part A benefits and therefore be viewed as a Full-Dual member within the AIDS/Full-Dual COA group. This adjustment accounts for the movement of members from AIDS Non-Dual to AIDS/Full-Dual, as well as the reduction in costs associated with these members that will now be covered by Medicare Part A.

Eligibility and encounter data from the SFY 2023–24 time period was used to develop both member month impacts for members switching out of AIDS Non-Dual, and cost relativities of the eligible AIDS Non-Dual Part A buy-in members as compared to the larger AIDS Non-Dual COA (inclusive of Part A buy-in eligible members). The member month impacts, and cost relativities were used to calculate the PMPM impacts of removing these members from the AIDS Non-Dual COA. Further, these membership impacts and cost relativities were then used to calculate the PMPM impacts of adding these members to the AIDS/Full-Dual COA, while applying reductions to Medicare Part A covered services consistent with the new benefit coverage these members will have.

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

Other rate development items were adjusted to account for the impact of the Medicare Part A buy-in, including but not limited to enrollment projections.

Program Changes Considered, but Not Adjusted For

In addition to the program changes mentioned in the sections above, Mercer analyzed several program and policy changes for inclusion in CY 2025 capitation rates, but ultimately found these to have zero rate impact.

Wellness Coach Benefit

Effective January 1, 2025, Wellness Coach is a policy change that implements a Certified Wellness Coach to provide Wellness Coach Services. These are preventive services to support non-clinical BH needs of children/youth aged 0–25 but is available to all Medi-Cal members. Services offered include wellness promotion and education, screening, care coordination, individual and group support, and crisis referral. These services must be recommended by a licensed practitioner in order to be offered to a member. The impact of this program change was determined to not be material for AHF capitation rates.

Asset Thresholds

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

From discussions with DHCS surrounding the incoming population, the projected incoming membership is minimal, and there is no reasonable indication these incoming members would have a different cost profile than the members currently in Medi-Cal managed care. Therefore, an explicit adjustment was not made for this program change.

Telehealth — Post Public Health Emergency

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

Doula Benefit

Doula services became a Medi-Cal covered benefit effective January 1, 2023. Doula services include personal support to women and families throughout a woman's pregnancy, childbirth, and postpartum experience. Medi-Cal's standard doula benefit will include maternity and labor support visits, which can be at the member’s home, or part of a member's office visit, and during delivery.

No explicit adjustment was made for this program change as there are no projected births for the CY 2025 rating period.

Community Health Worker

Effective July 1, 2022, CHW is an addition to the group of skilled and trained individuals who are currently able to provide clinically appropriate Medi-Cal covered benefits and services to Medi-Cal beneficiaries. While this benefit is also available through ECM, this program change is separate from the ECM COS detailed previously in this certification letter.

Through discussions with AHF, it was found that due to high acuity and attributes of this population, the services for CHW would be included in the ECM COS.

Rapid Whole Genome Sequencing

Rapid whole genome sequencing became a managed care covered benefit effective January 1, 2022. This benefit is available to infants' age's one year old and younger receiving IP hospital services in an ICU and covers individual sequencing, trio sequencing for parent(s) and their child, and ultra-rapid sequencing. This benefit is covered as a California Children's Services covered service when case review confirms the study is warranted and when the test relates to a California Children's Services eligible condition. As a result, this program change will not apply to AHF members.

COVID-19 Masks

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

Dyadic Health Care Services

Effective January 1, 2023, the Dyadic Health Care (DHC) program change considers an integrated BH care model that provides health care for the child delivered in the context of the caregiver and family (i.e., "DHC services"). Families are screened for various BH problems, including interpersonal safety, tobacco and substance misuse, and social determinants of health such as food insecurity and housing instability. Families who are given referrals receive follow-up to ensure they received the services. DHC services are available for Medi-Cal beneficiaries ages 0–20, and any services rendered during the DHC visit or child's medical visit are billable to the child's Medi-Cal ID. As AHF beneficiaries are aged 21 and older, this program change will not apply to AHF members.

Populations Transitioning from Fee-for-Service to Managed Care

Certain Medi-Cal populations within the FFS delivery system, including some designated by the CalAIM initiative, transitioned to managed care in CY 2022 and CY 2023 or will be transitioning within CY 2024.

The populations identified to transition from FFS to managed care are as follows:

- Trafficking and Crime Victims Assistance Program, excluding the share of cost population
- Accelerated Enrollment
- Child Health and Disability Prevention Infant Deeming
- Pregnancy-related Medi-Cal
- BCCTP
- Beneficiaries with Other Healthcare Coverage
- Beneficiaries in rural zip codes
- Partial Dual beneficiaries in GMC, Regional, Single-Plan, and Two-Plan Counties

For pregnancy-related Medi-Cal members, only newly enrolled members enrolled in managed care in CY 2022, and members who were already in FFS prior to CY 2022 did not transition.

The populations identified to transition from FFS to managed care in GMC, Regional, and Two-Plan counties on January 1, 2023, designated as part of CalAIM — Phase II, are as follows:

- Full-Dual beneficiaries
- Members previously subject to mandatory managed care, but not in managed care.
- Beneficiaries residing in an LTC facility

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

- Intermediate Care Facility for the Developmentally Disabled and SA beneficiaries

Membership experience and claims were analyzed to see if there were any applicable members within the encounters experience within the base data and ultimately found no applicable members from these populations who could be enrolled in AHF on the respective effective dates.

Unsatisfactory Immigration Status Population Ages 26 to 49

Effective January 1, 2024, the State will transition Medi-Cal members ages 26 to 49 to full-scope Medi-Cal and move them into managed care, regardless of the member's immigration status. This population was identified to be in the Adult, ACA Expansion, and SPD COAs.

Membership experience and claims were analyzed to see if there were any applicable members within the encounters experience within the base data. While some members were identified to enroll in AHF and projected enrollment reflects the impact of this transitioning population, an explicit adjustment was not applied to the UIS rates for AHF.

Children and Youth Behavioral Health Initiative

Effective January 1, 2024, Children and Youth Health Behavioral Initiative is a policy change and State directed payment that implements a universal fee schedule for school-linked behavior health services. Local Education Agencies and Institutes of Higher Education participating in the program collaborate with providers to offer school and community-based BH services to students aged 5–25. As AHF beneficiaries are aged 21 and older, this program change was deemed to be immaterial for AHF capitation rates.

Long-Term Care Fee-For-Service Minimum Fee Schedule Directed Payment

Effective January 1, 2023 for all skilled nursing facility (SNF) services, DHCS implemented a delivery system reform State directed payment under 42 CFR § 438.6(c) for the facility per diem reimbursement of LTC services. All Plan Letter (APL) 23-004 provides further detail regarding these requirements, in accordance with Welfare and Institutions Code § 14184.201(b) and (c). As part of the delivery system reform State directed payment, requirements were set forth by DHCS within COHS and CCI counties that MCPs are required to pay a minimum of the Medi-Cal FFS per diem rate, rather than exactly the FFS per diem rate. RDT discussion guide conversations with AHF revealed they were not paying under 100% of the FFS rates. As such, Mercer did not apply any adjustments to the LTC portion of the AHF rates for this consideration[3].

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

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

requirements set forth in Section 2702 of the ACA, but delayed compliance action until July 1, 2012.

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

Mercer initially reviewed potential encounter data information for making an appropriate adjustment (though because AHF went full risk on July 1, 2019, encounter data is very limited). 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. Health plans are assumed to not pay for HACs as part of contractual requirements. No adjustments have been included within these rates.

Graduate Medical Education

Regarding graduate medical education 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 AHF managed care contracts regarding graduate medical education. AHF does not pay specific rates that contain graduate medical education or other graduate medical education-related provisions. As MCP data serves as the base data for the rate ranges, graduate medical education expenses are not part of the capitation rate development process.

Third-Party Liability

The AHF 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

The AHF program is not required to cover retrospective eligibility periods for their enrollees. These periods are covered in the Medi-Cal FFS program. Since MCP 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

Regarding the MH Parity and Addiction Equity Act, DHCS staff has confirmed there are no provisions in the AHF managed care contracts in violation of MH Parity and Addiction Equity Act.

Institutions for Mental Disease

Covered benefits associated with these capitation rates do not include services associated with an Institution for Mental Disease (IMD). In addition, if a managed care member is in an IMD in a given month, the state does not pursue federal match for that individual for that month. Therefore, the only potential rate impact from a federal perspective for members utilizing an IMD for more than 15 days in a given month would be associated with the potential impact of those members experiencing significantly higher 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. AHF was 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 not directly related to benefit costs, which include the following:

- Administration
- Underwriting gain
- MCO tax

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

Administration

The administration loading for AHF was developed from a review of AHF's historical reported administrative expenses, which are submitted as part of their attested RDTs on an annual basis. The administrative costs are reviewed to ensure they are appropriate for the approved State Plan services and Medicaid eligible members. Mercer utilized its experience and professional judgement in determining the mid-point and lower/upper bound percentages for the AHF population that are reasonable and appropriate within the context of this certification, considering the size and specialized nature of the AHF population. The administration load for the lower bound, mid-point, and upper bound are all 13.0%.

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

Underwriting Gain

The underwriting gain component at the lower bound, mid-point, and upper bound are all established at 2.0%. Mercer has implicitly and broadly considered the cost of capital within Mercer's rating assumptions. Mercer's conclusion is that Mercer's assumptions surrounding underwriting gain, as well as the income an MCP generates from investments, are sufficient to cover at least the minimum cost of capital needs for the typical MCP.

Managed Care Organization Tax

The MCO tax does not apply to AHF.

Section 6

Special Contract Provisions Related to Payment

This section describes the following contract provisions impacting the rates and the final net payments to the MCPs for reasons other than risk adjustment under the MCP contract:

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

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

Incentive Arrangements

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

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

Withhold Arrangements

There are no withhold arrangements between DHCS and AHF. This subsection is not applicable to this rate certification.

Risk Sharing Mechanisms

Proposition 56/General Fund

The state is continuing two-sided risk corridors associated with the Prop 56/General Fund directed payment initiatives applicable to this certification which had such mechanisms in the prior rating period (CY 2024). These are financial monitoring mechanisms to ensure the State directed payments are distributed in accordance with the state's contractual terms and terms of the CMS-approved preprints and are not subject to 42 CFR 438.6(b)(1). These arrangements are further discussed in the Delivery System and Provider Payment Initiative subsection if this report. This risk

mitigation mechanism will be applicable to all MCPs receiving Prop 56/General Fund add-ons (including AHF).

Rationale for the Use of the Risk-Sharing Arrangement

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

Description of How the Risk-Sharing Arrangement is Implemented

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

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

Both risk corridors will consist of the following bands:

- If the aggregate MEP is less than or equal to 98 percent, the MCP will remit to DHCS within 90 days of notice the difference between 98 percent of the medical portion of the MCP's Prop 56/General Fund Directed Payments capitation payment revenues and the aggregate amount of the MCP's MEP numerator, plus a proportional amount for the non-medical portion of the capitation payments aligned with the Prop 56/General Fund Directed Payments.

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

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

There is no impact on the CY 2025 capitation rates for the provision of a risk corridor. The CY 2025 capitation rates, outlined in this rate certification, reflects Mercer's best estimate of the anticipated costs associated with the Prop 56/General Fund Directed Payments.

