Mercer

Government Human Services Consulting

Medi-Cal Managed Care

Capitation Rate Development and Certification

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

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Contents

Section 1

Executive Summary

The State of California Department of Health Care Services (DHCS) contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to develop actuarially sound capitation rates for use during the rating period of January 1, 2025 through December 31, 2025 (calendar year [CY] 2025). The capitation rates that are the subject of this certification report are for the Mainstream managed care program, which includes the following models:

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

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

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

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

Multiple attachments are included as part of this rate certification package. These attachments include summaries of the CY 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 certified capitation rates by rating region and category of aid (COA) groupings (synonymous with rate cell), including a comparison to the prior CY 2024 certified capitation rates, can be found in the attached file, *CY 2025 Medi-Cal Rate Summaries 2024 12.xlsx*.

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

Within the CY 2025 rating period, there were several changes to the program and also in the development of the capitation rates. Some notable items are listed below:

- The implementation of the California Advancing and Innovating Medi-Cal (CalAIM) proposal is continuing, which is a multi-year initiative by DHCS to improve the quality of life and health outcomes for the Medi-Cal population. Multiple components of this initiative are addressed throughout the body of this report.
- The State re-procured the contracted health plans within the Medi-Cal managed care program. As part of this process, there were new contractors in various regions across the State, effective January 1, 2024.

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

A comparison of the certified CY 2025 capitation rates to the certified CY 2024 capitation rates is also provided in an attachment. Each certified CY 2025 rate is compared to the capitation rates certified within the CY 2024 rating period. There are

instances where there are large changes at the rating region and COA level in this comparison. There are many potential drivers of this depending on the rate cell being reviewed, including an updated year of base data, managed care organization (MCO) tax, adjustments for the reprocurement, and emerging experience.

It should also be noted there will be a future amendment to this certification that will be submitted to CMS. The potential updates include a new State directed payment for non-hospital 340B providers and the impacts of Proposition 35.

Section 2
General Information

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

- Program history
- 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

California's managed care delivery models have been in existence since the 1980s. There have been various changes in the model types over the years. With the procurement effective January 1, 2024, there are five models within the Mainstream managed care program, listed below:

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

local and one commercial) operate with an option for Kaiser in all counties except Alpine.

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

Effective January 1, 2023, the CCI program ended, and members previously covered under CCI transitioned into their respective non-CCI managed care models. The CY 2025 capitation rates were developed inclusive of these (and other) transitioning members; there are no longer rates specific to the CCI program. Now, capitation rate development for CCI Full-Dual eligible members, in addition to non-dual and partial dual members (as in prior years), are covered within this certification.

The Mainstream managed care program encompasses all 58 counties within California. For capitation rate payment purposes, counties are consolidated into rating regions (with rating regions consisting of one or more counties). Within each rating region, MCPs are paid a capitation rate for each county in which they operate. For a list of rating regions and their applicable counties, please refer to the Excel file titled *CY 2025 Medi-Cal Rate Summaries 2024 12.xlsx*.

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

Medi-Cal Plan Participation

For CY 2025, there are 22 distinct MCPs operating in the Mainstream managed care program. Each MCP has different regions in which they operate. Some MCPs only operate in one region while other MCPs operate in multiple regions. For a complete list of the MCPs and regions in which they operate, please see the rate summary sheets, which can be found in the attached Excel file titled *CY 2025 Medi-Cal Rate Summaries 2024 12.xlsx*. Capitation rates are set at the regional level and risk adjusted to create capitation rates for each MCP at the rating region and COA level.

Covered Services

Generally, services covered through the Mainstream managed care program include hospital services (including inpatient [IP], outpatient [OP], and emergency room [ER] services), physician services, applied behavioral analysis services, transportation services, laboratory and radiology services, hospice care services, and community-based adult services (CBAS). Additionally, mental health (MH) services for members with mild to moderate MH needs and conditions are covered.

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

Notable services carved out of the Mainstream managed care program (with exceptions listed below) include the following:

- Specialty MH services (including IP and OP behavioral health [BH] services).
- Alcohol and substance use disorder treatment services.
- Home- and Community-Based Services (HCBS) (apart from CBAS in all counties).
- Dental services (except medically necessary federally required adult dental services and fluoride varnish dental services that may be performed by a medical professional) are carved out, apart from members covered by the Health Plan of San Mateo (HPSM) under their pilot dental program.
- Administration and ingredient costs of Coronavirus Disease 2019 (COVID-19) vaccines.
- Services covered under the California Children's Services (CCS) program in one COHS and all GMC, Regional, Single-Plan, and Two-Plan counties. In all COHS counties excluding Ventura, CCS services are a managed care covered benefit. CCS-eligible members in these counties make up the WCM rate cell.
- Effective January 1, 2022, the following pharmacy benefits, when billed by a pharmacy on a pharmacy claim: covered OP drugs, including physician administered drugs, medical supplies, and enteral nutritional products.

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

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

- Major organ transplants (MOT) in GMC, Regional, Single-Plan, and Two-Plan counties (these were already covered in COHS counties and only kidney and corneal transplants were covered in non-COHS counties)
- Enhanced care management (ECM) services
- 14 Community Supports (CS) services are allowable in the MCP contracts in accordance with 42 CFR § 438.3(e) and/or the terms and conditions of California's 1115 and Section 1915(b) waivers.

Covered Populations

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

As part of the CalAIM initiative, various additional populations have or will become enrolled in managed care effective from CY 2022 through CY 2025. Additional details on the transitioning populations can be found in the "Data" and "Projected Benefit Costs and Trends" sections of this report.

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

Rate Structure

The base data sets used to develop the Mainstream CY 2025 capitation rate ranges were divided into cohorts representing consolidated COA (or aid code) or supplemental groupings, which inherently represent differing levels of risk. Rate ranges are developed for each of these cohorts. As noted for the COA and supplemental payment groupings below, there are differences that exist across the various counties. The COA groups for which capitation rates are paid and supplemental payment groupings are listed below (with variations noted as well).

Capitation Rate Category of Aid Groups (Rate Cells)

- Child
- Adult
- ACA Expansion
- SPD-LTC
  - This COA consists of SPD members, partial dual eligible members with an SPD or ACA Expansion aid code, and LTC aid code members
- SPD-LTC/Full-Dual

  - This COA consists of SPD/Full-Dual members, Full-Dual eligible members with an ACA Expansion aid code, and Full-Dual members with an LTC aid code.

- WCM (applicable in all COHS counties except Ventura County)

New for CY 2025, in all regions, the SPD and LTC COA groups were blended into one capitation rate payable for members in either COA group and the SPD/Full-Dual and LTC/Full-Dual groups were blended into one capitation rate payable for members in either COA group. Previously, in CY 2024, a blended rate was paid only in counties that were COHS counties prior to January 1, 2024.

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

Maternity Supplemental Payment

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

Federal Medical Assistance Percentage

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

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

Populations that receive a higher FMAP than the regular FMAP include the Breast and Cervical Cancer Treatment Program (BCCTP) population (a subset of the SPD-LTC population) who meet federal standards, the CHIP population, and the ACA Expansion population. For CY 2025, the BCCTP and CHIP populations receive 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.

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

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

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

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

Rate Methodology Overview

Capitation rates for the Mainstream 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; however, this report certifies to a final rate within the developed rate ranges as federally required.

For rate range development for the Mainstream managed care program, Mercer used July 1, 2022 through June 30, 2023 (state fiscal year [SFY] 2022–23) MCP-reported encounter data, the SFY 2022–23 rate development template (RDT) data (from direct contractors with DHCS and also the MCPs' global subcontractors) and other ad hoc claims data reported by DHCS and the MCPs. The most recently available, quarterly submitted, Medi-Cal-specific financial reports at the time the rate ranges were determined were also considered in the rate range development process.

The RDT data used in the development of the rate ranges is data collected from each MCP within the Medi-Cal managed care program separately for each rating region in which each MCP operates. The data requested from each MCP is completed by the MCPs at the level of detail needed for rate setting purposes, which includes membership, medical utilization, and medical cost data for the most recent time periods (SFY 2022–23 for the CY 2025 rate ranges) by COA group and by category of service (COS).

Adjustments were made to the selected base data to match the covered population risk and the State Plan approved benefit package for CY 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.
- Budget-neutral relational modeling for smoothing.
- Any observed changes in the population case mix and underlying risk of the MCPs from the base data period.
- Trend factors to forecast the expenditures and utilization to the rating period.
- Administration and underwriting gain loading.

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

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

The above approach has been utilized in the development of the rate ranges for the CY 2025 Mainstream managed care program. DHCS will offer the final certified rates within the actuarially sound rate ranges by region, with MCP-specific risk-adjustment factors applied. Each MCP 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 a medical loss ratio (MLR) greater than 85%. Mercer reviewed available annual MLR reports for CY 2021 and CY 2022 as well as recent quarterly financial information. While some select MCPs' reported MLRs were under 85% in recent years, the program-wide MLR has been greater than 85%. In addition, Mercer's review of recent quarterly financial information and emerging experience has demonstrated an overall recent increase in MLRs and indicates MCPs have a reasonable likelihood of achieving an

MLR of at least 85% for CY 2025. This recent experience was considered in the development of rates as described in the "Recent Experience Review" subsection of Section 3. Data.

The CY 2025 internal rate ranges utilize a full rebase incorporating the most complete and current data period (SFY 2022–23). This rebase, along with the non-medical loads, detailed below by model, result in aggregate priced-for effective MLRs greater than 85%.

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

- GMC, Regional, Single-Plan, and Two-Plan models:
  - Assumed upper bound MLR: 100%–12.4% (upper bound non-medical load) = **87.6%.**
  - Assumed lower bound MLR: 100%–8.6% (lower bound non-medical load) = **91.4%.**
- COHS models:
  - Assumed upper bound MLR: 100%–12.7% (highest upper bound non-medical load across COHS plans) = **87.3%.**
  - Assumed lower bound MLR: 100%–8.9% (highest lower bound non-medical load across COHS plans) = **91.1%.**

For CY 2025, the State will impose remittance provisions related to this MLR. Any revenue will 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 each MCP, Mercer provides DHCS with rate ranges developed using an actuarially sound process. The COA-specific rate ranges were developed using appropriate actuarial considerations to arrive at both a lower and upper bound rate. To the extent the final contracted rates fall within the bounds of the Mercer rate ranges, the contracted rates will be determined actuarially sound and certified as such. Mercer is certifying the contracted rates and not the rate ranges.

The lower and upper bounds of the rate ranges are developed by varying certain assumptions throughout the rate development process. Once the "Mercer estimate" assumptions are determined, the assumptions are then varied by an appropriate amount to reflect a degree of uncertainty and the potential for variability in actual results by 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 rate range development was MCP encounter data, requested MCP RDT data (including global subcontracting MCP RDTs), FFS data for certain transitioning populations and services, ad hoc claims data, and financial reporting. SFY 2022–23 served as the base data period. The SFY 2022–23 encounter and SFY 2022–23 RDT claims data included utilization and unit cost detail by COA group, immigration status, region, MCP, and 18 consolidated provider types or COS, including:

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

New to the SFY 2022–23 base are the CS and ECM COS. Both were CalAIM initiatives effective January 1, 2022 and collected as part of the RDT.

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, MCP RDT and encounter data served as the starting base data for rate setting as well as FFS data for certain transitioning populations and services described later in this section. Mercer assessed the quality, timeliness, and completeness of the data per Actuarial Standard of Practice number 23, *Data Quality,* to deem the data sufficient to support rate setting. This assessment included reviewing the submitted MCP RDT and encounter data for changes year-over-year, and inclusive of the FFS data, for errors in reporting, overall reasonableness, and consistency across data sources to ensure it was appropriate to incorporate into rate development. The RDT data submissions are thoroughly reviewed, vetted, and discussed with each MCP during the rate setting process. Encounter data undergoes considerable edits within DHCS to ensure quality and appropriateness of the data for rate setting purposes. Base period MCP COA eligibility (described below) and encounter data were pulled consistent with service code mappings from DHCS, including lists of excluded services, such as State-only funded abortion services. Mercer has relied on data and other information provided by the MCPs and DHCS in the development of these rate ranges. Mercer did not audit the data or information, and if the data or information is materially incomplete or inaccurate, Mercer's conclusions may require revision.

The RDT submissions already include incurred but not reported (IBNR) adjustments which are reviewed for appropriateness and discussed with the health plans as part of the rate development process. If necessary, adjustments were applied to amounts reported by the health plans based on this review. The encounter data received adjustments to reflect potential underreporting and additional runout and was ultimately completed to align with the RDT reported information across all service categories. These factors are applied to recognize that the encounter data may be underreported by the MCPs (e.g., encounters from providers who are paid via a capitation arrangement may be understated), and potentially not reflective of all liabilities still outstanding for the base period.

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

As mentioned in earlier sections, the base data is separated by immigration status before the application of any base data adjustments. Global subcontractor RDT reporting also played a large role in the development of the region average base. The final base data, after base data adjustments and smoothing, is further adjusted to

reflect the impact of historical program changes, trend applications, and potential managed care adjustments. This is discussed in later sections in the certification report.