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

Mercer confirms the CY 2025 Prop 56/General Fund Directed Payment add-on risk sharing mechanism was developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medi-Cal covered populations and services under the MCP contract.

Enhanced Care Management

DHCS will continue to use a symmetrical, two-sided risk corridor which was originally implemented during CY 2022 as part of the CY 2025 ECM program.

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. MCP-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 MCPs. 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 MCPs relative to ECM costs funded within the capitation rates. The risk corridor shall be based on a calculated MEP achieved by each MCP. The MEP shall be calculated in aggregate across all applicable COA and rating regions where the MCP operates for dates of service within the rating period. The risk corridor calculations shall be performed no sooner than 12 months after the end of the rating period.

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

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

The denominator of the MEP shall be equal to the total of the medical (i.e., non-administrative and non-underwriting gain) portion of the MCPs applicable ECM 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 MCP will remit to the state within 90 days of notice the difference between 95% of the medical portion of the MCP's applicable ECM capitation payment revenues and the aggregate amount of the MCP's MEP numerator.
- If the aggregate MEP is greater than or equal to 95%, but less than or equal to 105%, the MCP will retain all gains or losses, with no reconciliation payments from the state to the MCP, or vice versa.
- If the aggregate MEP is greater than 105%, the state will remit to the MCP the difference between 105% of the medical portion of the MCP's applicable ECM capitation payment revenues and the aggregate amount of the MCP's MEP numerator.

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

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

- Non-medical expenses (e.g., non-service investments for infrastructure and capacity).

- IBNR expenses that cannot be adequately supported.
- Medical expenses for non-ECM services and populations (e.g., expenses for CS services, expenses for members who do not meet ECM population, or phase-in criteria).
- Unreasonable outlier medical expense levels for which the MCP 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 MCPs 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.

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

Allowable medical expenses will include appropriate expenses for ECM services delivered by the MCP, subject to DHCS having previously authorized the MCP'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 2025 capitation rates for the provision of a risk corridor. The CY 2025 capitation rates, outlined in this rate certification, reflects Mercer's best estimate of the anticipated costs associated with ECM.

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

Mercer confirms the CY 2025 ECM 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 MCP contract.

Major Organ Transplant

DHCS will continue the use of a risk corridor that was originally implemented in CY 2022 for the portion of the CY 2025 MOT PMPM add-on associated with the directed payment that directs MCPs to pay for the transplant event itself at Medi-Cal

FFS-equivalent rates. This is a financial monitoring mechanism to ensure the State directed payments are distributed in accordance with the state's contractual terms and terms of the CMS-approved preprints and is not subject to 42 CFR § 438.6(b)(1). The risk corridor will not apply to plans in COHS counties.

Rationale for the Use of the Risk-Sharing Arrangement

Due to the initial roll-out of the MOT benefit in GMC, Regional, Single-Plan, and Two-Plan counties effective January 1, 2022 and potential differences in observed MCP 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 MCPs 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 MCP. The MEP shall be calculated in aggregate across all applicable COAs and rating regions where the MCP 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 MCP'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 MCP'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 MCP will remit to the state within 90 days of notice the difference between 95% of the medical portion of the MCP's applicable MOT add-on capitation payment revenues and the aggregate amount of the MCP's MEP numerator.
- If the aggregate MEP is greater than or equal to 95%, but less than or equal to 105%, the MCP will retain all gains or losses, with no reconciliation payments from the state to the MCP, or vice versa.
- If the aggregate MEP is greater than 105%, the state will remit to the MCP the difference between 105% of the medical portion of the MCP's applicable MOT

add-on capitation payment revenues and the aggregate amount of the MCP's MEP numerator.

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

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

- Non-medical expenses.
- IBNR 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 MCP-reported expense items that are identified during the State's review of each MCP's data.

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

There is no impact on the CY 2025 capitation rates for the provision of this risk corridor. The CY 2025 capitation rates, outlined in this rate certification, reflects Mercer's best estimate of the anticipated costs associated with MOT.

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

Mercer confirms the CY 2025 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.

Medical Loss Ratio Remittance

The State will impose an 85% minimum MLR for CY 2025. The formula for calculating the Contractor's MLR is a/b, where a is the total covered benefit and service costs of the MCP, including IBNR claim completion in accordance with 42 CFR 438.8(e) and b is the total capitation payments received the MCP, including any withhold payments minus taxes, licensing, and regulatory fees, in accordance with 42 CFR 438.8(f). Remittance takes place when the Contractor's MLR is below the 85%

minimum requirement and is the difference (excess) between the two percentages. Further details of the MLR can be found in the MCP contracts.

Although capitation rates are not directly affected by the minimum MLR requirement, the rates were developed in such a way that the MCPs are reasonably expected to achieve an MLR of at least 85% for CY 2025. This risk mitigation mechanism has been developed in accordance with generally accepted actuarial principles and practices.

State Directed Payments

There are several State directed payments applicable to the CY 2025 AHF capitation rates. All applicable directed payments are summarized in Table 3 below. The following subsections provide more detail around each initiative.

Table 3

Control Name of the State Directed Payment	Type of Payment	Brief Description	Is the Payment Included as a Rate Adjustment or Separate Payment Term?
CA_Fee_Oth2_Renewal_20250101-20251231 — Prop 56 Family Planning	Uniform dollar increase	Uniform dollar increases for specific Family Planning services	Rate adjustment
ACE Screening (no preprint required)	Minimum fee schedule using State Plan approved rates	Minimum fee schedule for specific ACE Screening services	Rate adjustment
Control Name TBD — MOT	Delivery system reform	FFS-equivalent payment requirement for network and non-network providers for newly transitioning transplant surgeries	Rate adjustment
CA_Fee_IPH.OPH1_Renewal_20250101-20251231 — Private Hospital Directed Payment (PHDP)	Uniform dollar increase	Uniform dollar increases for services limited to predetermined pool amounts for IP and OP/ER	Separate payment term

Control Name of the State Directed Payment	Type of Payment	Brief Description	Is the Payment Included as a Rate Adjustment or Separate Payment Term?
CA_Fee_IPH.OPH.AMC.PC.SP.NF_Renewal_20250101-20251231 — Enhanced Payment Program (EPP)	Uniform dollar or percentage increases	Uniform percentage increase to capitation payments and uniform dollar increase for FFS services limited to predetermined pool amounts by Designated Public Hospital (DPH) class and IP/non-IP service sub-pools	Separate payment term
CA_Fee_IPH.OPH.NF_Renewal_20250101-20251231 — District and Municipal Public Hospital Directed Payment (DHDP)	Uniform dollar increase	Uniform dollar increases for services limited to predetermined pool amounts for IP/non-IP service sub-pools	Separate payment term
CA_VBP_IPH.OPH2_Renewal_20250101-20251231 — DPH Quality Incentive Program (QIP)	Quality/performance payments	Payments based on performance on designated measures with specified maximum allowable payments for each DPH	Separate payment term
CA_VBP_IPH.OPH_Renewal_20250101-20251231." — District and Municipal Public Hospital (DMPH) QIP	Quality/performance payments	Payments based on performance on designated measures with specified maximum allowable payments for each DMPH	Separate payment term
Control Name TBD — Skilled Nursing Facility (SNF) Workforce	Quality-adjusted uniform dollar increase	Uniform dollar increase for contracted services modified by quality-	Separate payment term

Control Name of the State Directed Payment	Type of Payment	Brief Description	Is the Payment Included as a Rate Adjustment or Separate Payment Term?
and Quality Incentive Program (WQIP)		based scores at the provider level	
TRI (no preprint required)	Minimum fee schedule using State Plan approved rates	Minimum fee schedule for professional, obstetric, and non-specialty MH services.	Rate adjustment
CA_VBP_NF.Oth_New_20230101-20251231 — LTC FFS Equivalent	Delivery system reform	FFS-equivalent payment requirement for network providers for qualifying LTC services in transitioning counties; at-least FFS-equivalent requirement for qualifying LTC services in non-transitioning counties	Rate adjustment
CA_Fee_IPH.OPH.Oth_Renewal_20250101-20251231 — Children's Hospital Supplemental Payment (CHSP)	Uniform dollar increase	Uniform dollar increases for services limited to predetermined pool amounts for IP and OP/ER	Separate payment term

There are no additional directed payments in the program applicable to AHF for CY 2025 that are not addressed in this rate certification. There are no requirements regarding the reimbursement rates the health plans must pay to any providers unless specified in the certification as a directed payment or pass-through payment or authorized under applicable law, regulation, or waiver.

Proposition 56/General Fund Directed Payments

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

- Prop 56 Family Planning
- ACE Screening

Prop 56 add-ons are contingent on appropriations of funds being approved by the California Legislature. Currently, all components are effective for the entire CY 2025 period (January 1, 2025 through December 31, 2025). To the extent the California Legislatures does not appropriate Prop 56 funds for the State share for one or more of these payment initiatives for any portion of the CY 2025 period, the state will either discontinue the program(s) as of that date (and submit a rate certification amendment) or continue the program(s) using State General Fund for the State share. The ACE Screening initiative, listed above with no reference of "Prop 56", will be funded by State General Fund for the State share in CY 2025.

To facilitate CMS rate review for each of the Prop 56/General Fund payment initiatives, Table 4 below summarizes the Prop 56/General Fund payments incorporated into the capitation rates as a rate adjustment. The rest of this section is structured to provide documentation individually for each directed payment.

Table 4

Control Name of the Directed Payment	Rate Cells Affected	Impact	Description of the Adjustment	Confirmation the Rates are Consistent with the Preprint	For Maximum Fee Schedules, Provide the Information Requested
CA_Fee_Oth 2_Renewal_2 0250101-20251231 — Prop 56 Family Planning	AIDS Non-Dual	See "Sum – Add-On Details" tabs in file titled *CY 2025 AIDS Healthcare Foundation*	Adjustment is applied as a PMPM add-on to the rates. A description of the data, assumptions and	Confirmed. The preprint was submitted to CMS in December 2024.	Not applicable

Control Name of the Directed Payment	Rate Cells Affected	Impact	Description of the Adjustment	Confirmation the Rates are Consistent with the Preprint	For Maximum Fee Schedules, Provide the Information Requested
		Rates 2024 12.xlsx	methodology is provided in the narrative below.		
ACE Screening	AIDS Non-Dual	See exhibit referenced above	See prior description	No preprint required (minimum fee schedule).	Not applicable

Adverse Childhood Experiences Screening

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

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

Table 5

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

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

The service was added in CY 2021, and Mercer was able to rely on experience data available in the SFY 2022–23 base period to help inform the take-up assumptions for the CY 2025 contract period. Similar to the rate development approach used for the prior period, Mercer identified eligible enrollees in the base period eligibility data based on their Medicare coverage status and specific age groups (age group 0–18 and age group 19–64) by COA across all model types. Mercer also relied on actual experience data for these codes within the SFY 2022–23 base period to inform the take-up assumptions used for the CY 2024 contract period. This service is primarily intended for children, but adults under 65 are also eligible to receive this service if deemed medically necessary. Therefore, the assumed take-up assumptions are much lower for adults compared to children. Given the assumed utilizations for each group, the age group mix for each COA, and the known unit cost (minimum fee schedule), Mercer then calculated the expected claims PMPM as the benefit cost component of the add-on rates to calculate the percentage of members eligible for this service within each COA. Enrollees above age 65 or with Medicare Part B coverage are not eligible for this service. Mercer worked together with the State to develop age group specific take-up assumptions around the percentages of eligible members within each age group who will receive this service within the contract period for the CY 2025 rating period. This benefit cost PMPM is developed on a combined basis for all SIS and UIS populations. Acuity factors, as well as percentages of pregnancy-related and emergency services for the UIS population, were developed using code level SFY 2022–23 base period encounter data by COA on a statewide basis. UIS and SIS PMPM add-on rates were then calculated in a "budget-neutral" manner from the combined add-on rate PMPM and the projected CY 2025 SIS and UIS enrollment. Note, 0% of the ACE Screening services was found to meet the criteria as a pregnancy-related or emergency service. As a result, no portion of the UIS rates specific to this directed payment is part of this certification. Lastly, the PMPM amount of each add-on rate component was adjusted to include half of the plan-specific administrative load, which provides for the variable component of the administrative costs of the program while the fixed administrative costs are covered in the base capitation rates, and an underwriting gain of 2.0%. Further detail of these components including MCP-specific amounts are provided in the accompanying rate development exhibits in Excel format.