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

Base Data Adjustments — Medi-Cal Managed Care Plan-Specific

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

Some MCPs choose to enter into global subcapitation arrangements (defined as delegating the entire or vast majority of the risk of a beneficiary to another MCP) to administer managed care coverage for some of their Medi-Cal population. Specific to base data assumptions for members who are globally subcapitated from one MCP to another, two sources of data are used: actual experience based on the global MCPs' reporting, and payment amounts from the direct MCP to the global MCP. The base data adjustments below are specific to the actual experience as reported by the global MCP. Within the final development of base data for globally subcontracted members, a 50% weight is given to the global MCP-reported experience and 50% based on the direct payments to the global MCP.

Additional Claims Runout

Due to the timing of the RDT submissions, the SFY 2022–23 RDT base data as reported by the plans only had claims runout through August 2023. While MCPs are instructed to include assumptions for completion, this limited runout lends to a higher dependency on each MCP's estimate of IBNR rather than actual claims especially in the later months of the base period. To reduce this possible variance from actual experience, a refresh of one reporting schedule in the RDT, which includes claims lag triangles, capitation payments, settlements, and the plan's estimate of remaining

unpaid claim liability, was requested at a later time to allow for more claims runout. In this refresh, claims incurred dates aligned with the original submission; however, plans used a claims runout of no earlier than February 2024. The original and restated IBNR schedules were compared and the SFY 2022–23 base data was adjusted to align with the amounts reported in the refreshed schedule, accounting for the additional runout and in turn, reduction in estimated outstanding liability. This adjustment reduced the SFY 2022–23 base data costs by approximately $156.0 million statewide across all COA groups.

San Francisco Health Plan Hospital Adjustment

San Francisco Health Plan (SFHP) communicated to DHCS/Mercer of a contract change with a large hospital provider in San Francisco effective January 1, 2023. Previously, SFHP and the hospital had a capitation arrangement for provided services. However, the hospital requested a restructuring of the payment arrangement into an FFS contract. As this contract change was known prior to the rating period and only partially reflected in the base, DHCS/Mercer elected to make a base data adjustment and worked with SFHP to develop the adjustment.

SFHP repriced the services rendered at the hospital to provide an estimate of the change in base data costs due to the updated contracts. SFHP reviewed SFY 2022–23 encounters and repriced them to be in line with the contracted FFS rate. DHCS/Mercer reviewed their analysis and, along with comparison to hospital costs for nearby health plans, found the results reasonable and appropriate. Across all COA groups, this adjustment, increased the SFY 2022–23 base data costs by approximately $24.3 million.

Maternity Base Data Carve-Out

The RDT-reported experience for maternity delivery events was removed from the SFY 2022–23 base data by COA and COS. This was done since costs for delivery events are covered through a supplemental payment. The SFY 2022–23 RDTs required MCPs to separately report maternity utilization and cost data for each of the COAs (Child, Adult, ACA Expansion, and WCM) that are subject to the maternity supplemental payment. The data was reviewed for reasonableness, compared to prior year values, and deemed reasonable to use in this adjustment. This adjustment removed approximately $1.128 billion from the SFY 2022–23 base data.

Provider Incentive Adjustments

Within the MCP-submitted RDTs, there is a schedule for MCPs to describe their provider incentive arrangements, in addition to providing the amounts paid under those arrangements. Through a review of this information, there was one incentive arrangement, reported by California Health & Wellness, that was deemed not appropriate to include in the base data as it was a profit-sharing arrangement, and not indicative of expected future cost levels during the contract period. Approximately $2.7 million was removed from the SFY 2022–23 base data due to this adjustment.

Value-Added Services Carve-Out

As part of the RDT data submissions, the MCPs were required to report costs for services that were not a part of the State Plan benefit package during the SFY 2022–23 base data period but were provided as value-added services. This adjustment removed all costs for the entire SFY 2022–23 base data period for value-added services.

Across all of Mainstream, approximately $23.6 million was removed from the SFY 2022–23 direct base data because of this adjustment.

COVID-19 Temporary Unit Cost Increase Carve-Out

Due to the impact of the COVID-19 pandemic, some health plans made enhanced payments to various providers that otherwise would not have been made. These costs, characterized as temporary and related to the public health emergency (PHE), were collected by quarter as part of the RDT data. These are all expenses that were voluntarily made by the MCPs with no direction of payment from the State. Examples of these costs include increased facility payments for COVID-19 isolations and incentive payments to encourage continued preventive care utilization. A description provided by the health plan was reviewed for each of these costs to confirm they were truly temporary in nature and would not be carried forward to the contract period. Approximately $65.4 million was removed from the base data for this adjustment.

Cal Medi-Connect Base Data Development

From July 2022 through December 2022, the Cal Medi-Connect (CMC) program was in effect, with the discontinuation of the program effective January 2023. This program was specific to the dual eligible population in CCI counties, where a single plan covered all Medi-Cal and Medicare related costs. Cost and utilization information from the July 2022 through December 2022 time period was under this program, and data from this time period was used in the development of the base data for the affected dual population. The base data starting point for the CMC populations in CCI counties was the combined Medi-Cal, Medicare, and “Unable to Separate” cost and utilization reported by the health plans in the RDT submissions. The CMC adjustment reduces the base data to reflect only the Medi-Cal liability. Similar to the historical CCI rate development process, Mercer reviewed each plan’s reported Medi-Cal expense as a percentage of the total to determine if the plan’s reporting of Medi-Cal liability was reasonable and appropriate for rate setting. If deemed reasonable, Mercer adjusted the total CMC spend to reflect the health plan-reported CMC Medi-Cal expense; otherwise, the CMC base utilization/per member per month (PMPM) was set equal to that of the health plan’s direct member experience for the CMC eligible but not enrolled (EBNE) population. For health plans with a CMC contract in LA County, that are not also a direct contractor in that county, their CMC member months were assigned to the prime health plan they contract with for other populations (e.g., EBNE), along with a cost/utilization profile equal to that prime health plan’s global EBNE population. This member transition is consistent

with the sunset of CCI, and the exclusively aligned enrollment process when CMC health plans transitioned to Dual Eligible Special Needs Plans. Further, as pharmacy costs were still a managed care covered benefit through the end of December 2022 for CMC populations, pharmacy costs were also removed in the development of CMC base data.

This adjustment carved approximately $1.0 billion dollars out of the SFY 2022–23 base period, representative of both the Medicare liability and pharmacy costs for these CMC members. The resulting CMC specific experience (member months, dollars, and units by COA) after this adjustment was then added into the applicable MCP and COA.

Kaiser and Aetna Base Data Development

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

Kaiser Foundation Health Plan

Consistent with prior rating periods, Kaiser's RDT-reported information was not deemed fully credible to use in the development of base data. For CY 2025, three sources for Kaiser base data were utilized, each described below:

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

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

2. A repriced version of the Kaiser RDT data

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

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

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

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

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

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

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

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

Aetna Better Health

Consistent with prior rating periods, Aetna RDT-reported information alone was not deemed fully credible to use in the development of base data. Aetna exited the Medi-Cal managed care program effective January 2024. While Aetna is not operating in the Medi-Cal managed care program in CY 2025, their members' experience needs to be accounted for as part of the base. To develop Aetna's portion of the Sacramento and San Diego base data for CY 2025, a credibility weighted blend of the risk-adjusted region average data (consistent with the process for Kaiser described above) and a pure region average excluding Aetna was used.

Shift of Eligible Members into Whole Child Model

With the expansion of WCM into Mariposa, San Benito, and the Rural Upper Central region, eligible CCS children in these regions and their associated managed care paid costs were shifted out of their existing rate cell to the WCM rate cell. At this point in the process, the WCM rate cell did not include their FFS paid CCS costs. These costs were added at a later step in the base data development process.

All base data adjustments described up to this point are based on direct member experience and actual experience for globally subcontracted members. The remaining base data adjustments are for the globally subcontracted member data only, and represent adjustments made to the component of the base data related to the payment amounts paid by the direct MCP to the globally subcontracted MCPs. For globally subcontracted members, base data is based on 50% actual RDT experience and 50% direct to global payments.

Global Coordinated Care Initiative Capitation Payment Risk Stratification

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

Within CCI counties, some MCPs utilized a blended rate for their globally subcapitated CCI Full-Dual populations, similar to the historical capitation payment structure from DHCS to the MCPs for these members. Consequently, some MCPs reported PMPMs in their RDT that were equivalent (or nearly equivalent) across all their globally subcontracted CCI Full-Dual COA groups (e.g., Adult, SPD/Full-Dual, and LTC/Full-Dual) and CCI populations. In these instances, to appropriately reflect the relative risk of these COA groups, Mercer developed relativity factors based on direct member PMPMs, and the population mix of global members for each of these MCPs, effectively shifting dollar amounts between COA groups and the CCI populations in a budget neutral fashion.

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

For members covered by Kaiser in Solano County, MH services to treat beneficiaries with a serious mental illness (SMI) have historically been included in the subcapitation rate paid by Partnership HealthPlan of California (PHC) to Kaiser. For CY 2025, as this is no longer a covered service, this adjustment removed $3.8 million paid by PHC to Kaiser for SMI services from the Solano County base data.

Global Unsatisfactory Immigration Status Capitation Payment Risk Stratification

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

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

Due to a change in COA age definitions from the base period to the contract period, MCPs were requested to shift 19–20 year olds from the Adult COA to the Child COA within the RDT. For global subcapitation payments, while plans reported subcapitation payments associated with these members to align with the new COA definitions, these payments still represented the old COA age definition (i.e., Adult subcapitation payments for 19–20 year olds were present within the Child COA). To better reflect the acuity of these members, a budget neutral adjustment was applied to shift subcapitation payment amounts between the two COAs within a given plan to align with the 19–20 year olds now in the Child COA for CY 2025. The statewide impact of this transition shifted $41.2 million in global subcapitation payments from Child to Adult.

Global Rebase and Non-Medical Expense Adjustment

Within the CY 2025 rate development process, a 50%/50% blend of global reported experience as well as the medical component of direct to global subcapitation payments was used to form the base data for members delegated in global subcontractor arrangements. Similar to prior rating periods, these direct to global subcapitation payments were reduced by appropriate non-medical loads to reflect the medical component of subcapitation in the base; 6% for instances where the global subcontractor was Kaiser, and 8% otherwise.

Aggregate Into CY 2025 Rate Cells

All adjustments noted above were done to MCP-specific data at the COA level consistent with RDT reporting. In this step, the base data, after the adjustments described in this section, was aggregated to the region level, consistent with the regions that capitation rates are paid out to the MCPs. Further, the SPD and LTC, as

well as, SPD/Full-Dual and LTC/Full-Dual COAs were collapsed into the SPD-LTC and SPD-LTC/Full-Dual rate cells respectively, statewide.

All steps in the base data development process noted above only includes populations and services present within managed care during the base data period. The next subsections describe the FFS data that was used in the development of the base data, including various transitioning populations from FFS to managed care as well as services for some existing managed care beneficiaries moving from FFS to managed care. All data noted below was grouped consistently with the COA structure after the SPD and LTC blend for non-duals and Full-Duals.

San Benito Fee-For-Service Transitioning Population Base Data

Effective January 1, 2024, San Benito County transitioned from a voluntary managed care county to a mandatory managed care county. During the SFY 2022–23 time period, approximately 50% of members in San Benito County were in an MCP. With San Benito's transition, the MCP RDT does not sufficiently represent the base costs for these members in SFY 2022–23. In order to supplement the existing San Benito MCP RDT data, FFS members, who would have been in managed care prior to the CalAIM transitioning populations (which began in CY 2022) if not for San Benito's voluntary status, were identified and their associated cost profile was combined with the existing MCP RDT data.

Fee-For-Service Transitioning Population Base Data

Effective January 1, 2023 and January 1, 2024, certain FFS populations were transitioned from the FFS delivery system to managed care. In the prior year rates, these populations were accounted for through program change adjustments. For CY 2025 rates, these populations were moved into the base data development process. The populations adjusted for within the base data are the following (with additional transitioning populations accounted for within the program change adjustments):

- Beneficiaries with an Applicable LTC Aid Code — Beneficiaries with one of the four LTC aid codes (13, 23, 53, or 63) transitioned into Medi-Cal managed care effective January 1, 2023. Beneficiaries with an LTC aid code will be classified within the SPD-LTC and SPD-LTC/Full-Dual COAs for rate setting and capitation payment purposes.
- LTC Utilizers in Non-LTC Aid Codes — The LTC utilizers in non-LTC COA population consists of members in FFS who reside in an institutional setting, but do not have one of the aforementioned LTC aid codes. In non-CCI and non-COHS counties, these members transitioned to managed care effective January 1, 2023, and can be found in any COA group, depending on the aid code of the beneficiary.
- Dual eligible beneficiaries in non-CCI and non-COHS counties — This population consists of FFS beneficiaries with either Medicare Part A or Medicare Part B coverage in GMC, Regional, Single-Plan, and Two-Plan counties. This population

transitioned from voluntary managed care status to mandatory managed care status on January 1, 2023. This population was most impactful to the SPD-LTC and SPD-LTC/Full-Dual COA groups.

- Intermediate Care Facilities-Developmentally Disabled (ICF-DD) and Subacute (SA) LTC Populations — The ICF-DD and SA populations consist of members in FFS who reside in either type of these two institutional settings. ICF-DD members were carved out of managed care in all GMC, Regional, Single-Plan, and Two-Plan counties during the base period, while SA beneficiaries were carved out of managed care in only GMC, Regional, Single-Plan, and Two-Plan non-CCI counties. These members transitioned to managed care effective January 1, 2024, and can be found in any COA group, depending on the aid code of the beneficiary.
- San Benito Mandatory Managed Care Transition — FFS members in San Benito were transitioned into Medi-Cal managed care effective January 1, 2024.

SFY 2022–23 FFS data served as the base data for these populations. For the FFS data, once the appropriate members and claims were identified, the following adjustments were made to make FFS claims more appropriate for the expected costs in managed care:

- Repriced FQHC FFS units to managed care costs, which do not reflect wrap-around payments made by DHCS.
- Excluded claims for services that would not be covered by MCPs.
- Excluded abortion and delivery claims for the Child, Adult, ACA Optional Expansion, and WCM COAs.

Once these adjustments were made, this FFS data was combined with the applicable managed care data by region, COA, and COS to arrive at the base data inclusive of the managed care and FFS populations, and representative of membership into the CY 2025 contract period.

CCS Services for Transitioning WCM Regions

As noted previously, the WCM program will expand to eligible members in Mariposa, San Benito, and the Rural Upper Central region on January 1, 2025. These members were generally already enrolled in managed care during the base data period, but costs associated with the CCS program were carved out of managed and covered through FFS for these members. To account for the new managed care coverage of this benefit, FFS-specific CCS costs for these beneficiaries from the SFY 2022–23 time period were added to the WCM COA base data in these three regions.

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

Data Smoothing

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

Smoothing and Data Credibility Adjustment Process

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

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

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

The credibility factors can be different for each region, COA, and COS. Depending on the member months for the base data year (SFY 2022–23) for a given region and COA combination, base factors are established, giving credibility to the region-specific RDT data, region-specific encounter data, smoothed RDT data, and smoothed encounter data. Larger member month counts correspond to more credibility given to the region-specific RDT and encounter data and less to the smoothed amounts. For example, for a fully credible region based on member months exceeding 25,000, these amounts would be 45% region-specific RDT data, 45% region-specific encounter data, 5% smoothed RDT data, and 5% smoothed encounter data. For a smaller COA, having less than 5,000 but greater than 2,500 member months, these amounts would be 36% region-specific RDT data, 36% region-specific encounter data, 14% smoothed RDT data, and 14% smoothed encounter data.

Another component of this process includes having the RDT and encounter data run through smoothing ranges, based on reasonable ranges of PMPM and unit cost. If the region-specific data (separate by COA and COS) is not deemed reasonable (i.e., does not fit into the smoothing ranges), that region-specific data element is given zero credibility, and the base factors are renormalized to add to 100%. For example, if the region-specific encounter data was not deemed reasonable, but the RDT was reasonable, these amounts would be 81.8% region-specific RDT data,

0% region-specific encounter data, 9.1% smoothed RDT data, and 9.1% smoothed encounter data for a fully credible COA. Based on this, it is possible for either or both region-specific RDT and encounter data to be deemed unreasonable. For the latter, all credibility would be given to the smoothed values.

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

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

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

Relational Modeling

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

Base Data Adjustments — Region-specific

After the smoothing process described above, the following adjustments were applied at the CY 2025 region level.

Emergency Department Efficiency Adjustment

Mercer performed a retrospective analysis of the SFY 2022–23 encounter data to identify emergency department (ED) visits considered preventable or preemptive. For the CY 2025 rate development, Mercer analyzed preventable or preemptive low acuity non-emergent (LANE) visits. This analysis was not intended to imply members should be denied access to EDs or MCPs should deny payment for ED visits. Instead, the analysis was designed to reflect DHCS' objective that MCPs provide effective, efficient, and innovative managed care — care that could have prevented or preempted some members' need to seek care in the ED setting for low acuity, primary care treatable conditions.

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

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

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

The components of the replacement cost offset include:

- Physician office visit
- Laboratory
- Radiology

These replacement cost offsets are calculated by determining the cost of an average E&M visit (statewide) using Current Procedural Terminology (CPT) codes 99201–99215, average costs of common laboratory tests, and average costs of common radiology testing. The replacement cost offsets dampen the value of

potentially preventable LANE visits by adding costs back into the rate in recognition that care, and services would still need to be rendered in an OP setting.

The adjustment is applied to the Child, Adult, ACA Expansion, and SPD-LTC COA groups, and varies by each region and immigration status (SIS and UIS). This adjustment reduced the base by approximately $120.5 million.

Potentially Preventable Admissions

For CY 2025, DHCS is utilizing an adjustment to the managed care IP base data that analyzes levels of inefficiency and/or potentially avoidable expenses present in the MCP encounter data.

Potentially preventable admissions were identified through the SFY 2022–23 Medi-Cal MCP encounter data using criteria from the Agency for Healthcare Research and Quality (AHRQ) Guide to Prevention Quality Indicators (PQI) and Pediatric Quality Indicators (PDI). Additional exclusions for enrollment duration and risk were made as part of the analysis.

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

The adjustment is applied to the Child, Adult, ACA Expansion, and SPD-LTC COA groups, and varies by each region and immigration status (SIS and UIS). This adjustment reduced the base by approximately $408.5 million.

Physician Administered Drugs

The final efficiency adjustment Mercer completed was to identify potentially avoidable costs due to reimbursement inefficiencies for physician-administered medications. Mercer reviewed the MCP SFY 2022–23 professional and OP encounter data to identify drug-related Healthcare Common Procedure Coding System (HCPCS) codes and potential savings associated with those codes.

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

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

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

This adjustment was applied to both the OP and Specialty Physician COS' to reflect where physician administered drugs are expected to occur.

Los Angeles County Cost-Based Reimbursement Clinics

In LA County for the SPD-LTC COA and FQHC COS only, in addition to the general base data development of the FQHC COS, the base data includes an additional adjustment to account for the portion of the cost-based reimbursement clinics (CBRC) costs not historically reflected in the base data and not reported in the RDT data. For CY 2025, these costs are reflected within the base data adding $61.47 (SIS) and $5.36 (UIS, Federal component) PMPM to the LA County SPD-LTC base.

The data for this adjustment utilized SFY 2022–23 CBRC experience provided by LA County Department of Health Services. This data reflected the LA Care and Health Net SPD CBRC experience from this period, which aligned with the base data utilized for rate setting. The SFY 2022–23 RDT information from each of the MCPs was also utilized as it represented the baseline information prior to the subsequent adjustment. The differential between the amounts of LA County Department of Health Services reported experience for each MCP and the underreported MCP experience dictated the needed adjustment.

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

Institution for Mental Disease

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

Existing Care Coordination Carve

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

Unsatisfactory Immigration Status Federal Percentage Development

Up to this point, all base data for the UIS population contained all services, including federally eligible and state only services. As a result, an adjustment was needed to limit the UIS base data to federal services only. In the development of the percentage of the UIS base data for federally eligible services, SFY 2022–23 encounter data for the UIS population was utilized by analyzing both pregnancy-related and emergency services PMPM spend as a percentage of total UIS PMPM spend. The percentage of UIS dollars for pregnancy-related services and the percentage of UIS dollars for emergency services were analyzed and developed separately. However, the total of the two components makes up the total federal percentage that drives the base data calculation. Within the coding logic, various flags in the data were derived and services were flagged as either pregnancy-related or emergency using a hierarchy logic so each encounter or FFS claim only flagged once as either pregnancy-related or emergency. No encounters or FFS claims were flagged twice in the event that a service was flagged as both pregnancy-related and emergency-related. The coding logic used to derive the federal percentages (both emergency- and pregnancy-related services) can be found in Appendix A.

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

The result of this was PMPM amounts by region, COA, and COS for the UIS population for pregnancy-related and emergency services, as a percentage of the total UIS PMPMs, separately. In the development of the percentages utilized for the federal capitation rate development, smoothing ranges were developed at the COA and COS level separately for pregnancy-related and emergency services. The smoothing ranges were developed based on a review of each region’s data points for the same COA and COS combination. In the smoothing process, if a region-specific percentage fell within the smoothing range, this value was accepted and used in the calculation of a statewide average percentage of total UIS dollars. This was done separately for pregnancy-related and emergency percentages. The result of this was

a statewide average percentage of total UIS PMPM spend that is for pregnancy-related and emergency services, by COA and COS. These statewide federal percentages (the sum of pregnancy-related and emergency percentages) were then blended with the region-specific federal percentages to derive the federal percentages applied for each region, by COA and COS. A 50% factor was used for the region percentages and the remaining 50% factor was used for the statewide average percentages. This blend was done to introduce variation seen in the percentages by region. These final blended percentages were then applied to the UIS base data in total by region, COA, and COS to derive the UIS base data for federal services only. Remaining services for the UIS population are included in the state-only rates that are not part of this certification.

Effective January 1, 2025, DHCS changed the federal services definition specific to post stabilization services provided during IP hospital stays that originated through the ED. 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 ED or had an IP admission code indicating an emergency.

To derive the adjustment to the federal percentages as a result of this change, only IP records that originated through the ED 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 ED). 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.

Recent Experience Review Adjustment

Within the program over the past several years, there have been many changes. These changes include, but are not limited to, the recent MCP re-procurement, transitioning/expanding populations (in particular the LTC transitioning members), the ongoing Continuous Coverage Unwind (CCU), and the implementation of ECM and CS. As a result of these changes over the past several years, a review of recent experience past the base data period of SFY 2022–23 was necessary. As MCP-submitted SFY 2023–24 RDT data was available at the time of rate development, the additional data (specifically January 2024 through June 2024) was reviewed and compared to experience from the SFY 2022–23 base time period. Specifically, projected medical expenses from the rates based on the SFY 2022–23

base period with applicable adjustments to project these costs into CY 2025 were reviewed against costs projected into CY 2025 based on the more recent experience. Since many of the previously noted changes are more inherently accounted for in data into CY 2024, this provided a more accurate projection into CY 2025. To make an apples-to-apples comparison of the two data sources, the January 2024 through June 2024 RDT data was adjusted to remove services subject to the maternity supplemental payment, and further adjustments were applied consistent with the capitation rate development such as trend and population acuity.

The two sources were compared across all services, with specific interest in the LTC, BHT, CBAS, and CS COS lines given the emerging trends seen for these categories beyond the base data period. Where statewide trends were evident in this review (as in the case of BHT and CS), these were accounted for in trend development, as explained in a later section. This adjustment solely aims to account for region variation seen due to the procurement, transitioning populations, CCU, and other region-specific changes. In aggregate across all populations, this adjustment added approximately $1.830 billion to the base data.

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

Maternity Supplemental — Design

- Payment made on delivery event that generates a state vital record.
- One supplemental payment per delivery regardless of number of births.

- One blended supplemental payment combining caesarean and vaginal deliveries.
- Supplemental payment varies by region, but not by MCP within a region.
- 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 the Child, Adult, ACA Expansion, and WCM COA groups if a delivery event occurs.
- Inclusion of both direct and global member experience.

Maternity Supplemental — Base Data Development Approach

In general, a similar process used for the development of the base data by COA group is utilized in the development of the base data for the maternity supplemental payment. The RDT data for maternity for the SFY 2022–23 base data includes both direct and global members as the main source for this base data development. In addition, only the SIS population was used for the maternity base data development which is consistent with the development of base data for CY 2024. The UIS population data was reviewed but given the large influx of deliveries anticipated with the expansion of full-scope Medi-Cal beneficiaries regardless of immigration status, it was assumed the base data for the UIS population will be the same as the SIS population. This is consistent with the actual UIS data for SFY 2022–23, which suggested no major differences in maternity per member delivery costs, and prior analyses for historical rates. The general process for the development of the maternity base data is described below:

- Calculate per delivery costs and utilization from SFY 2022–23 MCP RDT data by delivery type and COS.
- Same general data selection process used as in regular rate range development:
  - Smoothing and data selection process done by delivery type (caesarean and vaginal).
- Develop smoothed data points to replace missing or unreasonable data.
- Blend reported and smoothed base costs from the MCPs to generate base data by MCP, delivery type, and COS.
- Aggregate base data across region and delivery type.