See Table 6 below for detailed impacts for the 12-month period.

Table 6

ACEs Screening	January 2025–December 2025				
Population	**COA**	**Projected Member Months**	**Prop 56 Add-on Projected Units**	**Total PMPM**	**Total Dollars**
SIS	Child	51,230,919	907,504	$0.54	$27,664,696
SIS	Adult	17,430,799	70,401	$0.12	$2,091,696
SIS	ACA Expansion	42,730,795	123,556	$0.09	$3,845,772
SIS	SPD-LTC	7,293,000	32,874	$0.14	$1,021,020
SIS	WCM	390,217	6,912	$0.54	$210,717
SIS	AIDS Non-Dual	6,136	28	$0.13	$798
SIS	**All COAs**	**119,081,866**	**1,141,275**	**$0.28**	**$34,834,699**

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

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

Family Planning Proposition 56

The Family Planning Prop 56 directed payment is a payment arrangement, which directs MCPs to pay a uniform and fixed dollar amount add-on payment for specific family planning services to eligible network providers based on the utilization and delivery of qualifying services for eligible enrollees covered under the contract. The preprints for this payment initiative have been approved for three prior rating periods and the renewal version applicable to the current rating period was submitted to CMS for approval on December 11, 2024, with no changes to major terms and conditions.

The following provides a brief description of this payment initiative:

- The type of this directed payment arrangement is a uniform dollar increase payment initiative.

- MCPs are required to pay the eligible providers for the applicable incurred period using the following uniform dollar increase schedule by procedure code for qualifying covered services provided to eligible managed care enrollees.

Table 7

Procedure Code[4]	Description	Uniform Dollar Amount
J7294	CONTRACEPTIVE VAGINAL RING: SEGESTERONE ACETATE AND ETHINYL ESTRADIOL	$301.00
J7295	CONTRACEPTIVE VAGINAL RING: ETHINYL ESTRADIO AND ETONOGESTREL	$301.00
J7296	LEVONORGESTREL-RELEASING IU COC SYS 19.5 MG	$2,727.00
J7297	LEVONORGESTREL-RLS INTRAUTERINE COC SYS 52 MG	$2,053.00
J7298	LEVONORGESTREL-RLS INTRAUTERINE COC SYS 52 MG	$2,727.00
J7300	INTRAUTERINE COPPER CONTRACEPTIVE	$2,426.00
J7301	LEVONORGESTREL-RLS INTRAUTERINE COC SYS 13.5 MG	$2,271.00
J7307	ETONOGESTREL CNTRACPT IMPL SYS INCL IMPL & SPL	$2,671.00
J3490U8	DEPO-PROVERA	$340.00
J7304U1	CONTRACEPTIVE PATCH: NORELGESTROMIN AND ETHINYL ESTRADIOL	$110.00
J7304U2	CONTRACEPTIVE PATCH: LEVONORGESTREL AND ETHINYL ESTRADIOL	$110.00
J3490U5	EMERG CONTRACEPTION: ULIPRISTAL ACETATE 30 MG	$72.00
J3490U6	EMERG CONTRACEPTION: LEVONORGESTREL 0.75 MG (2) & 1.5 MG (1)	$50.00
11976	REMOVE CONTRACEPTIVE CAPSULE	$399.00

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

Procedure Code[4]	Description	Uniform Dollar Amount
11981	INSERT DRUG IMPLANT DEVICE	$835.00
58300	INSERT INTRAUTERINE DEVICE	$673.00
58301	REMOVE INTRAUTERINE DEVICE	$195.00
81025	URINE PREGNANGY TEST	$6.00
55250	REMOVAL OF SPERM DUCT(S)	$521.00
58340	CATHETER FOR HYSTEROGRAPHY	$371.00
58600	DIVISION OF FALLOPIAN TUBE	$1,515.00
58615	OCCLUDE FALLOPIAN TUBE(S)	$1,115.00
58661	LAPAROSCOPY REMOVE ADNEXA	$978.00
58670	LAPAROSCOPY TUBAL CAUTERY	$843.00
58671	LAPAROSCOPY TUBAL BLOCK	$892.00
58700	REMOVAL OF FALLOPIAN TUBE	$1,216.00

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

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

There was relatively complete and credible claims experience data available in the base period, though it is subject to encounter under-reporting and other data issues. Similar to the rate development approach used for the prior period, Mercer leveraged the SFY 2022–23 base period encounter data of the listed procedure codes to develop the base utilization by COA for each procedure code across all model types. Mercer adjusted the base utilization for estimated encounter under-reporting and anticipated ramp-up due to the enhanced payment under this payment initiative based on literature review of expected national utilization levels of family planning services by the following major service types among childbearing age females:

- Long-acting contraceptives
- Other contraceptives (other than oral contraceptives) when provided as a medical benefit
- Emergency contraceptives when provided as a medical benefit
- Pregnancy testing

- Sterilization procedures (for females and males)

Given the assumed utilizations for each code by COA and the known additional unit cost (uniform dollar increase schedule), Mercer then calculated the expected claims PMPM on a statewide basis as the benefit cost component of the add-on rate. Services provided within FQHC/RHC facilities are also excluded from the add-on payments due to the wrap-around payment structure associated with these types of facilities. Additional payments to American Indian Health & Services providers and CBRCs are also excluded. In addition, because the network provider mix varies substantially across individual MCPs and individual rating regions, Mercer further adjusted the statewide claims PMPM using rating region specific and MCP-specific FQHC/RHC provider exclusion factors to develop the final claims PMPM, which vary by MCP and rating region. This benefit cost PMPM is developed on a combined basis for all SIS and UIS populations. Acuity factors as well as percentages of pregnancy-related and emergency services for the UIS population were developed using code level SFY 2022–23 base period encounter data by COA on a statewide basis. UIS and SIS PMPM add-on rates were then calculated in a "budget-neutral" manner from the combined add-on rate PMPM and the projected CY 2025 SIS and UIS enrollment. Note, 0% of the Family Planning services was found to meet the criteria as a pregnancy-related or emergency service. As a result, no portion of the UIS rates specific to this directed payment are part of this certification. Lastly, the PMPM amount of each rate component was adjusted to include half of the plan-specific administrative load, which provides for the variable component of the administrative costs of the program while the fixed administrative costs are covered in the base capitation rates, and an underwriting gain of 2.0%. Further detail of these components, including MCP-specific amounts are provided in the accompanying rate development exhibits in Excel format.

See Table 8 below for detailed impacts for the 12-month period.

Table 8

Family Planning	(January 2025–December 2025)				
Population	**COA**	**Projected Member Months**	**Prop 56 Add-on Projected Units**	**Total PMPM**	**Total Dollars**
SIS	Child	51,230,919	195,322	$0.76	$38,885,661
SIS	Adult	17,430,799	633,346	$9.22	$160,634,761
SIS	ACA Expansion	42,730,795	622,487	$2.78	$118,958,326
SIS	SPD-LTC	7,293,000	40,862	$0.85	$6,202,068

Family Planning	(January 2025–December 2025)				
SIS	WCM	390,217	1,537	$0.78	$304,481
SIS	AIDS Non-Dual	6,136	33	$0.69	$4,234
SIS	**All COAs**	**119,081,866**	**1,493,588**	**$2.73**	**$324,989,531**

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

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

Hospital Directed Payments

The following directed payments outlined below are paid as separate payment terms, apart from MOT, and the actual payments associated with these directed payments will be paid in the future. A summary of the separate payment term directed payments is provided in Table 9 below.

Table 9

Control Name of the State Directed Payment	Aggregate Amount Included in the Certification	Statement that the Actuary is Certifying the Separate Payment Term	The Magnitude on a PMPM Basis	Confirmation the Rate Development is Consistent with the Preprint	Confirmation that the State and Actuary will Submit Required Documentation at the End of the Rating Period (as applicable)
CA_Fee_IPH.OPH1_Renewal_20250101-20251231 — PHDP	$13,187.26 million	The actuary certifies the incorporation of the separate payment term	See pink labeled columns in file titled *CY 2025 Medi-Cal Hospital Directed Payment Summary 2024 12.xlsx* for the PMPM estimates	Confirmed. The preprint was submitted to CMS on December 11, 2024.	Confirmed
CA_Fee_IPH.OPH.AMC.PC.SP.NF_Renewal_20250101-20251231 — EPP	$3,865.00 million	The actuary certifies the incorporation of the separate payment term	See exhibit referenced above	Confirmed. The preprint was submitted to CMS on December 11, 2024.	Confirmed
CA_Fee_IPH.OPH.NF_Renewal_20250101-20251231 — DHDP	$842.39 million	The actuary certifies the incorporation of the separate payment term	See exhibit referenced above	Confirmed. The preprint was submitted to CMS 0n December 11, 2024.	Confirmed

Control Name of the State Directed Payment	Aggregate Amount Included in the Certification	Statement that the Actuary is Certifying the Separate Payment Term	The Magnitude on a PMPM Basis	Confirmation the Rate Development is Consistent with the Preprint	Confirmation that the State and Actuary will Submit Required Documentation at the End of the Rating Period (as applicable)
CA_VBP_IPH.OPH2_Renewal_20250101-20251231 — DPH QIP	$3,463.69 million	The actuary certifies the incorporation of the separate payment term	See exhibit referenced above	Confirmed. The preprint was submitted to CMS 0n December 11, 2024.	Confirmed
CA_VBP_IPH.OPH_Renewal_20250101-20251231 — DMPH QIP	$178.52 million	The actuary certifies the incorporation of the separate payment term	See exhibit referenced above	Confirmed. The preprint was submitted to CMS 0n December 11, 2024.	Confirmed
CA_Fee_IPH.OPH.Oth_Renewal_20250101-20251231 — Children's Hospital Supplemental Payment (CHSP)	$230.00 million	The actuary certifies the incorporation of the separate payment term	See exhibit referenced above	Confirmed. The preprint was submitted to CMS on December 11, 2024.	Confirmed

Information included in the attached spreadsheet *(CY 2025 Medi-Cal Hospital Directed Payment Summary 2024 12.xlsx)* includes the estimated PMPM impacts associated with each of these separate payment term directed payments by rate cell.

The approach for developing the estimated PMPM impacts of each directed payment is similar to prior years. Mercer collected supplemental data from each health plan on historical utilization and expenditures by COS and provider class as well as the

contracted share of those expenditures (payments associated with the MCP having a contract in place with the facilities). Based on a review of this supplemental data, for each directed payment provider class within each applicable COS, Mercer estimated the contracted share of revenue as well as the unit cost differential compared to the average unit cost across all providers, by rate cell. These metrics were utilized to estimate the PMPM impacts for each directed payment as described below.

Private Hospital Directed Payment Uniform Dollar Increase

The PHDP preprint was submitted to CMS on December 11, 2024. The PHDP is a uniform dollar add-on payment for services provided by two classes of network private hospitals, children's private hospitals and non-children's private hospitals, limited to pre-determined pool amounts, with 90.5% designated to non-children's hospitals and 9.5% to children's hospitals. Within each class, 56% is designated to IP services, and 44% to OP/ER services. The PHDP is a separate payment term; the actual uniform dollar increase will be calculated after the end of each half of the CY 2025 period based on actual contracted IP and OP/ER services utilized within each class.

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

The total impact of the PHDP directed payment across the classes is targeted to be approximately $13,187.26 million. The attached exhibit (*Exhibit I CY 2025 Directed Payments PHDP 2024 12.pdf*) contains the full detail of these calculations for each class and COS. The resulting estimates on a PMPM basis by rate cell are provided in the attached spreadsheet (*CY 2025 Medi-Cal Hospital Directed Payment Summary 2024 12.xlsx*) as noted previously.

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

Enhanced Payment Program

The EPP directed payment preprint was submitted to CMS on December 11, 2024. The EPP consists of two parts; first, uniform dollar add-on payment for services provided by the four classes of DPHs and second, uniform percentage increase to subcapitation (capitation) payments made to Class A and Class B DPHs. Payments are limited to predetermined pool amounts by DPH provider class. The pool amounts are split into capitation and FFS service sub-pools for applicable DPH classes, and non-capitation pool amounts are further split into IP and non-IP sub-pools. The EPP

is a separate payment term; the actual uniform dollar add-on payments and uniform percentage increases will be calculated after the end of each half of the CY 2025 period based on actual contracted services utilized within the applicable provider classes and COS.

Classes A through D are outlined below:

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

Fee-For-Service Uniform Dollar Increase

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

The methodology that will be used to allocate actual payments associated with these directed payments will be consistent with the methods discussed in this certification and the 42 CFR § 438.6(c) preprint. AHF's contracted utilization at DPHs was assumed to be zero for the CY 2025 contract period. As described in the EPP preprint, acuity factors will be applied within the final calculations. The application of the acuity factors will be done in a budget neutral fashion whereby the pooled amounts will still be distributed in total. The exclusion of an adjustment for acuity within these current calculations was driven by the insufficient level of detail within the base data and supplemental data utilized in this estimated impact development. However, the resulting estimates produced are considered appropriate for this process.

Capitation Uniform Percentage Increase

The approach for producing the estimated uniform percentage increase to capitation is similar to prior years. Mercer collected supplemental data from each health plan participating in Class A and Class B counties on historical capitation payments to DPHs and volume of DPH-assigned members. Based on a review of this supplemental data, Mercer estimated the capitation payments for DPH-assigned members anticipated during the rating period and the projected member months for the DPH assigned members by class and rate cell. These calculations produced

estimated DPH capitation expenditures, by rate cell and in total, that formed the basis for creating estimated uniform percentage increases that would total the intended directed payment target for the given provider class. The methodology used to allocate actual payments associated with these directed payments will be consistent with the methods discussed in this certification and the 42 CFR § 438.6(c) preprint. AHF's contracted utilization at DPHs was assumed to be zero for the CY 2025 contract period.

The total impact of the EPP directed payment across the classes is targeted to be approximately $3,865.00 million. The attached exhibits (*Exhibit II CY 2025 Directed Payments EPP 2024 12.pdf*) contain the full detail of these calculations by class, sub-pool, and impacted COS. The resulting estimates on a PMPM basis by rate cell are provided in the attached spreadsheet (*CY 2025 Medi-Cal Hospital Directed Payment Summary 2024 12.xlsx*).

District and Municipal Public Hospital Directed Payment Uniform Dollar Increase

The DHDP preprint was submitted to CMS on December 11, 2024. The DHDP is a uniform dollar add-on payment for services provided by the class of network DMPHs, limited to a predetermined pool amount, with 55% designated to IP (IP/LTC) services, and 45% to non-IP (OP/ER) services. The DHDP is a separate payment term; the actual uniform dollar increase will be calculated after the end of each half of the CY 2025 period based on actual contracted IP and non-IP services utilized within the class.

The approach for developing the estimated DHDP uniform dollar increases and PMPM impacts is similar to prior years. The estimated contracted share of revenue and unit cost differentials for the DMPH class were applied to the GME PMPM component of the capitation rate by rate cell for each impacted COS (IP, LTC, and OP/ER). These calculations produced estimated DMPH contracted days (for IP) or visits (for non-IP), by and in total, that formed the basis for creating estimated uniform dollar add-on payment for each COS that would total the intended directed payment target. AHF's contracted utilization at DMPHs was assumed to be zero for the CY 2025 contract period.

The total impact of the PHDP directed payment across the classes is targeted to be approximately $842.39 million. The attached exhibit (*Exhibit III CY 2025 Directed Payments DHDP 2024 12.pdf*) contains the full detail of these calculations for each COS. The resulting estimates on a PMPM basis by rate cell are provided in the attached spreadsheet (*CY 2025 Medi-Cal Hospital Directed Payment Summary 2024 12.xlsx*) as noted previously.

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

Designated Public Hospital Quality Incentive Pool

The QIP DPH directed payment preprint was submitted to CMS on December 11, 2024. The DPH QIP directed payment provides value-based payments to DPHs for meeting specified performance measures linked to the utilization and delivery of services under the MCP contracts. Each county with an applicable non-UC DPH is designated a specified maximum allowable pool payment amount, and the UC facilities statewide are designated a maximum allowable pool payment amount.

The approach for producing the estimated impact is similar to prior years. The QIP DPH directed payment estimates are calculated as a uniform percentage increase to anticipated DPH expenditures in CY 2025 by rate cell; the uniform percentage estimate is modeled on a region-specific basis for the counties with non-UC DPHs and a statewide basis for the UC facilities. Each region and UC facilities are allocated a portion of the total respective QIPs. The estimated contracted share of revenue was applied to the capitation GME PMPM by rate cell for the non-UC DPHs and the UC DPHs. These calculations produced estimated DPH capitation expenditures, by rate cell and in total, which formed the basis for creating uniform percentage increases that would total the intended directed payment maximum allowable payment target for each non-UC region and for the UC facilities. AHF's contracted utilization at DPHs was assumed to be zero for the CY 2025 contract period.

The total impact of the QIP DPH directed payment is targeted to be approximately $3,463.69 million. The attached exhibits (*Exhibit IV CY 2025 Directed Payments DPH QIP 2024 12.pdf*) contain the full detail of these calculations. The resulting estimates on a PMPM basis by rate cell are provided in the attached spreadsheet (*CY 2025 Medi-Cal Hospital Directed Payment Summary 2024 12.xlsx*).

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

District and Municipal Public Hospital Quality Incentive Pool

The DMPH QIP directed payment preprint was submitted to CMS on December 11, 2024. The DMPH QIP directed payment provides value-based payments to DMPHs for meeting specified performance measures linked to the utilization and delivery of services under the managed care contracts. Each county with an applicable DMPH is designated a specified maximum allowable pool payment amount.

The approach for producing the estimated impact is similar to prior years and similar to the calculation of the non-UC QIP DPH estimates. The QIP DMPH directed payment estimates are calculated as a uniform percentage increase to anticipated DMPH expenditures in CY 2025 by rate cell; the uniform percentage estimate is modeled on a county-specific basis for the counties with DMPHs. Each county/region is allocated a portion of the total respective QIP. The estimated DMPH contracted

share of revenue was applied to the capitation GME PMPM by rate cell. These calculations produced estimated DMPH capitation expenditures, by rate cell and by county, which formed the basis for creating uniform percentage increases that would total the intended directed payment maximum allowable payment target for each DMPH county. AHF's contracted utilization at DMPHs was assumed to be zero for the CY 2025 contract period.

The total impact of the DMPH QIP directed payment is targeted to be approximately $178.52 million. The attached exhibits (*Exhibit V CY 2025 Directed Payments DMPH QIP 2024 12.pdf*) contain the full detail of these calculations. The resulting estimates on a PMPM basis by rate cell are provided in the second tab of the attached spreadsheet (*CY 2025 Medi-Cal Hospital Directed Payment Summary 2024 12.xlsx*).

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

Children's Hospital Supplemental Payment

The CHSP preprint was submitted to CMS on December 11, 2024. The CHSP is a uniform dollar add-on payment for services provided by three classes of network private children's hospitals, limited to pre-determined pool amounts. Within Class 1, 56% is designated to IP services and 44% to OP/ER services; within Class 2 and Class 3, 70% is designated to IP services and 30% to OP/ER services. The CHSP is a separate payment term; the actual uniform dollar increase will be calculated after the end of each half of the CY 2025 period based on actual contracted IP and OP/ER services utilized within each class.

The approach for developing the estimated CHSP uniform dollar increases and PMPM impacts is similar to PHDP described above. The estimated contracted share of revenue and unit cost differential for each class were applied to the gross medical expense (GME) PMPM component of the capitation rate by rate cell for each impacted COS (IP and OP/ER). These calculations produced estimated contracted days (for IP) or visits (for non-IP) by class, by rate cell and in total, which formed the basis for creating estimated uniform dollar add-on payment for each class and COS that would total the intended directed payment target. AHF's contracted utilization at Children's Hospital was assumed to be zero for the CY 2025 contract period.

The total impact of the CHSP directed payment across the classes is targeted to be approximately $230.00 million. The attached exhibit (*Exhibit VI CY 2025 Directed Payments CHSP 2024 12.pdf*) contains the full detail of these calculations for each class and COS. The resulting estimates on a PMPM basis by rate cell are provided in the attached spreadsheet (*CY 2025 Medi-Cal Hospital Directed Payment Summary 2024 12.xlsx*) as noted previously.

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

Major Organ Transplant Hospital Directed Payment

The MOT directed payment preprint will be submitted to CMS for approval no later than December 31, 2024. This directed payment is specific to hospital stays incorporating the MOT event and only applies to transplants transitioning from FFS to Medi-Cal managed care. This directed payment directs MCPs to pay hospitals at levels that would be paid in the Medi-Cal FFS delivery system.

To facilitate CMS rate review for the MOT directed payment, Table 10 below summarizes the directed payment, since it is incorporated into the capitation rates as a rate adjustment.