In the final step of the base data development process, the MCP-specific data (after smoothing and credibility adjustments) is blended across MCPs in each region and across caesarean and vaginal deliveries. As part of this process, the caesarean and vaginal ratios reported by each MCP are reviewed, and appropriate adjustments are made when the reported ratios are unreasonable. In studying historical averages in birth rate types, as well as applying actuarial judgement, an acceptable range of

caesarean births as a percentage of total birth count was developed as a quantitative measure in examining what appropriate ratio levels should be. It is our experience that from year-to-year most plan-reported data would fall within an acceptable range conducive to matching payment with risk. However, in some instances when it is clear data quality might compromise the soundness of the rate, Mercer deems it necessary to adjust the ratio to a more normalized level. Once this process was complete, a final factor was applied across all COS so that the resulting per member per delivery cost is the same as the amount carved out of the MCP's base data.

Section 4

Projected Benefit Costs and Trends

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

- Trend from SFY 2022–23 to CY 2025
- Program Changes
- Population Adjustments
- CBRC in LA County
- Maternity Supplemental Payment Rate Development

The adjustments listed above are shown within the various columns of the CRCS by region, COA group, and COS, or 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 Mainstream managed care program, Mercer developed trend rates at the COA level and for the maternity supplemental payment for each provider type or COS separately by utilization and unit cost components. Notably, Mercer selected the same trends for the SIS and UIS populations for each COA. This was done, as it is Mercer's expectation that utilization or unit cost trends will not differ materially 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 SFY 2022–23 base data was trended forward 30 months from the mid-point of SFY 2022–23 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 through June 2024, 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 in order to inform the final trends.

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

Trends were newly set for CS for the CY 2025 rates. For the CY 2024 rates, CS was embedded within other COS lines. Further, base and program change adjustments were applied to project the CS spend into the contract period for CY 2024 rate development; 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, there is an explicit COS for these benefits, and utilization and unit cost trends were developed to project the PMPM into the contract period.

Trends were also 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% 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. The development of the ECM PMPMs are described later in this section.

There are nine 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

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

reviewing newer and emerging information (as described above) to appropriately align prospective payment levels. Please see Table 1 below for a summary of material changes in midpoint trend assumptions by COS.

Table 1

Annual Aggregate PMPM Trend Factors — All SIS			
COS	**CY 2024**	**CY 2025**	**Change**
OP Hospital	4.39%	5.41%	1.02%
ER	5.86%	4.26%	-1.60%
PCP	3.62%	4.80%	1.18%
Specialty Physician	3.89%	5.15%	1.26%
FQHC	3.60%	5.39%	1.79%
MHOP	5.06%	8.75%	3.69%
BHT	5.51%	22.95%	17.44%
CBAS	0.90%	3.72%	2.82%
Hospice	2.00%	0.00%	-2.00%
CS	N/A	14.31%	N/A
ECM	N/A	79.60%	N/A

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 midpoint trends were determined, a trend range was created by adding 0.25% to each of the utilization and unit cost components as the upper bound and subtracting 0.25% as the lower bound. In aggregate, the annualized midpoint claim cost trends for the SIS population, across all regions, all COA groups, and all COS, average 3.0% for utilization and 2.2% for unit cost, or 5.2% PMPM. This represents an increase of 1.8% over the aggregate trend figures at the midpoint from those developed for the CY 2024 capitation rates.

The specific trend levels by utilization and unit cost 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 by region and COA group can be found within the program change charts provided within the Excel file titled *CY 2025 Medi-Cal Rate Summaries 2024 12.xlsx*. Additionally, the program change adjustments identified below are applied in columns (F) and (G) of the CRCS, unless otherwise indicated.

Ground Emergency Medical Transportation Fee Increase

Pursuant to approved State Plan Amendment (SPA) 18-0004, and subsequent continuances in approved SPAs 19-0020, 20-0009, 21-0017, and 22-0040, and anticipated future continuances, DHCS makes add-on payments to Ground Emergency Medical Transportation (GEMT) providers in the State's FFS program who meet specified requirements using proceeds from a GEMT provider quality assurance fee (QAF). Both State law (Welfare & Institutions Code § 14129.3[b]) and the approved SPAs establish the combination of the State's FFS base and add-on payments constitute the Rogers rates MCPs must pay to non-contracted GEMT providers serving Medi-Cal managed care enrollees for those fiscal years in which the GEMT add-on is effective. Similar to prior years, the certified capitation rates have included a program change adjustment 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 Assembly Bill 1705

Effective January 1, 2023, Assembly Bill (AB) 1705 established the Public Provider GEMT program, increasing the per trip rate 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 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 rate impacts associated with this increase will be captured in a future rate amendment.

Assembly Bill 97 Buybacks

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

- Podiatrists
- Prosthetists

Adjustments were developed using encounter data, by COA and separated for SIS and UIS beneficiaries, for the provider types listed above during the period of July 1, 2022 to June 30, 2023. This adjustment accounts for pricing pressures based on FFS payment increases which MCPs are anticipated to pay.

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 in the Medi-Cal managed care program, effective January 1, 2022:

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

Community Supports Adjustment

Mercer reviewed multiple sources of data including RDT data submissions in which MCPs were required to report CS experience and publicly available quarterly CS utilization reports. All available data suggests CS utilization will continue to increase. Based on this data Mercer developed a utilization trend factor for the CS COS. Additionally, as these CS services are offered in lieu of traditional services, Mercer assumed unit costs for CS would trend similarly to those of the related categories of service. While the utilization trend is constant across categories of aid, the unit costs trends vary.

Table 2

COA	Annualized Utilization Trend Increase	Annualized Unit Cost Trend Increase
Child, Adult, OE, and SPD-LTC	10.00%	4.00%

COA	Annualized Utilization Trend Increase	Annualized Unit Cost Trend Increase
SPD-LTC/Full-Dual	10.00%	3.75%
WCM	10.00%	3.50%

In Lieu of Services Documentation

For requirements outlined in CMS' communication on In Lieu of Services (ILOS) with the State Medical Directors letter #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 file titled *CA In Lieu of Services (ILOS) Policy Guide 2024 12.pdf*.
- For State Plan services crosswalk, please see page 62 of the file titled *CA In Lieu of Services (ILOS) Policy Guide 2024 12.pdf*.
- For target populations, please see page 66 of the file titled *CA In Lieu of Services (ILOS) Policy Guide 2024 12.pdf*.
- For the projected ILOS Cost Percentage, please refer to the file named *CY 2025 Prospective ILOS Cost Percentage 2024 12.pdf*.
- For a review on cost-effectiveness, please refer to the file titled *CA ILOS Literature Review 2024 12.pdf*.

Community Health Worker

Effective July 1, 2022, community health worker (CHW) is an addition to the group of skilled and trained individuals who are currently able to provide clinically appropriate Medi-Cal covered benefits and services to Medi-Cal beneficiaries. Effective January 1, 2023, CHWs were also allowed to be reimbursed for asthma remediation services and violence prevention services. While CHWs are also providers of ECM, this program change is separate from the ECM COS detailed later in this certification.

Leveraging research on CHW staffing and using a build-up similar to the ECM model in identifying potential CHW utilizers, approximately 5.0% of the Medi-Cal managed care population were estimated to be potential utilizers of CHW services.

The expected program change adjustment for CHW was reduced from the adjustment applied in prior years as initial CHW experience was reviewed and the ramp up of this benefit is lower than was originally anticipated. As such, the expected ramp up of this benefit was revised downwards. This benefit for CY 2025 is expected to be 5.5% of the ultimate steady state of this benefit. This was calculated based on experience data and revision of the expected ramp up based on this data.

Dyadic Services

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

New Benefits from Dyadic Services Policy:

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

Existing Benefits Impacted by Dyadic Services Policy:

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

General Methodology

To determine the impact of this program change on the capitation rates, Mercer calculated the aggregate dollar impact based on the anticipated utilization of impacted services and their prospective unit costs. The starting point for anticipated utilization was to determine the average number of monthly members with BH needs

through clinical assumptions and SFY 2022–23 eligibility; furthermore, how many of those members would utilize dyadic visits during their well-child visits. The assumed dyadic visits vary by age groups that align with the suggested well-child visits from the Bright Futures Periodicity Schedule[2]. Using this utilization of dyadic visits, Mercer estimated the number of additional services provided (for both new and existing benefits) as a result of the dyadic services policy. This expected new utilization of the impacted benefits was analyzed based on the following two categories:

- During the Dyadic Visit
  - In addition to the new utilization of the dyadic visit itself, Mercer analyzed the remaining impacted services for the likelihood of them also being provided during the dyadic visit on a by service basis. Based on these likelihoods, Mercer calculated the total utilization of all services (both new and existing) to be performed during dyadic visits throughout the CY. Per DHCS' policy, all services provided during the dyadic visit are billable under the child's Medi-Cal ID. As such, this new utilization during the dyadic visit is mostly attributable to the Child and WCM COA groups, with smaller amounts impacting the SPD (for disabled children ages 0–20) and ACA Expansion (for children ages 19–20 years old) COAs.
- After the Dyadic Visit (Downstream Services)
  - Given that referrals for certain services are an expected outcome of dyadic visits, it was necessary to include an estimate for the increase in existing services beyond the dyadic visit resulting from the dyadic services policy in the calculation of new utilization. For the estimate of this increase, Mercer analyzed managed care encounters to determine baseline utilization levels of the specific impacted services in the SFY 2022–23 base period. Mercer then assumed a growth percentage of 10% for these existing services as a result of the dyadic services policy and included this growth within the expected new utilization from this program change. Per DHCS' policy, only services provided during the dyadic visit are billable under the child's Medi-Cal ID. Given this category of new utilization occurs outside of the dyadic visit, this increased utilization of existing services was allocated to the various COA groups according to the baseline amounts initially determined in the SFY 2022–23 data.

To calculate the financial impact associated with this expected new utilization of services, Mercer relied upon CY 2025 reimbursement rates provided by DHCS for certain services, where available, supplemented by aggregate Medi-Cal managed care unit cost data (for applicable procedure codes). Using these various unit costs and the expected new utilization of services, Mercer determined a partially ramped-up, based on slower-than-expected emerging experience, prospective impact of the dyadic services program change for CY 2025. Ultimately, an

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

adjustment was applied for the following five COA groups: Child, Adult, ACA Expansion, SPD, and WCM.

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

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

Effective January 1, 2023 for all skilled nursing facility (SNF) services (including ICF-DD and SA services which transitioned to managed care January 1, 2024), 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). Health plans that operate in non-COHS and non-CCI counties are required to reimburse network LTC providers at, and those providers are required to accept, the payment rate that would otherwise have been paid in the FFS delivery system (e.g., Medi-Cal FFS per diem rate). This requirement applies to all LTC services, both for services transitioning from FFS and all LTC services previously covered by the health plans in these counties.

LTC data used for rate development in non-COHS and non-CCI counties comes from two sources: RDT data and FFS claims. The RDT data for the first half of the base data period for these MCPs reflect the LTC services historically covered in managed care in these counties prior to the transition, which are short-term stays and the beginning portion of long-term stays (i.e., the month of entry plus the subsequent month); the FFS claims and the second half of the RDT base data represent all transitioning populations and services, the large majority of LTC services in these counties. Given the FFS claims data was already representative of Medi-Cal FFS per diem rates, no additional adjustment for the State directed payment was required for this portion of the rate development data. Similarly, given that the State directed payment was effective January 1, 2023, no additional adjustment was required for the second half of the RDT base data. However, through discussions with the MCPs, along with other data analysis and benchmarks (e.g., FFS per diem rates, other MCP reporting, etc.), it was determined many of the MCPs were paying at levels higher than FFS per diem rates for the LTC experience covered in managed care prior to the transition. As such, Mercer developed adjustments to reduce the RDT-reported LTC unit costs for certain health plans to reflect the FFS equivalent levels for the first half of the base period. This adjustment was applied as a program change to the managed care portion of LTC experience for the Child, Adult, ACA Expansion, and SPD-LTC COA groups.

It is notable, within the APL listed above, as part of the delivery system reform State directed payment, requirements were also set forth by DHCS within COHS and CCI counties that 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 these MCPs revealed none of them were paying under 100% of the FFS rates.

As such, Mercer did not apply any adjustments to the LTC portion of the rates within COHS and CCI counties for this consideration [3].

Populations Transitioning from Fee-for-Service to Managed Care

Certain Medi-Cal populations within the FFS delivery system, including some designated by the CalAIM initiative, transitioned to managed care in CY 2022 or after. Some of these populations were accounted for in the base data development process, while others were accounted for through a program change adjustment. The populations adjusted for through the base data are described in the Data section.

The populations who have transitioned from FFS to managed care, not included in the base data, include the following:

Effective January 1, 2023:

- Populations previously subject to managed care, but not transitioned prior to CalAIM and populations from prior CalAIM transitions that did not transition until a later date for various operational reasons

Effective January 1, 2024 and January 1, 2025:

- Foster Care Mandatory Transition for new COHS regions (San Benito, Rural Upper Central, and Mariposa County, which is a subset of the Central California region)
- Foster Care Mandatory Transition in Single-Plan regions (Alameda, Contra Costa, and Imperial)

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

General Methodology

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

Members and their associated claims were identified in both the SFY 2022–23 FFS data and emerging managed care encounter data to the extent it was available. For the FFS data, once the appropriate members and claims were identified, the following adjustments were made to make FFS claims more appropriate for these analyses:

- Repriced FQHC FFS units to managed care costs, which do not reflect wrap-around payments made by DHCS.
- Excluded claims for services that would not be covered by MCPs.

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

- Excluded abortion and delivery claims for the Child, Adult, ACA Optional Expansion, and WCM COAs.

For populations from prior CalAIM transitions that did not transition until a later date for various operational reasons, a combined adjustment was made across all of the populations and was mainly applicable to the UIS Child population. The remaining populations are the foster care members in new COHS and Single-Plan model counties and members who were previously subject to managed care but were not present within managed care.

Impacts for these program change adjustments can be found in the attached Excel rate documentation.

Unsatisfactory Immigration Status Population Ages 26 to 49

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

The UIS membership volume impacts by COA for the Mainstream managed care program compared to the corresponding SFY 2022–23 managed care UIS population are shown in Table 3 below.

Table 3

COA	Total Mainstream Managed Care Program
Adult	126.1%
ACA Expansion	41.6%
SPD-LTC	1.3%

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

1. SFY 2022–23 managed care encounter data was reviewed for the ages 26 to 49 population currently in managed care compared to encounter data for the total UIS population in managed care by COA group.
2. SFY 2022–23 FFS data for the actual population residing in FFS was also reviewed. However, since this population was restricted scope in SFY 2022–23, the comparison to managed care encounter data for the base population by COA was done only for the IP Hospital and ER services categories. This is because restricted scope eligibility means members are only eligible for emergency and

pregnancy-related services. These two service categories provide for a more appropriate comparison.

Using the two data sources described above, Mercer developed PMPM relativities by COA and by region. Relativities were developed using a blend of region-specific and model average data, with varying weights applied to each based on transitioning UIS population size in each region and COA. These PMPMs were then used in combination with the expected increase in managed care enrollment by region and COA to derive the program change adjustment applied for this expanding population.

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

Long-Term Care Rate Changes

As noted in the Trend subsection, unit cost trend factors were not developed for the LTC COS. In lieu of a trend adjustment, rate increases for LTC services are handled through a program change adjustment and are based on legislatively mandated annual FFS rate increases. Effective January 1, 2023, DHCS implemented a delivery system reform State directed payment under 42 CFR § 438.6(c) for the facility per diem reimbursement of LTC services. As noted previously, the LTC data utilized in rate development for non-COHS and non-CCI counties was adjusted to reflect these State directed payments, reflecting the FFS equivalent in the base period. The FFS rate increases adjust these payment levels to reflect the FFS equivalent in the prospective rating period. In general, managed care payment levels in non-transitioning counties have aligned closely with FFS payment levels for these services and it was deemed reasonable and appropriate to use the FFS rate increases in the managed care rate setting process.

Previously, rate increases for 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.

Transitional Care Services

Effective January 1, 2023, Transitional Care Services (TCS) were required for the following populations: IP discharges as a result of pregnancy, discharges for Children with Special Health Care Needs, and discharges for members in the Specialty MH and Drug Medi-Cal programs. These members were all considered high-risk for purposes of TCS.

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

For the CY 2025 rating period, PMPM adjustments were made at a region level for all TCS services with an assumed 51.5% ramp-up period as part of the program change adjustment. CY 2022 and CY 2023 managed care encounter data was averaged to develop estimated totals for CY 2025 TCS population groups. An average number of service hours per discharge was then developed for each low-risk and high-risk discharge. Ultimately, an average of 3.5 service hours per discharge was assumed for high-risk members and an average of 1.07 hours for low-risk members. The staffing model produced for ECM was leveraged for TCS services, and a weighted staffing cost was developed assuming 15% licensed and 85% unlicensed staff for low-risk members, and 70% licensed and 30% unlicensed staff for high-risk members.

Medi-Cal Targeted Provider Rate Increases

Pursuant to the 2023 Budget Act and AB 118, the State will establish a minimum fee schedule directed payment for select primary care services, obstetrics services, and non-specialty MH services. The State aims to create a new fee schedule that will supersede the current FFS rates for select procedure codes and that will be “87.5% of the lowest maximum allowance established by the federal Medicare Program for the same or similar services or the level of reimbursement, as specified”. 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 is only applicable to the following providers billed on a CMS-1500 form:

- 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 included within this adjustment.

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

Identification of Applicable Data

SFY 2022–23 encounter data, as well as SFY 2022–23 FFS data for transitioning populations adjusted for within the base, were reviewed. Specifically, detailed claim lines with the applicable procedure codes are used for the basis of this adjustment. For the select primary care services, the data was limited to the applicable providers subject to the directed payment, as noted above.

General Repricing Methodology

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

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

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

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

Non-Dual or Part A-Only Claims

For these claims, the TRI for each claim detail line was assumed to be the difference between the targeted rate and the assumed 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 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 E&M 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 the following considerations:

- Each detailed claim line was categorized as either non-capitated or subcapitated using both the client number 101 field and the paid amount on the encounter detail line.
- Based on assigned contract payment type, Mercer assigned the initial base unit cost for the encounter detail line as follows:
  - For identified non-capitated claims, the reported paid amount was set as the initial managed care payment level. Reported service units were then utilized to calculate the initial paid unit cost for the detail line.
  - For identified subcapitated claims, Mercer utilized supplemental subcapitation data collected from MCPs to project an assumed paid amount.
    - Within the supplemental data request, plans benchmarked contract costs for subcapitated entities providing TRI services during the SFY 2021–22 contracting period with the associated Medi-Cal Fee Schedule. Utilizing this information, an average percentage of Medi-Cal was calculated per MCP.
    - Mercer then calculated the Medi-Cal FFS allowed amounts for the SFY 2022–23 TRI encounters and applied these amounts against the MCP's assumed average percentage of Medi-Cal to calculate the initial managed care payment levels.
    - Reported service units in conjunction with the assumed paid levels were then utilized to calculate the initial paid unit cost for the detail line.
- The initial base unit costs were then adjusted for the following:
  - Increasing unit costs on the claim to account for the AB 97 Buyback program change.

- Trending unit costs for the detail line to proxy the cost of these claims in CY 2025.

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

The TRI was assumed to be the regional average paid unit cost per procedure developed for all non-dual or Part A-only encounters.

For applicable services performed at an FQHC facility, these facilities are not a technical part of the policy but are applied an average increase since plans must pay no less than what is paid to other providers to remain in compliance with federal regulations. Since plans subcapitate some TRI services to FQHCs, the average increase applied to these facilities was updated to include average increases from both subcapitated and non-capitated arrangements.

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 that are not eligible for Medicare reimbursement, the TRI is assumed to follow the same methodology as the non-dual or Part A-Only non-capitated claims.

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

Children and Youth Behavioral Health Initiative

Effective January 1, 2024, Children and Youth Health Behavioral Initiative (CYBHI) is a policy change and State directed payment that implements a universal fee schedule for school-linked behavior health services. Local Education Agencies (LEAs) and Institutes of Higher Education (IHEs) participating in the program collaborate with providers to offer school and community-based BH services to students aged 5–25. The providers then bill MCPs through the LEAs according to a universal fee schedule.

LEA participation in the program is occurring in cohorts, with Cohort 1 LEAs beginning January 1, 2024, Cohort 2 LEAs and IHEs beginning July 1, 2024, Cohort

3 LEAs and IHEs beginning January 1, 2025, and Cohort 4 LEAs and IHEs beginning July 1, 2025.

To determine the impact of this program change, various data sets were analyzed. First, data from CY 2022 was used to determine the percentage of Medi-Cal members in each cohort and archetype (Low Needs, Moderate Needs, High Needs) per region. This data identified members aged 5–25 who reside in zip codes covered by LEAs in Cohorts 1 and 2. Additionally, these members were evaluated based on specific criteria (i.e., homelessness, foster care status, ACEs screening, etc.), to place members into an archetype. Participating LEAs and IHEs in Cohorts 3 and 4 were unknown at the time of rate development, so assumptions were utilized to determine the percentage of Medi-Cal members in Cohorts 3 and 4 based on the percentage of members already in Cohorts 1 and 2. The percentages of members in each archetype in Cohort 2 were assumed for Cohorts 3 and 4.

Service utilization assumptions were developed by archetype. Low Needs members were assumed to utilize two services per year, Moderate Needs members were assumed to utilize five services per year, and High Needs members were assumed to utilize 20 services per year. Unit cost assumptions were developed by analyzing the CYBHI fee schedule and considering the mix of services likely to be used by each archetype.

Finally, the regional CYBHI rates for CY 2025 were developed by determining the projected member count in each Cohort and using the utilization and unit cost assumptions to calculate the projected dollars. Ramp up assumptions, varying by cohort, were then applied to the projected dollars. Additionally, since CYBHI procedure codes are existing service codes, SFY 2022–23 claims experience for these codes was carved out of the projected amounts in order to identify the dollars that are a result of the increased utilization from this program change.

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 SFY 2022–23 base data period. For the program change development, Mercer reviewed SFY 2022–23 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 for the SFY 2022–23 base data period 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 SFY 2022–23 base data.

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

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.

The total impact to projected CY 2025 medical expenses (excluding administration/underwriting gain loads) for the MOT program change is approximately $99 million, limited to the SIS population only. MOT encounter data for UIS and SIS members were separated for CY 2025 rate development and MOT PMPM program change adjustments are calculated separately for both populations. MOT for UIS beneficiaries is applicable to the state only UIS capitation rates and therefore not part of this certification.

Enhanced Care Management

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

The impact of the program to the CY 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 HHP, the rate impact calculation then incorporates a provider overhead assumption of 20% which includes provider costs in addition to ECM staff members such as facility costs, hardware/software, transportation costs associated with care management services, management staff, general administration, information technology, and human resource function costs. The rate development includes costs associated with ECM provider outreach efforts to ECM-eligible individuals prior to enrollment in the program.

Since the base per enrollee per month (PEPM) was developed using SFY 2022–23 salary information, 30 months of 5.0% annual provider cost trend was applied to bring the base data to the CY 2025 contract period.

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. County Rural Adjustment (applied to utilization) — similar to HHP, a 25% upward adjustment factor was applied to account for the additional service hours required to serve ECM enrollees residing in a rural setting.
3. Overlapping CM Program Adjustments — an important responsibility of ECM providers is to ensure there are not duplication of services with other CM programs. As such, the ECM rates contain offset adjustments for the portion of the projected population enrolled in multiple CM programs.
    A. Medicare Part B Dual Enrollees — this adjustment accounts for Part B eligible ECM enrollees who are eligible for CMS' Chronic Care Management (CCM), Behavioral Health Integration (BHI), or Medicare Advantage CM programs. ECM providers are expected to collaborate with the member's physician in order to pursue the appropriate CCM and BHI payments from CMS for their ECM enrollees with Part B coverage. Additionally, National Committee for Quality Assurance-accredited Medicare Advantage Plans have CM requirements similar to some ECM services. As CMS will be covering

ECM-like services through the CCM, BHI, and Medicare Advantage Plans programs, a portion of the CMs service hours (utilization) were reduced. The result is a downward rate adjustment to the SPD-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. CCS — similar to TCM, it is appropriate to apply a carve-out adjustment to the ECM rates for CM services children receive through CCS that overlap with ECM services.

D. Existing Care Coordination Adjustments — the WCM program includes some CM services comparable to those provided through ECM. The WCM CM services are accounted for the base data for the WCM population. Through our clinical review of the CM requirements of both programs, Mercer estimated WCM ECM enrollees have 25% of their ECM services already accounted for through the WCM base data. As such, 25% of the WCM ECM medical component PMPM is carved out of the WCM base data. This adjustment is also documented in the Data section.

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

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 [4]. 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 actual ECM enrollment through June 2024 and by an in-depth analysis of flags, where the flags represent condition groups or qualifying utilization statistics that would likely identify a member as potentially ECM-eligible. These flags were then assigned a “flag weight” depending on how closely they aligned with the populations of focus at the time of rate development and the underlying prevalence of the condition/category.

Ultimately, accounting for ramp-up assumptions, the rate development assumes, by the fourth quarter of CY 2025, 1.2% of managed care members will be enrolled in ECM.

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

The rate methodology and assumptions for UIS and SIS populations remain the same in the development of the monthly PEPM cost based on their length of time enrolled in ECM (i.e., 1–6 months, 7–12 months, and greater than 13 months). ECM

[4] *Identifying ECM “Eligible” Members for Outreach and Enrollment*

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

Wellness Coach Benefit

Effective January 1, 2025, Wellness Coach is a policy change that implements a Certified Wellness Coach (CWC) 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.

There are two tiers of CWCs based on different educational and workforce pathways. The rate for CWC 2 is assumed to be higher than the rate for CWC 1, as CWC 2 requirements include higher levels of education and more existing experience in the field.