Table 10

Control Name of the Directed Payment	Rate Cells Affected	Impact	Description of the Adjustment	Confirmation the Rates are Consistent with the Preprint	For Maximum Fee Schedules, Provide the Information Requested
Control Name TBD — MOT	All COAs	$0	Program change adjustment described previously.	Confirmed	Not applicable

Skilled Nursing Facility and Workforce and Quality Incentive Program

The SNF WQIP preprint will be submitted to CMS for approval no later than December 31, 2024. The SNF WQIP is a quality-adjusted uniform dollar add-on payment for services provided by the class of network SNFs for which Medi-Cal is the primary payer, limited to a predetermined pool amount. The SNF WQIP is a separate payment term; the actual uniform dollar increase will be calculated after the end of the CY 2025 period based on actual contracted LTC services utilized within the class and actual quality scores.

The approach for developing the estimated SNF WQIP uniform dollar increases and PMPM impacts is similar to prior years. The estimated contracted share of LTC days and unit cost differentials for the SNF WQIP class were applied to the GME PMPM component of the capitation rate by rate cell for the LTC COS. These calculations produced estimated SNF WQIP contracted days, by rate cell and in total, which formed the basis for creating an estimated uniform dollar add-on payment that would total the intended directed payment target. For this estimate, Mercer assumed uniform quality performance measures across all eligible days.

The total impact of the SNF WQIP directed payment is targeted to be approximately $304.8 million. The uniform dollar add-on payment estimate of $15.83 for LTC produced this impact of $304.8 million. The estimates on a PMPM basis by rate cell are provided in the attached spreadsheet (*CY 2025 Medi-Cal WQIP Directed Payment Summary 2024 12.xlsx*).

The methodology that will be used to allocate actual payments associated with this directed payment will be consistent with the methods discussed in this certification and the 42 CFR § 438.6(c) preprint. The final actual add-on payment will be adjusted based on facility-specific, curved WQIP performance measure scores. To facilitate CMS rate review for the SNF WQIP directed payment, Table 11 below summarizes the directed payment.

Table 11

Control Name of the State Directed Payment	Aggregate Amount Included in the Certification	Statement that the Actuary is Certifying the Separate Payment Term	The Magnitude on a PMPM Basis	Confirmation the Rate Development is Consistent with the Preprint	Confirmation that the State and Actuary will Submit Required Documentation at the End of the Rating Period (as applicable)
Control Name TBD — SNF WQIP	$304.8 million	The actuary certifies the incorporation of the separate payment term	See file titled *2025 Medi-Cal WQIP Directed Payment Summary 2024 12.xlsx* for the PMPM estimates	Confirmed	Confirmed

Targeted Provider Rate Increase

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

To facilitate CMS rate review for TRI, Table 12 below summarizes the directed payment, since it is incorporated into the capitation rates as a rate adjustment.

Table 12

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

Long-Term Care Directed Payment

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

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

Table 13

Control Name of the Directed Payment	Rate Cells Affected	Impact	Description of the Adjustment	Confirmation the Rates are Consistent with the Preprint	For Maximum Fee Schedules, Provide the Information Requested
CA_VBP_NF.Oth_New_20230101-20251231 — LTC Directed Payment	All	No impact for AHF.	Adjustment is applied in the base capitation rates and is a portion of the LTC COS. No adjustment was needed for AHF rates.	Confirmed.	See description above.

Pass-Through Payments

Pass-through payments, as described below, are applied in the AHF CY 2025 capitation rates.

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

Private Hospital — Hospital Quality Assurance Fee

Historical adjustments associated with the private hospital quality assurance fee (HQAF) are continuing for CY 2025. The approach for making these adjustments within the capitation rates is being addressed through two paths; first, Pass-through Payments as defined by 42 CFR § 438.6(d), and 2) Directed Payments as defined by 42 CFR § 438.6(c). The directed payment approach is described earlier within this certification report and is paid through a separate payment term. The pass-through components of the HQAF adjustments are paid as a PMPM add-on amount by rate cell, included within the certified rates. These have been developed in a fashion similar to historical approaches.

The estimated share of revenue for the private hospitals was applied to the capitation GME PMPM by rate cell for each impacted COS (IP and OP/ER). These calculations produced estimated private PMPMs, by rate cell and in total. It should be noted the GME amounts utilized to produce the baseline amounts are inclusive of projected maternity costs. This approach was taken so these adjustments did not impact the maternity supplemental payments (this is consistent with historical practice). The private hospital components of the capitation rates were increased by a uniform percentage increase to the IP component and a uniform percentage increase to the OP/ER component. The total target impact of
$1,200 million is projected across all regions. The development of the add-on amounts did not impact the underlying data or assumptions associated with the regular development of the capitation rates. Consistent with historical approaches, no additional administrative load or underwriting gain is included within these add-on amounts for HQAF.

The resulting PMPM add-on rates by rate cell are provided in the “Sum - Add-On Details” tabs within the attached spreadsheet *CY 2025 AIDS Healthcare Foundation 2024 12.xlsx*. The development of these add-on amounts did not impact the underlying data or assumptions associated with the regular development of the capitation rates. These pass-through payments are paid to private hospitals and DMPHs. AHF was assumed to have no contracted utilization at a DMPH during the CY 2025 contract period.

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

Martin Luther King, Jr. Community Hospital in Los Angeles County

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

The estimated share of IP revenue for MLK was applied to the capitation IP GME PMPM by rate cell. These calculations produced estimated MLK PMPMs by rate cell and in total. It should be noted, the GME amounts utilized to produce the baseline amounts are inclusive of projected maternity costs. This approach was taken so

these adjustments did not impact the maternity supplemental payments (this is consistent with historical practice). A uniform percentage increase for the MLK component of the IP COS was established to provide the needed adjustments to reflect the required costs. The development of these adjustments also includes a 3.30% administrative load, which aligns with administrative costs assigned to the maternity supplemental payment as well as the administrative load included with the Prop 56 directed payment add-on payments. An underwriting gain of 2.00%, also consistent with the other payment mechanisms previously mentioned, is included as part of the add-on payment. The total adjustment including administrative load and underwriting gain is estimated to be $46.88 million across CY 2025 based upon enrollment projections.

Included attachment labeled *Exhibit C CY 2025 MLK IP Pass-Through 2024 12.pdf* contains the detailed components behind these calculations. The resulting PMPM add-on rates by rate cell are provided in the "Sum - Add-On Details" tabs within the attached spreadsheet *CY 2025 AIDS Healthcare Foundation Rates 2024 12.xlsx*.

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

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

Pass-Through Payments Base Amount Calculation

For the CY 2025 rating period, DHCS has confirmed the projected aggregate amount of pass-through payments to hospitals does not exceed either of:

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

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

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

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

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

General Methodology

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

1. Thirty (30) percent of the base amount defined at 42 CFR § 438.6(d)(2) applicable to the period of January 1, 2025 through June 30, 2025.
2. Twenty (20) percent of the base amount defined at 42 CFR § 438.6(d)(2) applicable to the period of July 1, 2025 through December 31, 2025.

The aggregate amount resulting from this calculation is $1,991,775,659 as displayed in the exhibit *CY 2025 Base Amount Calculation 2024 12.pdf*.

The 42 CFR § 438.6(d)(2)(i) component of the base amount is equal to the aggregate difference between the amounts calculated in accordance with 42 CFR § 438.6(d)(2)(i)(A) and (d)(2)(i)(B). This amount is the differential between the amount paid under Medicaid managed care and the amount Medicare FFS would have paid for IP and OP hospital services provided to eligible populations under the MCP contracts for the 12-month period immediately two years prior to the CY 2025 rating period, which corresponds to CY 2023.

The 42 CFR § 438.6(d)(2)(i)(A) calculation includes two elements; unit cost and utilization. All state-only services were excluded in the cost and utilization data for this part of the calculation. Unit costs were based on Department of Health Care Access and Information, previously the Office of Statewide Health Planning and Development, statewide data for Medicare FFS beneficiaries. CY 2022 data was leveraged to arrive at estimated CY 2023 average unit costs for IP and OP hospital services. To maintain consistency with the approach used for the 42 CFR § 438.6(d)(2)(i)(B) component, unit cost trend was applied to the CY 2022 data in order to determine a reasonable estimate of CY 2023 unit costs. The trend applied was based on the Consumer Price Index for All Urban Consumers for hospital related services over the previous five SFYs (SFY 2018–19 through SFY 2022–23). The resulting estimated IP and OP unit costs are 3.43% higher year-over-year compared to the CY 2022 unit costs.

Utilization was calculated based on SFY 2022–23 base data used in Medi-Cal managed care rate development that was trended forward to CY 2023. Distinct trends were applied for IP and OP hospital services based on the base data utilization change from CY 2019 through SFY 2022–23. For simplicity, the base period data was not trended to the rating period; however, the state may elect to apply trend adjustments, as appropriate, in the calculation of the base amount applicable to future rating periods.

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

The 42 CFR § 438.6(d)(2)(i)(B) calculation includes three elements: unit cost, utilization, and directed payments. SFY 2022–23 data was trended to arrive at estimated CY 2023 average unit costs for IP and OP hospital services. The same trend used for the 42 CFR § 438.6(d)(2)(i)(A) component of the calculation was utilized here. Utilization is identical to that used for the 42 CFR § 438.6(d)(2)(i)(A) component of the calculation. Unit cost was multiplied by utilization for both IP and OP hospital services, respectively. The resulting amounts were then summed and further increased by the amount of applicable directed payments for IP and OP hospital services for the CY 2023 base period to arrive at the total amount for 42 CFR § 438.6(d)(2)(i)(B). The applicable directed payments were made as part of the DPH EPP and PDHP. While the DPH EPP and PHDP directed payments were first implemented beginning on July 1, 2017, the DHDP first implemented beginning on January 1, 2023.

Aggregate Difference

The aggregate difference between the total amounts of 42 CFR § 438.6(d)(2)(i)(A) and (d)(2)(i)(B) is $7,967,102,637. This amount was multiplied by a factor of 0.25 to account for the 30% and 20% phase-down levels associated with the eighth and ninth fiscal years, respectively, occurring after July 1, 2017.

Trend Adjustments

At the time of this calculation, SFY 2022–23 cost and utilization data specific to Medi-Cal managed care was available for use in this calculation and trended forward to determine the reasonable estimates in calculating the Base Amount for the CY 2025 rating period. Both unit cost and utilization trends were applied in the calculation of the amount specified by 42 CFR § 438.6(d)(2)(i). Trends were applied consistently for both 42 CFR § 438.6(d)(2)(i)(A) and (d)(2)(i)(B).

The unit cost trend adjustment is based on the Consumer Price Index for All Urban Consumers, Hospital, and Related Services. The year-over-year growth from July 1, 2018 through July 1, 2023 was used to determine an annual trend percentage of 3.24%. This source of growth is consistent with the annual growth rate historically approved by CMS in the preprint for the state's QIP. Based on CMS' approval of this data source for determining unit cost growth, DHCS believes this source is reasonable and appropriate. While alternative trends are possible and may be reasonable, that fact does not diminish the reasonableness of the state's approach in utilizing an established cost index to inform the trend assumption.

The utilization trend adjustment is based on the year-over-year growth from CY 2018 through SFY 2022–23 of the base data used for rate development. This data source remains consistent with the utilization driving the base amount calculation beginning with the SFY 2017–18 rating period.

Fiscal Impact

The following displays the fiscal impact of applying unit cost and utilization trends on the phased-down base amount:

Phased-Down Base Amount with Trends = $1,991,775,659

Unit Cost Trend Removed = $1,797,817,888

Utilization Trend Removed = $1,907,794,812

Unit Cost Trend and Utilization Trend Removed = $1,719,579,635

DHCS believes both the unit cost and utilization trends applied in this calculation are reasonable and appropriate. However, the removal of either utilization or unit cost trend, or both, would not change the fact that the phased-down based amount exceeds the projected aggregate amount of pass-through payments for the CY 2025 rating period.

The 42 CFR § 438.6(d)(2)(ii) component of the base amount is assumed to be equal to $0 at this time, consistent with the approach used for prior rating periods. The amount in accordance with 42 CFR § 438.6(d)(2)(ii) is the differential between the amount paid under Medicaid FFS and the amount Medicare FFS would have paid for IP and OP hospital services provided to eligible populations through the Medicaid FFS delivery system for the 12-month period immediately two years prior to the CY 2025 rating period that have subsequently shifted to the Medicaid managed care delivery system. There were material shifts of IP and OP hospital services, and of eligible populations, from Medicaid FFS to Medicaid managed care for the applicable time periods. However, given the 42 CFR § 438.6(d)(2)(i) component on its own exceeds the projected aggregate amount of pass-through payments for the CY 2025 rating period, DHCS has opted to keep this component of the calculation $0 at the current time. The state reserves the right to utilize this component of the calculation in a future amendment of this certification or for future rating periods.

Section 7

Certification and Final Rates

This certification assumes items in the Medicaid State Plan or Waiver, as well as the AHF 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 MCPs, and its vendors. DHCS, its MCPs, 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 capitation rates, for CY 2025, January 1, 2025 through December 31, 2025, were developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medi-Cal covered populations and services under the managed care contract. Capitation rates are "actuarially sound" if, for the business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes. The undersigned actuaries are members of the American Academy of Actuaries and meet its qualification standards to certify to the actuarial soundness of these Medicaid Medi-Cal 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 MCP 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.

MCPs 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 MCPs for any purpose. Mercer recommends that any MCP considering contracting with DHCS should analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to these rates before deciding whether to contract with DHCS.

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

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

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

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

If you have any questions on the above or the certification report, please feel free to contact Samantha Callender at samantha.callender@mercer.com, or Rodney Armstrong at rodney.armstrong@mercer.com.

Sincerely,

[redacted]

Samantha Callender, ASA, MAAA
Principal

[redacted]

Rodney Armstrong, ASA, MAAA
Principal

Appendix A

Pregnancy-related and Emergency Service Identification Logic

This appendix details the logic and codes that were used in the identification of pregnancy-related and emergency services, which make up the federally eligible capitation rates for the UIS population. The process utilized contained logic and codes developed both by DHCS and Mercer. In this process, each encounter for the UIS population was flagged (yes or no) into different types of categorizations identified as either pregnancy-related or emergency services. After each encounter was categorized into these flags, a hierarchy was used to ensure each encounter only flagged into one category. Finally, based on the final category for each encounter, each encounter was then classified as pregnancy-related, emergency, or neither. Encounters identified as pregnancy-related or emergency were the basis of the development of the pregnancy-related and emergency percentages and the federally eligible capitation rates for the UIS population.

Below is a list of the different types of emergency and pregnancy-related categories. Additionally, an indication as to whether the categorization is emergency or pregnancy-related is also shown. Detailed codes and logic for each category are listed later in this Appendix. Note, the Rx claims are not present within the logic below since Rx services were carved out of the MCP contracts effective January 1, 2022. Additionally, the order of the categorizations below corresponds to the hierarchy used as well.

1. Labor and Delivery (Emergency) — Labor and delivery is separated out from other maternity-related services since labor and delivery is considered emergency for claiming purposes.

2. Maternity DHCS (Pregnancy-related) — The State maintains an existing set of business rules or logic/criteria it uses to identify applicable maternity-related services for FFS claiming on the UIS population. This category corresponds to this logic. Mercer reviewed the State's logic to ensure agreement that the services identified by the logic would be related to a maternity-related service. Mercer's assessment was that the logic included was a reasonable basis for the identification of the maternity services.

3. Maternity Mercer (Pregnancy-related) — Mercer maintains a set of codes and coding methodology to identify maternity-related services in encounter data for capitation rate development purposes. Mercer's coding and methodology was

developed by and is continually refined by Mercer's team of clinicians and coding and data specialists.

4. Pregnancy-related "Catch All" (Pregnancy-related) — This logic identified live birth or delivery events. Using that birth/delivery event date, all encounters were pulled within SFY 2021–22 for these members with dates of service 238 days prior to the delivery event (pregnancy-related services). The 238-day threshold (34 weeks) was selected because based on information from the National Center for Health Statistics, only 3% of babies are born before 34 weeks of pregnancy. That means 97% of all births are at 34 weeks of pregnancy or later. This 238-day threshold is viewed as conservative because it does not account for the first few weeks of pregnancy for most births (90% of births are at 37 weeks or later). The assumption here is that virtually every service delivered during pregnancy is ultimately for the benefit of the unborn child.
5. Emergency Medical Transportation (Emergency)
6. Emergency Facility (Emergency)
7. Emergency Other (Emergency)
8. IP Admissions that Originated Through the ER (Emergency)
9. Dialysis (Emergency)
10. Emergency DHCS (Emergency) — Similar to the Maternity DHCS categorization, the State maintains existing business rules or logic/criteria is uses to identify emergency-related services for FFS claiming on the UIS population. Mercer reviewed the State's logic to ensure agreement that the services identified by the logic would be related to an emergency-related service. Mercer's assessment was that the logic included was a reasonable basis for the identification of the emergency services.

Effective January 1, 2025, DHCS updated its definition of an emergency for certain IP services. As noted in the Data section within this certification, IP hospital admissions that occurred as an emergency or originated through the emergency department were further split into costs associated with the IP stay up to the stabilization of the patient and after the stabilization of the patient. For purposes of the federal claiming logic, emergency IP days are defined to be any IP day in which the beneficiary is in the ICU plus the first two days of each admission when a beneficiary is not in the ICU. Any other day within an IP stay that originated as an emergency is considered State only. This logic only applies to IP days that originated through the ER or had an IP admission code indicating the admission was an emergency. All other IP days within the logic are unaffected by this change.

Detailed Codes and Logic

Note, in the logic provided below, overlap does occur. As noted previously, all encounters flagging into multiple categories were ultimately only flagged into one category due to the hierarchical logic applied.

1. Labor and Delivery Criteria

The following conditions must be satisfied for an encounter to be considered a Labor and Delivery encounter.

Criteria Set 1:

A. The encounter has one of the 25 diagnosis code fields populated with one of the following codes:

'O6010X0', 'O6010X1', 'O6010X2', 'O6010X3', 'O6010X4', 'O6010X5', 'O6010X9', 'O6012X0', 'O6012X1', 'O6012X2', 'O6012X3', 'O6012X4', 'O6012X5', 'O6012X9', 'O6013X0', 'O6013X1', 'O6013X2', 'O6013X3', 'O6013X4', 'O6013X5', 'O6013X9', 'O6014X0', 'O6014X1', 'O6014X2', 'O6014X3', 'O6014X4', 'O6014X5', 'O6014X9', 'O6020X0', 'O6020X1', 'O6020X2', 'O6020X3', 'O6020X4', 'O6020X5', 'O6020X9', 'O6022X0', 'O6022X1', 'O6022X2', 'O6022X3', 'O6022X4', 'O6022X5', 'O6022X9', 'O6023X0', 'O6023X1', 'O6023X2', 'O6023X3', 'O6023X4', 'O6023X5', 'O6023X9', 'O670', 'O678', 'O679', 'O68', 'O690XX0', 'O690XX1', 'O690XX2', 'O690XX3', 'O690XX4', 'O690XX5', 'O690XX9', 'O691XX0', 'O691XX1', 'O691XX2', 'O691XX3', 'O691XX4', 'O691XX5', 'O691XX9', 'O692XX0', 'O692XX1', 'O692XX2', 'O692XX3', 'O692XX4', 'O692XX5', 'O692XX9', 'O693XX0', 'O693XX1', 'O693XX2', 'O693XX3', 'O693XX4', 'O693XX5', 'O693XX9', 'O694XX0', 'O694XX1', 'O694XX2', 'O694XX3', 'O694XX4', 'O694XX5', 'O694XX9', 'O695XX0', 'O695XX1', 'O695XX2', 'O695XX3', 'O695XX4', 'O695XX5', 'O695XX9', 'O6981X0', 'O6981X1', 'O6981X2', 'O6981X3', 'O6981X4', 'O6981X5', 'O6981X9', 'O6982X0', 'O6982X1', 'O6982X2', 'O6982X3', 'O6982X4', 'O6982X5', 'O6982X9', 'O6989X0', 'O6989X1', 'O6989X2', 'O6989X3', 'O6989X4', 'O6989X5', 'O6989X9', 'O699XX0', 'O699XX1', 'O699XX2', 'O699XX3', 'O699XX4', 'O699XX5', 'O699XX9', 'O700', 'O701', 'O7020', 'O7021', 'O7022', 'O7023', 'O703', 'O704', 'O709', 'O720', 'O721', 'O722', 'O723', 'O730', 'O731', 'O740', 'O741', 'O742', 'O743', 'O744', 'O745', 'O746', 'O747', 'O748', 'O749', 'O750', 'O751', 'O752', 'O753', 'O754', 'O755', 'O7581', 'O7582', 'O7589', 'O759', 'O76', 'O770', 'O771', 'O778', 'O779', 'O80', 'O82', 'Z370', 'Z371', 'Z372', 'Z373', 'Z374', 'Z3750', 'Z3751', 'Z3752', 'Z3753', 'Z3754', 'Z3759', 'Z3760', 'Z3761', 'Z3762', 'Z3763', 'Z3764', 'Z3769', 'Z377', 'Z379'

or

B. The encounter has one of the following procedure codes:

'59400', '59409', '59410', '59510', '59514', '59515', '59610', '59612', '59614', '59618', '59620', '59622', '59899', '01960', '01961'

or

C. The encounter has one of the following surgical procedure codes:

'10D00Z0', '10D00Z1', '10D00Z2', '10D07Z3', '10D07Z4', '10D07Z5', '10D07Z6', '10D07Z7', '10D07Z8', '10D17Z9', '10D17ZZ', '10D18Z9', '10D18ZZ', '10E0XZZ'

Criteria Set 2:

Identify the IP encounter tied to the delivery event (delivery event falls between start and end dates of service, where COS equals IP). Consider all encounters within this span of time to be Labor and Delivery encounters.

2. **Maternity DHCS**

This was taken from Business Rules 001A and 006 from SDN 17041–TSD document provided by DHCS.