To determine the impact of this program change at a Statewide level, it was assumed that ultimately (after program ramp up) 25% of the eligible population will have demand for wellness coach services. It was then assumed that each utilizer will receive an average of four CWC services each month, from which we determined the projected hours provided per month by COA. It was assumed that 99% of these hours were performed in a Managed Care setting. Final program dollars were then calculated with the assumption that 70% of services will be performed by CWC 1's and 30% performed by CWC 2's. At this time, we are projecting a 5-year ramp up for the CWC program with 10% of the ramp occurring in CY 2025. The projected dollars were then allocated to Title XIX members, Title XXI members, and ACA OE members. Please note that this adjustment only applies to the SIS population, since any impacts to the UIS population are considered to be State only.

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 SPD-LTC COA would now receive Medicare Part A benefits and therefore be viewed as a Full-Dual member within the SPD-LTC/Full-Dual COA group. This adjustment accounts for the movement of members from SPD-LTC to SPD-LTC/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 SPD-LTC, and cost relativities of the eligible SPD-LTC Part A buy-in members as compared to the larger SPD-LTC 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 SPD-LTC COA. Further, these membership impacts, and cost relativities were then used to calculate the PMPM impacts of adding these members to the SPD-LTC/Full-Dual COA, while applying reductions to Medicare Part A covered services consistent with the new benefit coverage these members will have.

This adjustment was only applied for the SIS population given the significantly low volume of experience within the UIS population. Further, 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 and risk adjustment.

Program Changes Applied as Add-ons to the Rate

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

Health Plan of San Mateo Dental

Effective January 1, 2022, dental services are covered by HPSM in San Mateo County through a dental pilot program. This add-on is applicable only to HPSM and only to the SIS population. The add-on for the UIS population is considered State only. Data for the additional dental benefit was excluded from the main RDT submission and submitted through a separate RDT specific to the dental pilot program. The base data utilized was CY 2023 Medi-Cal Dental RDT data reported by HPSM. Expenditures related to the Prop 56 Dental State directed payment under 42 CFR § 438.6(c) were separated out and projected separately. The base data for both the Prop 56 and the non-Prop 56 components were then adjusted for the following items:

1. Annualized trend factors were applied for 24 months from the midpoint of the CY 2023 base period to the midpoint of the CY 2025 rating period. As the pilot program was relatively new, Mercer observed significant ramp up of utilization throughout CY 2023 and into CY 2024. Mercer considered this ramp up alongside experience for other mature dental programs in the State in the development of the trend assumptions. For the non-Prop 56 component, annualized utilization trends varied from 17.00% to 25.00% by COA, and unit cost trends were 2.00% for all COAs. The Prop 56 component was adjusted for utilization trend only, varying from 5.00% to 8.00%.
2. A population acuity adjustment was applied consistent with the adjustment applied in the broader (non-dental) rate development, adjusted to reflect the underlying CY 2023 base period used for the dental add-on, as the non-dental base rate leverages a SFY 2022–23 base period.

3. Lower bound administration and underwriting gain loads consistent with the broader rate development were utilized in the development of the PMPM add-on.

The development of the dental add-ons and each adjustment described above is detailed within the Excel file titled *CY 2025 Medi-Cal San Mateo Dental Add-on CRCS 2024 12.xlsx*.

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 no rate impact.

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, no explicit adjustment was made for this program change.

Veteran's Home Centers in New COHS and Single-Plan Counties

Effective January 1, 2024, in new COHS counties and in Single-Plan counties, this population, who were voluntary managed care members, transitioned into the managed care delivery systems in Alameda, Contra Costa, San Benito, Imperial, Rural Upper Central, and Central California regions due to new CY 2024 contracting changes.

Telehealth — Post Public Health Emergency

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

Acupuncture

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

managed care encounters, this program change was determined to be immaterial for managed care capitated rate setting.

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

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

Newborn Gateway Enrollment

Effective July 1, 2024, this policy change aimed to enroll newborns into Medi-Cal via the Newborn Gateway. The main procedural change effective November 26, 2024 will be that the newborn will receive their own client identification number (CIN) within 72 hours after birth or 24 hours after discharge through the Newborn Gateway and will be enrolled in the mother's health plan. Mercer would anticipate the health plan receiving a capitation rate for these costs once the Child receives their own CIN. Previously, MCPs would not receive a separate capitation payment for the Child COA until the newborn received their own CIN, which was up to the first two months after birth.

Mercer did not adjust for this program change for the following reasons. First, since newborns in the Neonatal Intensive Care Unit already have an expedited avenue to receive a CIN, the majority of the costs impacted by this procedural change would likely be for well newborns, whose costs have already been considered within the experience for the Adult COA. In addition, costs for these newborns are embedded within the mother's claims and are difficult to separately identify. As this process is being operationalized and implemented throughout CY 2025, it is reasonable to assume that there would be no impact for this policy change for CY 2025.

However, Mercer will continue to review the impacts of this policy change for future capitation rate setting.

Expanded Biomarker and Pharmacogenomic Testing

Effective July 1, 2024, this program change would expand availability of Biomarker and Pharmacogenomic tests not previously covered by SB 535 Biomarker testing. The expansion would require prior authorization, and the new tests would not be a widely available benefit. Predicted utilization of the new expanded benefits is low and it was determined that there was no impact to the rates.

However, Mercer will continue to review the impacts of this policy change for future capitation rate setting.

Respiratory Syncytial Virus Vaccines

Effective October 1, 2023, this program change made Respiratory Syncytial Virus Vaccines available as either a pharmacy or medical benefit. Mercer reviewed utilization of vaccines administered as a medical benefit and determined there was no impact to the rates for this program change.

Doula Benefit

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

Mercer did not adjust for this program change, given the immaterial amount of usage of this benefit being observed within the managed care program since its inception.

Population Adjustments

For CY 2025, additional adjustments were applied to the managed care data. The adjustments are applied within columns (K) and (L) of the CRCS in the Excel files *titled CY 2025 Medi-Cal Detail CRCS Package LB Rate Smry 2024 12.xlsx and CY 2025 Medi-Cal Detail CRCS Package UB Rate Smry 2024 12.xlsx*. More detail on the adjustments is described below.

Population Acuity Adjustment

Since the beginning of the PHE (beginning March 1, 2020), Medi-Cal ceased disenrolling members with certain exceptions such as members who moved out of state, passed away, or voluntarily requested to be disenrolled. As a result, managed care enrollment numbers began increasing significantly; a reversal of the slightly declining trend observed prior to March 1, 2020. Numerous historical (and current) analyses have demonstrated members who disenroll from Medi-Cal are, on average, lower acuity than those who remain enrolled. The PHE continued throughout the entirety of the SFY 2022–23 base period, resulting in a surplus of members remaining enrolled, and who's experience was represented in the base period.

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

1. The acuity differential between leavers and those who will remain enrolled (i.e., non-leavers)

2. The volume of the surplus members who accumulated during the PHE and are projected to be disenrolled through the unwinding.

Leaver Acuity Differential

As mentioned above, Mercer identified members who were disenrolled since the beginning of unwinding and compared them to those who did not disenroll (i.e., non-leavers) by analyzing encounter cost and non-utilizer statistics.

Encounter data was reviewed for the SFY 2022–23 base period, as well as more recent encounter data through December 2023. Mercer analyzed and compared PMPM costs, along with the portion of each group that were non-utilizers. In each of these comparisons, Mercer varied the classification of leavers to measure the sensitivity of the results. Some examples of different iterations of leaver classification are those who left by September 2023 and remained disenrolled through March 2024, those who left by December 2023 and remained disenrolled through March 2024, and all those who were disenrolled as of March 2024 (regardless of when they disenrolled). The rationale for reviewing multiple iterations was to control for churn (i.e., members who disenroll but re-enroll in the relatively short time period).

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

Surplus Member Volume

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

To determine the base period leaver volume, a baseline leaver volume was set using disenrollment counts and patterns from CY 2019, before the PHE. With disenrollments stopping in March 2020, the gap between actual disenrollments and historical averages indicated the volume of pent-up leavers for the SFY 2022–23 base period.

The amount of pent-up leaver member months peaked in June 2023 and then began to decline as the unwinding commenced in July 2023. Mercer continued to monitor actual disenrollment counts through June 2024, representing the first 12 months of the unwinding. Additionally, DHCS' Medi-Cal Eligibility Division informed Mercer that DHCS was making use of CMS' extension of temporary unwinding flexibilities related to the section 1902(e)(14)(A) waivers, ensuring coverage continuity and preventing inappropriate disenrollments. All of this served to inform Mercer's enrollment projections for CY 2025, and specifically the proportion of surplus member months through CY 2025.

For the SIS population, the COA groups who experienced the most significant enrollment changes from the start of the PHE were Child, Adult, and ACA Expansion.

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

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

The adjustment varied by region based on region-specific enrollment trends, as the effect the PHE had on enrollment varied by region. The statewide average adjustment for CY 2025 was higher than what was applied in the CY 2024 rating period, due to CY 2024 occurring much earlier in the unwinding time period. This adjustment is applied to all COS' within column (K) of the CRCS in the Excel files titled *CY 2025 Medi-Cal Detail CRCS Package LB Rate Smry 2024 12.xlsx* and *CY 2025 Medi-Cal Detail CRCS Package UB Rate Smry 2024 12.xlsx*. In aggregate, the impact of this adjustment was as follows:

Table 4

COA	CY 2024	CY 2025	Change
Child — SIS	2.0%	4.8%	2.8%
Adult — SIS	3.9%	5.8%	1.9%
ACA OE — SIS	3.7%	6.2%	2.5%
Child — UIS	1.1%	2.2%	1.1%

Cost-Based Reimbursement Clinics in Los Angeles County

As discussed in Section 3, additional amounts for CBRCs were added to the FQHC base data for the SPD-LTC COA in LA County. These additional amounts were projected into CY 2025 using the FQHC trend factors. As a result, these CBRC amounts are fully reflected in column (O) of the CRCS for LA County for the SPD-LTC COA (in addition to the original FQHC and CBRC costs already reflected in the base data and projected to CY 2025). As noted previously, due to the higher costs associated with CBRCs, the CBRC costs were split into two components. One

component subject to risk adjustment, reflecting unit cost levels in line with typical professional services, and a "not subject to risk adjustment" carve-out amount containing the cost levels above and beyond typical professional services cost levels. Within column (S) of the CRCS, the carve-out amounts not subject to risk adjustment are removed from the region-specific rate calculation. These region-specific rates then flow through the risk-adjustment process, which is described later in this certification report. Once the risk-adjusted region average rates are calculated, the medical component of the "not subject to risk adjustment" carve-out amount is added back into the capitation rates for both LA Care and Health Net. For the SIS rates, the medical component carve-out amounts added back into the capitation rates are $81.96 and $49.20 for LA Care and Health Net, respectively, at the lower bound, and $83.99 and $50.41 at the upper bound. Similarly, $5.15 PMPM and $5.51 PMPM was added to the federal component of the UIS rates for SPD-LTC members in LA Care and Health Net, respectively ($5.28 and $5.64 at the upper bound). As Kaiser does not contract with LA DHS and does not utilize CBRCs, this "not subject to risk adjustment" add-on does not apply to Kaiser.

Maternity Supplemental Payment Development

In the development of the maternity supplemental payment, the base data (as described in Section 3) was projected into CY 2025. The steps below describe the process utilized in the development of the CY 2025 maternity supplemental payment rates applicable to the Child, Adult, ACA Expansion, and WCM COA groups.

- Trend base costs forward to the midpoint of the rating period.
  - The trend development process is described in a previous subsection.
- Adjust for applicable program changes:
  - The program change for TRI was applied to the Professional service categories (i.e., PCP, Specialty, FQHC, and NPP).
- Add load for administration and underwriting gain:
  - The development of non-benefit load assumptions is described in Section 5 of this certification report. For the maternity supplemental payment, the assumed administrative expense load leveraged the process described in Section 5 for the standard CY 2025 capitation rates, with a focus on the variable component that typically represents approximately half of the total administrative loading. This is a supplemental payment and is consistent with the historical approach where only the variable portion of the administrative load is applied since the fixed portion is included in the member's monthly capitation payment. Section 5 provides a summary of the detailed administrative loading percentages specific to supplemental payments including maternity. The underwriting gain load for this payment rate is consistent with those applied for the standard CY 2025 capitation rates (2% at the lower bound, 3% at the midpoint, and 4% at the upper bound).

- SIS and UIS Payment Rates
  - As noted in Section 3, the maternity supplemental payment base data is the same for the UIS and SIS populations. Since no differences are assumed in trend and program change factors by COS, the resulting supplemental payment rates are the same for the UIS and SIS populations by region. The maternity payment specific for the UIS population is considered 100% federal.

Whole Child Model Managed Care Adjustment

The WCM rate cell for new COHS counties (San Benito, Rural Upper Central counties, and Mariposa) is a rate cell new to the CY 2025 rating period for these counties. In review of the base data information (including managed care experience as well as CCS-covered FFS costs), it was noted that the PMPM amounts were significantly lower than other WCM PMPMs in existing WCM counties. This, coupled with contracting difficulties in these regions voiced by PHC and Central California Alliance for Health, necessitated an adjustment in order to ensure that costs built in for these rate cells are reasonable, appropriate, and attainable for these rate cells. This ultimately resulted in utilization adjustments to Rural Upper Central and San Benito for the Professional COS' (PCP, Specialty, FQHC, NPP) and Transportation, and unit cost adjustments to IP, OP, ER, and the Professional COS'. The adjustments were based on a review of WCM experience in these new COHS counties compared to the existing COHS counties that have more mature WCM programs. The impact of this adjustment was a 9.3% and 62.9% increase to San Benito and Rural Upper Central WCM PMPMs, respectively. No adjustment was deemed necessary for Mariposa within the Central California region, as this county represents a very small portion of member in this region.