Any one of the following conditions (criteria set) must be satisfied:

Criteria Set 1:

A. Any of the 25 diagnosis codes are any of the ICD–10 codes mentioned in Appendix table row code set two of DHCS SDN 17041–TSD document:

'O000' through 'O039', 'O050' through 'O069', 'O080' through 'O089', 'O0900' through 'O0993', 'O10011' through 'O16999', 'O200' through 'O2993', 'O30001' through 'O481', 'O6000' through 'O779', 'O85' through 'O9279', 'O94' through 'O9989', 'Z3400' through 'Z3493', 'Z3A00' through 'Z3A49', 'Z370' through 'Z3799', 'Z390' through 'Z392', 'A34', 'M830', 'O80', 'O82', beginning with ‘F53’, beginning with ‘Z36’, beginning with ‘O9989’, beginning with ‘Z37’

Criteria Set 2:

A. Procedure code is any of the codes mentioned in Appendix table row code set three of DHCS SDN 17041–TSD document:

'00842', '59400', '59409', '59414', '59510', '59514', '59525', '59610', '59612', '59618', '59620', '76946', '80055', '81508', '81511', '82106', '82731', '88267', '88269', 'S0190', 'S0197', 'S0199', 'Z1030', 'Z1032', 'Z1034', 'Z1036', 'Z1038', '01958' through '01965', '01967' through '01969', '59000' through '59076', '59100' through '59160', '59300' through '59350', '59831' through '59857', '59870' through '59899', '76801' through '76828', 'Z6200' through 'Z6500'

Criteria Set 3:

A. Any of the 25 surgical procedure codes are any of the below ICD–10 surgical procedure codes mentioned in Appendix table row code set four of DHCS SDN 17041–TSD document:

'10900ZA' through '10900ZD', '10903ZA' through '10903ZD', '10904ZA' through '10904ZD', '10907ZA' through '10907ZD', '10908ZA' through '10908ZD', '10D00Z0' through '10D00Z2', '10D07Z3' through '10D07Z8', '10Q00YE' through '10Q00YH', '10Q00YJ' through '10Q00YN', '10Q00YP' through '10Q00YT', '10Q00ZE' through ‘10Q00ZH', '10Q00ZJ' through '10Q00ZN', '10Q00ZP' through '10Q00ZT', '10Q03YE' through '10Q03YH', '10Q03YJ' through '10Q03YN', '10Q03YP' through '10Q03YT', '10Q03ZE' through '10Q03ZH', '10Q03ZJ' through '10Q03ZN', '10Q03ZP' through '10Q03ZT', '10Q04YE' through '10Q04YH', '10Q04YJ' through '10Q04YN', '10Q04YP' through '10Q04YT', '10Q04ZE' through '10Q04ZH', '10Q04ZJ' through '10Q04ZN', '10Q04ZP' through '10Q04ZT', '10Q07YE' through '10Q07YH', '10Q07YJ' through '10Q07YN', '10Q07YP' through '10Q07YT', '10Q07ZE' through '10Q07ZH', '10Q07ZJ' through '10Q07ZN', '10Q07ZP' through '10Q07ZT', '10Q08YE' through '10Q08YH', '10Q08YJ' through '10Q08YN', '10Q08YP' through '10Q08YT', '10Q08ZE' through '10Q08ZH', '10Q08ZJ' through '10Q08ZN', '10Q08ZP' through '10Q08ZT', '10Y03ZJ' through '10Y03ZN', '10Y03ZP' through '10Y03ZT', '10Y04ZE' through '10Y04ZH', '10Y04ZJ' through '10Y04ZN', '10Y04ZP' through '10Y04ZT', '10Y07ZE' through '10Y07ZH', '10Y07ZJ' through '10Y07ZN', '10Y07ZP' through '10Y07ZT', '0W8NXZZ', '0WQNXZZ', '10900Z9', '10900ZU', '10903Z9', '10903ZU', '10904Z9', '10904ZU', '10907Z9', '10907ZU', '10908Z9', '10908ZU', '10D17ZZ', '10D18ZZ', '10E0XZZ', '10H003Z', '10H00YZ', '10H073Z', '10H07YZ', '10J00ZZ', '10J03ZZ', '10J04ZZ', '10J07ZZ', '10J08ZZ', '10J0XZZ', '10J10ZZ', '10J13ZZ', '10J14ZZ', '10J17ZZ', '10J18ZZ', '10J1XZZ', '10J20ZZ', '10J23ZZ', '10J24ZZ', '10J27ZZ', '10J28ZZ', '10J2XZZ', '10P003Z', '10P00YZ', '10P073Z', '10P07YZ', '10Q00YV', '10Q00YY', '10Q00ZV', '10Q00ZY', '10Q03YV', '10Q03YY', '10Q03ZV', '10Q03ZY', '10Q04YV', '10Q04YY', '10Q04ZV', '10Q04ZY', '10Q07YV', '10Q07YY', '10Q07ZV', '10Q07ZY', '10Q08YV', '10Q08YY', '10Q08ZV', '10Q08ZY', '10S07ZZ', '10S0XZZ', '10T20ZZ', '10T23ZZ', '10T24ZZ', '10Y03ZE', '10Y03ZH', '10Y03ZV', '10Y03ZY', '10Y04ZV', '10Y04ZY', '10Y07ZV', '10Y07ZY', '30273H1', '30273J1', '30273K1', '30273L1', '30273M1', '30273N1', '30273P1', '30273Q1', '30273R1', '30273S1', '30273T1', '30273V1', '30273W1', '30277H1', '30277J1', '30277K1', '30277L1', '30277M1', '30277N1', '30277P1', '30277Q1', '30277R1', '30277S1', '30277T1', '30277V1', '30277W1', '3E053VJ', '3E0DXGC', '3E0E305', '3E0E33Z', '3E0E36Z', '3E0E37Z', '3E0E3BZ', '3E0E3GC', '3E0E3HZ', '3E0E3KZ', '3E0E3NZ', '3E0E3SF', '3E0E705', '3E0E73Z', '3E0E76Z', '3E0E77Z', '3E0E7BZ', '3E0E7GC', '3E0E7HZ', '3E0E7KZ', '3E0E7NZ', '3E0E7SF', '3E0E805', '3E0E83Z', '3E0E86Z', '3E0E87Z', '3E0E8BZ', '3E0E8GC', '3E0E8HZ', '3E0E8KZ', '3E0E8NZ', '3E0E8SF', '4A0H74Z', '4A0H7CZ', '4A0H7FZ', '4A0H7HZ', '4A0H84Z', '4A0H8CZ',

'4A0H8FZ', '4A0H8HZ', '4A0HX4Z', '4A0HXCZ', '4A0HXFZ', '4A0HXHZ', '4A0J72Z', '4A0J74Z', '4A0J7BZ', '4A0J82Z', '4A0J84Z', '4A0J8BZ', '4A0JX2Z', '4A0JX4Z', '4A0JXBZ', '4A1H74Z', '4A1H7CZ', '4A1H7FZ', '4A1H7HZ', '4A1H84Z', '4A1H8CZ', '4A1H8FZ', '4A1H8HZ', '4A1HX4Z', '4A1HXCZ', '4A1HXFZ', '4A1HXHZ', '4A1J72Z', '4A1J74Z', '4A1J7BZ', '4A1J82Z', '4A1J84Z', '4A1J8BZ', '4A1JX2Z', '4A1JX4Z', '4A1JXBZ'

Criteria Set 4:

A. Claim type is one of the following:

   i. Claim Type 04 = OP

   ii. Claim Type 05 = Medical

and

B. The provider type is not ‘009’ (Lab/Radiology)

and

C. The encounter has any one of the following CPT or CPSP (Comprehensive Perinatal Services Program) procedure codes:

   ‘59000’ through ‘59025’, ‘59030’ through ‘59051’, ‘59070’ through ‘59076’, ‘59100’ through ‘59151’, ‘59200’, ‘59400’, ‘59412’, ‘59300’ through ‘59325’, ‘59425’ through ‘59426’, ‘59510’, ‘59610’, ‘59618’, ‘59812’ through ‘59830’, ‘59870’ through ‘59899’, ‘S0197’, ‘Z1032’, ‘Z1034’, ‘Z1036’, ‘Z6200’ through ‘Z6204’, ‘Z6206’, ‘Z6210’, ‘Z6306’, ‘Z6300’ through ‘Z6304’, ‘Z6400’ through ‘Z6412’, ‘Z6500’

3. **Maternity Mercer**

The following codes are first checked for abortions, which will overwrite a delivery event as NULL if they fall within any of the coding ranges below:

A. Procedure codes ‘59812’, ‘59813’, ‘59814’, ‘59815’, ‘59816’, ‘59817’, ‘59818’, ‘59819’, ‘59820’, ‘59821’, ‘59822’, ‘59823’, ‘59824’, ‘59825’, ‘59826’, ‘59827’, ‘59828’, ‘59829’, ‘59830’,‘59840', '59841', '59850', '59851', '59852', '59855', '59856', '59857', '59866', 'X7724', 'X7726', 'Z0336', '01964', '01966', 'S0190', 'S0191', 'S0199', 'Z2004'

or

B. Diagnosis codes beginning with ‘O040’, ‘O070’, 'O0480', 'Z332', 'Z0371', 'Z0372', 'Z0373', 'Z0374', 'Z0375', 'Z0376', 'Z0377', 'Z0378', 'Z0379'

or

C. IP claim type code with the following IP surgical codes: '10A07ZX', '10A07ZZ', '10A08ZZ', '10A00ZZ', '10A03ZZ', '10A04ZZ', '10A07Z6', '10A07ZW', '3E0E3TZ', '3E0E7TZ', '3E0E8TZ'

Any of the following conditions (criteria set) must be satisfied for an encounter to be considered a Maternity Mercer encounter (note this logic is only applied when the beneficiary's sex is female and the beneficiary's age is between age 12 through 55, inclusive).

Criteria Set 1:

A. The encounter has any of the 25 diagnosis codes with the codes '082', '07582'

or

B. The encounter has any procedure code with the codes '59510' through '59515', '59620' through '59622', 59525, 59618, 01961, 01968

Criteria Set 2:

A. The encounter has any of the 25 surgical codes with codes:

'10D07Z3', '10D07Z4', '10D07Z5', '10D07Z6', '10D07Z8', '10D07Z7', '10D00Z0', '10D00Z1', '10D00Z2', '10D17ZZ', '10D18ZZ', '10D00Z0', '10D17Z9', '10D18Z9', '10E0XZZ'

or

B. The encounter has any of the 25 diagnosis codes with the codes:

'O80'. 'O703', 'O704', 'O709'

or

C. The encounter has a procedure code with the codes:

'59400' through '59410', '59610' through '59614', '59898' through '59899', '01967', '01960', '57022'

Criteria Set 3:

A. The encounter has any of the 25 diagnosis codes with the codes:

'O6010X0', 'O6010X1', 'O6010X2', 'O6010X3', 'O6010X4', 'O6010X5', 'O6010X9', 'O6012X0', 'O6012X1', 'O6012X2', 'O6012X3', 'O6012X4', 'O6012X5', 'O6012X9', 'O6013X0', 'O6013X1', 'O6013X2', 'O6013X3', 'O6013X4', 'O6013X5', 'O6013X9', 'O6014X0', 'O6014X1', 'O6014X2', 'O6014X3', 'O6014X4', 'O6014X5', 'O6014X9', 'O6020X0', 'O6020X1', 'O6020X2', 'O6020X3', 'O6020X4', 'O6020X5', 'O6020X9', 'O6022X0', 'O6022X1', 'O6022X2', 'O6022X3', 'O6022X4', 'O6022X5', 'O6022X9',

'O6023X0', 'O6023X1', 'O6023X2', 'O6023X3', 'O6023X4', 'O6023X5', 'O6023X9', 'O670', 'O678', 'O679', 'O68', 'O690XX0', 'O690XX1', 'O690XX2', 'O690XX3', 'O690XX4', 'O690XX5', 'O690XX9', 'O691XX0', 'O691XX1', 'O691XX2', 'O691XX3', 'O691XX4', 'O691XX5', 'O691XX9', 'O692XX0', 'O692XX1', 'O692XX2', 'O692XX3', 'O692XX4', 'O692XX5', 'O692XX9', 'O693XX0', 'O693XX1', 'O693XX2', 'O693XX3', 'O693XX4', 'O693XX5', 'O693XX9', 'O694XX0', 'O694XX1', 'O694XX2', 'O694XX3', 'O694XX4', 'O694XX5', 'O694XX9', 'O695XX0', 'O695XX1', 'O695XX2', 'O695XX3', 'O695XX4', 'O695XX5', 'O695XX9', 'O6981X0', 'O6981X1', 'O6981X2', 'O6981X3', 'O6981X4', 'O6981X5', 'O6981X9', 'O6982X0', 'O6982X1', 'O6982X2', 'O6982X3', 'O6982X4', 'O6982X5', 'O6982X9', 'O6989X0', 'O6989X1', 'O6989X2', 'O6989X3', 'O6989X4', 'O6989X5', 'O6989X9', 'O699XX0', 'O699XX1', 'O699XX2', 'O699XX3', 'O699XX4', 'O699XX5', 'O699XX9', 'O700', 'O701', 'O7020', 'O7021', 'O7022', 'O7023', 'O740', 'O741', 'O742', 'O743', 'O744', 'O745', 'O746', 'O747', 'O748', 'O749', 'O750', 'O751', 'O752', 'O753', 'O754', 'O755', 'O7581', 'O7589', 'O759', 'Z370', 'Z372', 'Z373', 'Z3750', 'Z3751', 'Z3752', 'Z3753', 'Z3754', 'Z3759', 'Z3760', 'Z3761', 'Z3762', 'Z3763', 'Z3764', 'Z3769', 'Z379', 'O770', 'O771',
'O711', 'O713', 'O714', 'O715', 'O716', 'O717', 'O7181', 'O7182', 'O7189', 'O719', 'O8802', 'O8812', 'O8822', 'O8832', 'O8882', 'O9812', 'O9822', 'O9832', 'O9842', 'O9852', 'O9862', 'O9872', 'O9882', 'O9892', 'O9902', 'O9912', 'O99214', 'O99284', 'O99314', 'O99324', 'O99334', 'O99344', 'O99354', 'O9942', 'O9952', 'O9962', 'O9972', 'O99814', 'O99824', 'O99834', 'O99844', 'O9A12', 'O9A22', 'O9A32', 'O9A42', 'O9A52'

Criteria Set 4:

A. The encounter has a procedure code from ‘59000’ through ‘59899’.

or

B. The encounter has a revenue code of ‘720’, ‘0720’, ‘721’, ‘0721’, ‘722’, ‘0722’, ‘724’, ‘0724’, ‘729’, ‘0729’, ‘112’, ‘0112’, ‘122’, ‘0122’, ‘132’, ‘0132’, ‘142’, ‘0142’, ‘152’, ‘0152’, ‘232’, ‘0232’.

or

C. The encounter has any of the 25 diagnosis codes with the codes:

‘O720','O721','O722'

or

D. The encounter has any 25 surgical procedure codes with the codes:

'0UJD7ZZ', '0JCB0ZZ', '0JCB3ZZ', '0US90ZZ', '0US94ZZ', '0US9XZZ', '10H003Z', '10H00YZ', '10P003Z', '10P00YZ', '10P073Z', '10P07YZ',

'10S07ZZ', '10900ZC', '10903ZC', '10904ZC', '10907ZC', '10908ZC', '0U7C7ZZ', '10D07Z7', '10J07ZZ', '3E053VJ', '10D17ZZ', '10D18ZZ'

Criteria Set 5:

A. The encounter has one of the following procedure codes:

'59425', '59426', 'X8170', 'Z1000', 'Z1008', 'Z1016', 'Z1018', 'Z1020', 'Z1022', 'Z1030', 'Z1032', 'Z1034', 'Z1036', 'Z2008', 'Z2502', 'Z2503', 'Z6410', 'Z6412'

Criteria Set 6:

A. The encounter has a procedure code with the codes ‘59430’, ‘Z1004’, ‘Z1012’, ‘Z1026’, ‘Z1038’

4. **Pregnancy-related “Catch All”**

The following conditions must be satisfied for an encounter to be considered a Pregnancy-related encounter:

A. Identify deliveries for members using the following criteria:

ii. Cesarean birth: Mercer Maternity Criteria 1 (from above).

iii. Vaginal birth: Mercer Maternity Criteria 2 (from above).

iv. Unspecified birth: Mercer Maternity Criteria 3 (from above).

or

i. A member must be included in Maternity Kick Payments file provided by DHCS, which is a file that lists each member who gave birth and the birth month for each member.

All encounters 238 days prior to the delivery event are considered Pregnancy-related encounters.

5. **Emergency Medical Transportation**

The below condition must be satisfied for an encounter to be considered an Emergency Medical Transportation encounter.

A. The encounter has any one of the following procedure codes:

'A0225','A0427','A0429','A0433','A0434'

6. **Emergency Facility**

The following conditions must be satisfied for an encounter to be considered an Emergency Facility encounter:

A. EDS claim type is 04 OP and Emergency Indicator equals YES.

and

B. FQHC National Provider Identifier is not equal to 1.

7. **Emergency Other**

Any of the following conditions must be satisfied for an encounter to be considered an Emergency Other encounter:

A. Place of service code is 0 ER.

or

B. The encounter has any one of the following procedure or revenue codes:

‘0450’, ‘0451’, ‘0452’, ‘0459’, ‘450’, ‘451’, ‘452’, ‘459’, ‘99281’ through ‘99288’.

8. **IP Admissions that Originated Through the ER**

The following condition must be satisfied for an encounter to be considered an Emergency IP encounter:

A. A member has both an ER and IP encounter (using COS) with the same date of service.

9. **Dialysis**

The following condition must be satisfied for an encounter to be considered a Dialysis encounter:

A. The encounter has any one of the following procedure codes:

ii. '90935', '90937', '90940', '90945', '90947', '90951', '90952', '90953', '90954', '90955', '90956', '90957', '90958', '90959', '90960', '90961', '90962', '90963', '90964', '90965', '90966', '90967', '90968', '90969', '90970', '90999', '99512', 'G0257', '0692T', 'S9335', 'S9339'

B. Any member who had an encounter with one of the above procedure codes must also have been diagnosed with end-stage renal disease, acute kidney failure, or stage 5 chronic kidney disease using the following diagnosis codes: ‘N170’, ‘N171’, ‘N172’, ‘N178’, ‘N179’, ‘N185’, ‘N186’

10. **Emergency DHCS**

This was taken from Business Rule 005 from SDN 17041 — TSD document provided by DHCS.

Any one of the below conditions must be satisfied for an encounter to have emergency service(s) for claiming FFP.

A. The provider type is not ‘009’ (Lab/Radiology)

and

B. The claim type is either 05 or 06

and

C. The emergency indicator (C54-CLM-EMERG-IND) in CP-F-54 file is ‘Y.’

or

A. The claim type is either 04 or 06 and emergency indicator (C54-CLM-EMERG-IND) in CP-F-54 file is ‘Y’

or

A. The claim type is 03 and the emergency indicator (C54-CLM-EMERG-IND) in File CP-F-54 is ‘Y’

or

A. The claim type is 03

and

B. Claim form code (C54-CLM-FORM-CODE-0273) in CP-F-54 file is SPACE

and

C. The claim admit type(C54-IN-ADMIT-TYPE) in CP-F-54 file is either 1,3, 4, 6

or

A. The claim type is 03

and

B. Claim form code (C54-CLM-FORM-CODE-0273) in CP-F-54 file is ‘U’

and

C. The claim admit type (C54-IN-ADMIT-TYPE) in CP-F-54 file is 1.

or

A. The claim type is either 04, 05, 06 and the encounter procedure codes is any of the codes mentioned in Appendix table row code set 6 of DHCS SDN 17041–TSD document:

ii. ‘15271’ through ‘15278’, ‘20527’, ‘26341’, ‘27267’, ‘27268’, ‘29582’ through ‘29584’, ‘32421’, ‘32422’, ‘32550’, ‘32551’, ‘33258’, ‘43753’, ‘46930’, ‘49082’ through ‘49084’, ‘51100’ through ‘51102’, ‘51797’, ‘59030’, ‘59050’,

‘59070’, ‘59072’, ‘59074’, ‘59076’, ‘59100’, ‘59120’, ‘59121, ‘59130’, ‘59135’, ‘59136’, ‘59140’, ‘59150’, ‘59151’, ‘59160’, ‘59300’, ‘59350’, ‘59409’, ‘59414’, ‘59514’, ‘59525’, ‘59612’, ‘59620’, ‘59812’, ‘59820’, ‘59821’, ‘59830’, ‘59897’, ‘60300’, ‘62370’, ‘64633’ through ‘64636’, ‘67041’ through ‘67043’, ‘67113’, ‘67229’, ‘68816’, ‘88720’, ‘88740’, ‘88741’, ‘90918’ through ‘90990’, ‘91100’, ‘91105’, ‘91110’, ‘92071’, ‘92072’, ‘92950’, ‘92953’, ‘92970’, ‘92971’, ‘92975’, ‘92977’, ‘92978’, ‘92979’, ‘92980’, ‘92981’, ‘92982’, ‘92984’, ‘92987’, ‘92990’, ‘92995’, ‘92996’, ‘93651’, ‘93652’, ‘93998’, ‘94002’, ‘94003’, ‘94656’, ‘94657’, ‘94728’, ‘94729’, ‘95885’, ‘95887’, ‘95938’, ‘95939’, ‘99281’ through ‘99285’, ‘99291’, ‘99292’, ‘99295’, ‘96360’, ‘96361’, ‘96365’ through ‘96376’, ‘96379’, ‘99296’, ‘99297’, ‘99464’, ‘99477’, ‘C1830’, ‘C1886’, ‘C8929’, ‘C8930’, ‘Q4100’ through ‘Q4114’, ‘Q4122’ through ‘Q4130’, ‘S5000’, ‘S5001’, ‘Z1002’, ‘Z1010’, ‘Z1024’, ‘Z6000’ through ‘Z6042’, ‘Z7502’, ‘Z7504’, ‘Z7506’, ‘Z7508’, ‘Z7510’, ‘Z7610’, ‘Z7612’.

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

Services provided by Mercer Health & Benefits LLC.