Other Items

Health Care-Acquired Conditions

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

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

Mercer initially reviewed potential encounter data information for making an appropriate adjustment. Unfortunately, the required information (a present on

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

Graduate Medical Education

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

Third-Party Liability

The MCP 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

MCPs in the Mainstream managed care program are not required to cover retrospective eligibility periods for their enrollees. These periods are covered in the Medi-Cal FFS program. Since MCP data predominantly serves as the base data for the rate ranges and FFS data is adjusted to remove initial months of enrollment for beneficiaries within managed care rate setting, retrospective eligibility periods are not part of the capitation rate development process. No further adjustments are necessary.

Mental Health Parity and Addiction Equity Act

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

Provider Overpayments

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

Section 5

Projected Non-Benefit Costs

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

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

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

Administration

Below is Table 5, detailing the aggregate mid-point administrative percentages assumed within the rate development for all model types for CY 2025. The range for the regular administrative loading is +/- 0.9% at the upper/lower bound from the mid-point value for all regions except Rural Upper Central, North Bay, and Rural North which had a +/- 0.6% range, Orange with a +/- 0.7% range, and Central Coast and San Mateo with a +/- 0.8% range at the upper/lower bound from the mid-point value. The range varies as it is targeted as a percentage (-/+ 12%) around the mid-point value which can vary by region.

Table 5

Region	CY 2024 Administrative Load	CY 2025 Administrative Load	CY 2025 Administrative Load For Supplemental Payments and Add-Ons
GMC, Regional, Single-Plan, and Two-Plan Regions	8.00%	7.50%	3.750%
San Benito	8.00%	7.50%	3.750%
Rural Upper Central	8.00%	5.20%	2.600%
Central California	7.90%	7.50%	3.750%

Region	CY 2024 Administrative Load	CY 2025 Administrative Load	CY 2025 Administrative Load For Supplemental Payments and Add-Ons
Central Coast	7.60%	6.95%	3.475%
Orange	6.00%	6.30%	3.150%
San Mateo	6.75%	6.85%	3.425%
Ventura	8.00%	7.80%	3.900%
North Bay	5.25%	5.20%	2.600%
Rural North	5.25%	5.20%	2.600%
Statewide	7.66%	7.17%	3.585%

Similar to prior years, the administrative load for the Medi-Cal Managed Care program is developed in aggregate across all COA groups. For COHS regions, this is developed using MCP/region-specific experience, consistent with prior rating periods. For CY 2025, the following additional considerations were factored into the calculation of administrative load:

- PHE Unwinding — Due to end of the continuous coverage requirement, CY 2025 enrollment is expected to be lower than what was experienced in CY 2024. The maintenance of fixed administrative expenses from year-to-year is therefore expected to spread across less membership and revenue.
- New Contracting Requirements — Additional contracting requirements were mandated for population health management, care coordination, management information systems, provider management, quality improvement and health equity transformation, and a community advisory program as well as additional reporting requirements.
- Significant Program Changes — The TRI program change, which replaces the Prop 56 Physicians Supplemental Payment, now adds significant additional dollars to the base amounts.

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

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

The midpoint percentage was developed in large part from a review of the MCPs' historically-reported administrative expenses. The administrative costs are reviewed to ensure they are appropriate for the approved State Plan services and Medicaid eligible members. Mercer also utilized its experience and actuarial judgment in determining the mid-point and lower/upper bound percentages to be reasonable. Based on the review of the most recent Medi-Cal specific administrative cost data and information, which indicates an overall decrease of administration percentage from multiple data sources including the most recent quarterly financial data through the second quarter of CY 2024, Mercer developed the assumed administration percentage level accordingly for CY 2025 rates.

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

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

If the fixed cost component of administrative costs is broken down and viewed on a PMPM basis, then this fixed dollar amount is a larger percentage of the capitation rate of the less expensive COA groups, and a smaller percentage of the capitation

rate for the more expensive COA groups. This concept has been applied in a budget-neutral fashion (no administrative dollars have been gained or lost) to the capitation rates, whereby the administrative percentage will be greater for less expensive COA groups than the aggregate administrative percentage over the entire population. Similarly, the administrative percentage for the more expensive COA groups will be less than the aggregate administrative percentage over the entire population.

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

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

Underwriting Gain

The mid-point underwriting gain remained consistent with the prior rating period at 3% for the CY 2025 rating period across all MCPs. The range for the underwriting gain component is +/- 1.0% at the upper/lower bounds from the mid-point value for all models. Mercer has implicitly and broadly considered the cost of capital within our rating assumptions.

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

Managed Care Organization Tax

DHCS submitted a modified MCO Tax proposal to CMS on June 30, 2024, that, if approved, would become effective retroactively to January 1, 2024. To calculate the total tax liability for each MCP, DHCS utilized enrollment from CY 2022. Based on this enrollment period, each MCP's member months were taxed at specific per member rates, categorized by tiers, which also varied depending on the member's type of coverage (Medicaid versus non-Medicaid). Included below is a table that summarizes the submitted tax structure for the CY 2025 rating period.

Table 6 — CY 2025 MCO Tax Structure

Medicaid		Non-Medicaid	
Member Range	Tax per member	Member Range	Tax per member
0–1,250,000	$0.00	0–1,250,000	$0.00
1,250,001–4,000,000	$274.00	1,250,001–4,000,000	$2.00
Over 4,000,000	$0.00	Over 4,000,000	$0.00

For the CY 2025 calculations currently included in the accompanying exhibits, Mercer used projections that were informed by enrollment through August 2024 to calculate the add-on PMPMs. DHCS is currently awaiting CMS approval on the MCO tax proposal. If the current structure is not approved or altered, the appropriate funding levels for the tax would be re-evaluated and incorporated in a future rate amendment.

Section 6
Risk Adjustment

Risk adjustment was applied to the region average capitation rates for certain COA groups and services with 100% credibility. Within the risk-adjustment process used for the CY 2025 capitation rates, certain services are separated within the region average rates and specific risk-adjustment mechanisms are used to create MCP-specific rates, separate for these services. Within the development of the risk-adjustment factors, the following services were separated out and risk-adjusted using different methodologies.

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

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

This section describes the methodology used to risk adjust each component of the capitation rates. All of the processes described below are done for both the UIS and SIS populations separately, with credibility considerations described later.

All Remaining Services

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

Mainstream capitation rates are risk-adjusted using the CDPS+Rx health-based payment model, Version 7.0, developed by researchers from the University of California (UC), San Diego. This risk-adjustment process applies to the UIS and SIS populations, specifically, the Child, Adult, ACA Expansion, and SPD-LTC COA groups only. In addition, since a separate maternity payment rate has been developed, maternity costs were excluded from the risk-adjustment process for the Child, Adult, and ACA Expansion COA groups.

Since risk adjustment is applied to distribute funds to MCPs within a region and some regions only have one MCP, capitation rates for MCPs in these regions are not risk-adjusted. Further, the WCM rates are not risk adjusted since no readily available model exists for this very specific population.

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

The individual acuity factors and final plan factors in effect for CY 2025 were based on claims and encounter data with dates of service November 1, 2022 through October 31, 2023 (referred to as the study period), using encounter data submitted by the MCPs to DHCS by April 30, 2024. After individual acuity factors are calculated using the above study period, these acuity factors are aggregated by MCP and COA groups using each plan's enrollment snapshot as of September 2024.

To ensure the risk-adjustment process does not increase or decrease the total amount of capitation payments, the MCPs' risk factors are adjusted for budget neutrality. The intent of this adjustment is to recalibrate all the MCP risk-adjustment factors to yield a region average of 1.0. Each MCP's own risk-adjustment factors is then applied to the region average base capitation rates (less BHT, CBAS, LTC long-term stays, and ECM components) to arrive at each MCP's risk-adjusted rate.

The risk-adjustment process only includes experience data for individuals who have at least six months of total Medi-Cal eligibility within the 12-month study period. Individuals who do not meet the six-month eligibility criterion are assigned an assumed risk score, which is typically the respective MCP's average risk factor associated with that individual's COA group (done separately for each region). The exception to this is for the Adult and ACA OE COA groups for the UIS population, where unscored members in the same region are assigned the same assumed score regardless of MCP. In this case, the assumed average score is derived from the assumed cost relativity used in the program change adjustment for the UIS age 26–49 member expansion.

The CDPS+Rx risk adjustment model, Version 7.0, has been further adjusted to more closely align with the risk associated with the Medi-Cal managed care covered benefits. For example, the cost weights reflected in the national model were developed assuming standard benefit packages (including options of including or excluding pharmacy and BH services), utilizing multiple states' data. Mercer modified the cost weights to better reflect California Medi-Cal-specific data and services covered under the managed care program (excluding pharmacy, BHT, CBAS, and LTC long-term stays services). For additional details of the CDPS+Rx risk adjustment methodology, please see the separate document *CY 2025 CA Final RAR Methodology Letter 2024 12.pdf*.

Behavioral Health Treatment Services

To calculate the risk-adjustment factors specific to BHT services, BHT utilizer prevalence was measured based on the state's eligibility data as well as the state's BHT supplemental payment records (available through December 2022, when the BHT supplemental payment was in effect).

The first step in this process was to limit to beneficiaries in the enrollment snapshot month of September 2024. Medi-Cal managed care enrollment for these members was reviewed for the CY 2022 time period, and if a member had six or more months of Medi-Cal managed care enrollment within the CY 2022 data period, the member was deemed scored; otherwise, the member was deemed unscored. Any member who had at least three BHT kick payments in CY 2022 was deemed a BHT utilizer. Based on this information, BHT utilizer statistics were generated based on the snapshot month. This process was done on scored recipients only. Unscored members were assumed to have the same utilizer mix as scored members, separate for each MCP, region, and COA group.

To derive the plan factors applicable to the BHT portion of the capitation rates, each MCP's plan-specific BHT utilizer percentage was divided by the region average.

Since the vast majority of BHT costs occur with the Child and SPD-LTC COA groups, this process only applies to these two COA groups. All other populations did not contain enough BHT service volume to warrant an application of risk adjustment, and all factors were defaulted to 1.0 in these cases.

Community-Based Adult Services

To calculate the risk-adjustment factors specific to CBAS services, CBAS utilizer prevalence was measured using encounter data from January 2023 through December 2023 (CY 2023) and the state's eligibility data. The encounter data was reviewed at a monthly level and checked for reasonableness against MCP-reported RDT experience, specific to CBAS services.

The first step in this process was to limit to beneficiaries in the enrollment snapshot month of September 2024. Medi-Cal managed care and FFS enrollment for these members was then reviewed for the CY 2023 time period, and if a member had six or more months of Medi-Cal managed care enrollment within the CY 2023 data period,

the member was deemed scored; otherwise, the member was deemed unscored. Any member who had at least 25 days of CBAS utilization in the study period was deemed a CBAS utilizer. Based on this information, CBAS utilizer statistics were generated based on the snapshot month. This process was done on scored recipients only. Unscored members were assumed to have the same utilizer mix as scored members, separate for each MCP, region, and COA group.

To derive the plan factors applicable to the CBAS portion of the capitation rates, each MCP's plan-specific CBAS utilizer percentage was divided by the region average.

Since the vast majority of CBAS costs occur within the SPD-LTC and SPD-LTC/Full-Dual COA groups, this process only applies to these two COA groups. All other populations did not contain enough CBAS service volume to warrant an application of risk adjustment, and all factors were defaulted to 1.0 in these cases.

Long-Term Care Long-Term Stays Services

Budget neutral risk-adjustment factors were created for the portion of the LTC COS attributable to long-term stays (i.e., 90 consecutive days or more). To calculate the risk-adjustment factors specific to LTC long-term stay services, LTC utilizer prevalence by certain facility types was measured using encounter data from April 2023 through December 2023 and the state's eligibility data.

The first step in this process was to limit to beneficiaries in the enrollment snapshot month of September 2024. Managed care and FFS enrollment for these members was then reviewed for the April 2023 through December 2023 time period, and if a member had three or more months of managed care enrollment within this data period, the member was deemed scored; otherwise, the member was deemed unscored. Any scored member who had at least 90 consecutive days in an LTC facility in the study period was deemed an LTC utilizer. These members were then further classified into three different risk groups hierarchically. The three risk groups hierarchically are the following: members residing in Distinct Part Skilled Nursing Facilities (DP-NF) facilities, members residing in ICF-DD facilities, and members residing in any other facility (such as a SNF-B facility). In order to be classified in the DP-NF or ICF-DD groups, the member had to have at least 30 days at one of those facilities. Each member was assigned the highest-level risk group that they were classified into within the study period. LTC utilizers classified as DP-NF received a cost weight value of 2.00, LTC utilizers classified as ICF-DD received a cost weight value of 1.15, and all other LTC utilizers received a cost weight value of 1.00. This was done to recognize different average cost levels associated with the different facility types. Members who are not LTC utilizers received a cost weight value of 0.00. Each MCP's unadjusted LTC risk score was calculated as the average cost weight value of all scored recipients and can be viewed as a "cost-weighted LTC utilizer prevalence". Unscored members were assumed to have the same LTC risk score as scored members, separate for each MCP, region, and COA group.

To derive the plan factors applicable to the LTC long-term stays portion of the capitation rates, each MCPs plan-specific average LTC risk score (as described above) was divided by the region average.

This process applies to all COA groups with the exception of Child and WCM, since these two COAs did not contain enough LTC service volume to warrant an application of risk adjustment. All factors were defaulted to 1.0 in these cases.

Enhanced Care Management

Budget neutral risk-adjustment factors were created by evaluating the relative proportion of members enrolled in ECM to the overall population, or ECM prevalence (i.e., the ratio of ECM member months to total member months). To identify members enrolled in ECM, ECM enrollment rosters submitted by the MCPs in quarterly reporting for June 2024 were used as the numerator. Total MCP enrollment in June 2024 by region and COA group from the State's eligibility data was used as the denominator.

To derive the plan factors applicable to the ECM benefit portion of the capitation rates, each MCP's plan-specific average ECM prevalence was divided by the region average. Then the resulting factors were averaged with a 1.0. This final adjustment was done to recognize the program is still ramping up from the program's inception in January 2022.

Finally, the ECM risk adjustment process only applies to the Child, Adult, ACA OE, SPD-LTC, and SPD-LTC/Full Dual COA groups.

Credibility Considerations

Within all risk adjustment processes, there were credibility requirements for an MCP to be risk adjusted. In order for an MCP to be credible in a certain region and COA group, the following criteria needed to be met:

- Scored recipients needed to be at least 500 in the enrollment snapshot month.
- Market share needed to be at least 2.0% in the enrollment snapshot month.

In the event an MCP in a certain region and COA group did not meet the credibility criteria noted above, its score was defaulted to a 1.0 factor and final budget neutral factors for all credible plans in that region/COA group were recalculated excluding the non-credible MCP.

Further, at the region and rate cell level for the BHT, CBAS, LTC, and ECM processes only, a minimum number of utilizers needed to be present in the enrollment snapshot in order for any MCP to be risk adjusted in that region and rate cell. If the number of utilizers was less than 30 across an entire region and rate cell, all MCPs within that region and rate cell were defaulted to a 1.0 factor.

All of the risk-adjustment processes apply to both the UIS and SIS populations. However, there are many instances where credibility criteria are not met, in particular

for the UIS population. As noted, final risk-adjustment scores are defaulted to a 1.0 in these cases.

Per Members Per Months Not Subject to Risk Adjustment

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

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

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

Section 7

Special Contract Provisions Related to Payment

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

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

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).

Quality Withhold and Incentive Program — Quality Incentive

The state implemented the Quality Withhold and Incentive (QWI) program beginning in CY 2024. The QWI program is designed to incentivize MCPs to improve the care quality received by Medi-Cal managed care members and reduce racial and ethnic disparities for specified quality measures.

Under the QWI program, a quality incentive is implemented alongside a quality withhold. Any withhold dollars not earned back by MCPs under the quality withhold will be paid out through the quality incentive. Documentation of the quality withhold is included in the Withhold Arrangements section of this certification.

All MCPs are in the program for CY 2025.

The QWI incentive has no effect on the development of capitation rates.

Further details of the quality incentive are described in the accompanying methodology letter titled *CY 2025 CA Quality Withhold and Incentive Methodology 2024 12.pdf.*

Withhold Arrangements

Quality Withhold and Incentive Program — Quality Withhold

The quality withhold is implemented alongside the quality incentive under the QWI program, as described in the previous section on Incentive Arrangements. Any withhold dollars not earned back by MCPs under the quality withhold will be paid out through the quality incentive.

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

The QWI program will withhold 0.76% from the final certified rates across all MCPs for CY 2025. The withhold will apply to both SIS and UIS rates across all COAs.

All MCPs will be expected to participate in the program for CY 2025. The enrollees covered by the QWI program include all Medi-Cal populations covered under the MCPs that are expected to participate in the program for CY 2025.

The QWI withhold has no effect on the development of capitation rates.

Of the total withheld amount, 0% is not reasonably achievable under the QWI program. Further details on the achievability and reasonableness of the quality withhold are described in the accompanying methodology letter titled *CY 2025 CA Quality Withhold and Incentive Methodology 2024 12.pdf.*

Risk Sharing Mechanisms

Proposition 56/General Fund

The state is continuing two-sided, risk corridors associated with the Prop 56/General Fund directed payment initiatives which had such mechanisms in the prior rating period (CY 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 of this report. No risk-sharing mechanism will be in place for the Prop 56 Dental directed payment.

Rationale for the Use of the Risk-Sharing Arrangement

Risk corridors are necessary for these programs for multiple reasons. First, for some of the Prop 56 arrangements, there was limited credible and complete claims experience data available in the base period with which to develop capitation rates. Also, the risk corridors support DHCS' policy interest in mitigating potential perverse financial incentives for 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

Two-sided risk corridors shall be in effect for Prop 56/General Fund 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 ACEs 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 categories of aid and rating regions where the MCP operates for dates of service within the program year. DHCS will perform the risk corridor calculations 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 amounts 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/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.

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 the risk corridors. The CY 2025 capitation rates, outlined in the rate certification, reflect 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 Directed Payment/General Fund add-on risk sharing mechanisms were 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 region 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 utilizing 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 MCP's applicable ECM add-on capitation payment revenues for the rating period.

The risk corridor will consist of the following bands:

- If the aggregate MEP is less than 95%, the 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 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 ECM add-on capitation payment revenues and the aggregate amount of the MCP's MEP numerator.

Once an 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 but reserves the right to use an alternative methodology if the State, in consultation with Mercer, deems the alternative to be reasonable and appropriate for this purpose.

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

- Non-medical expenses (e.g., non-service investments for infrastructure and capacity).
- 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 years 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 exclusively for administrative costs as defined in Title 28, California Code of Regulations, § 1300.78, such as but not limited to network development and claims processing.
- An assumed non-medical component of global subcapitation payments made by MCPs to global subcontractors that aligns with assumptions used in the CY 2025 rate development (see Base Data Adjustments related to Global Non-Medical Expense Adjustment). Reductions will be applied in a manner that ensures alignment between allowable medical expenses and medical costs considered in the rate development process.

The State reserves the right to make other appropriate adjustments to other MCP-reported expense items 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 originally implemented in CY 2022 for the portion of CY 2025 MOT PMPM expenses 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 regions.

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 regions 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 utilizing 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 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.

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 estimated MOT 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 estimated MOT 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 estimated MOT capitation payment revenues and the aggregate amount of the MCP's MEP numerator.

Once an 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 but reserves the right to use an alternative methodology if the

State, in consultation with Mercer, deems the alternative to be reasonable and appropriate for this purpose.

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

- Non-medical expenses.
- 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 MCP contract.

San Benito County

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

Rationale for the Use of the Risk-Sharing Arrangement

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

Description of How the Risk-Sharing Arrangement is Implemented

The risk-sharing arrangement will be a two-sided risk corridor utilizing actual expenditures experienced by the MCO, subject to appropriate adjustments as

described below. The risk corridor shall be based on a calculated MEP achieved by the MCO. The MEP shall be calculated in aggregate across all applicable COAs. The risk corridor calculations shall be performed no sooner than 12 months after the end of the rating period.

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

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

The risk corridor will consist of the following bands:

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

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

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

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

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

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

There is no impact on the CY 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.

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

Mercer confirms the CY 2025 San Benito County risk sharing mechanism was developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medi-Cal covered populations and services under the managed care contract.

Federally Qualified Health Centers Alternative Payment Model

Starting with the CY 2025 rating period, DHCS will implement a symmetrical, two-sided risk corridor for the new FQHC APM program. This risk mitigation mechanism will be applicable to all MCPs having members participating in the FQHC APM.

Rationale for the Use of the Risk-Sharing Arrangement

The potential variability associated with the implementation and ramp up of the FQHC APM supports the benefits of utilizing a two-sided risk corridor. Member enrollment and FQHC participation could vary significantly by COA, region, and health plan. MCPs do not have much autonomy in the process; the PMPM is mandated, the MCPs do not select the FQHCs who participate, and it is difficult to change member assignment with FQHCs. MCP-submitted encounters and plan reported supplemental data submitted in a DHCS template will be utilized in the risk corridor calculations. The use of a risk corridor helps promote accurate encounter and membership roster submissions from providers and MCPs. Therefore, the use of this risk corridor is an appropriate approach to better match the payments to the overall risk and will improve the completeness and accuracy of data submissions.

Description of How the Risk-Sharing Arrangement is Implemented

The risk-sharing arrangement will be a two-sided risk corridor that utilizes actual FQHC APM PMPM expenditures experienced by the MCPs relative to FQHC APM PMPM 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 MCP-submitted FQHC APM PMPM payments that have been accepted by the state in accordance with its policies and plan reported supplemental data reported in a template provided by DHCS.

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 FQHC APM PMPM add-on capitation payment revenues and the projected medical portion of the APM PMPM already included in the MCP's base capitation rate, for the rating period. The risk corridor will consist of the following bands:

- If the aggregate MEP is less than 99.25%, the MCP will remit to the state within 90 days of notice the difference between 99.25% of the medical portion of the MCP's applicable FQHC APM PMPM 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 99.25%, but less than or equal to 100.75%, 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 100.75%, the state will remit to the MCP the difference between 100.75% of the medical portion of the MCP's applicable FQHC APM PMPM add-on capitation payment revenues and the aggregate amount of the MCP's MEP numerator.

Once an 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 but reserves the right to use an alternative methodology if the State, in consultation with Mercer, deems the alternative to be reasonable and appropriate for this purpose.

DHCS will make appropriate adjustments to allowable medical expenses to exclude items such as non-medical expenses.

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 development of the CY 2025 capitation rates related to the risk corridor provision. The CY 2025 capitation rates, outlined in this rate certification, reflects Mercer's best estimate of the anticipated costs associated with FQHC APM PMPM.

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

Mercer confirms the CY 2025 FQHC APM PMPM 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 MCP contract.

Medical Loss Ratio Remittance

DHCS will continue to 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 by 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 Mainstream managed care program CY 2025 capitation rates. All applicable directed payments are summarized in Table 7 below. The following subsections provide more detail around each initiative.

Table 7

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
Control Name TBD — Prop 56 Dental	Uniform dollar and percentage increases	Uniform percentage and dollar increases for specific dental services	Rate adjustment
ACEs Screening (no preprint required)	Minimum fee schedule using State Plan approved rates	Minimum fee schedule for specific ACEs Screening services	Rate adjustment

Control Name of the State Directed Payment	Type of Payment	Brief Description	Is the Payment Included as a Rate Adjustment or Separate Payment Term?
Control Name TBD — Developmental Screenings	Uniform dollar increase	Uniform dollar increase for specific Developmental Screening services	Rate adjustment
Control Name TBD — MOT	Delivery system reform	FFS-equivalent payment requirement for network and non-network providers for newly transitioning organ and bone marrow transplant surgeries	Rate adjustment
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
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
CA_Fee_IPH.OPH.AMC.PC.SP.NF_Renewal_20250101-20251231 — Enhanced Payment Program (EPP)	Uniform dollar or percentage increases	Uniform percentage increases to capitation payments and uniform dollar increases for FFS services limited to predetermined pool amounts by Designated Public Hospital (DPH) class and IP/non-IP service sub-pools	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.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 — SNF Workforce and Quality Incentive Program (WQIP)	Quality-adjusted uniform dollar increase	Uniform dollar increase for contracted services modified by quality based scores at the provider level	Separate payment term
CA_VBP_NF.Oth_New_20230101-20251231 — 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	Rate adjustment

Control Name of the State Directed Payment	Type of Payment	Brief Description	Is the Payment Included as a Rate Adjustment or Separate Payment Term?
		services in non-transitioning counties	
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_Oth3_New_20240101-20261231 — Children and Youth Behavioral Health Initiative (CYBHI)	Delivery system reform.	A minimum/maximum fee schedule for school-linked behavioral health services	Rate adjustment
Control Name TBD — Equity and Transformation	Performance-adjusted uniform dollar increase	Uniform dollar increase for contracted services modified based on performance on designated measures and limited by assigned lives.	Separate payment term
CalAIM Dental Preventive Services (no preprint required)	Minimum fee schedule using State Plan approved rates	Minimum fee schedule for specified preventive service codes at the equivalent of 75% above the State's Schedule of Maximum Allowances	Rate adjustment
FQHC APM (no preprint required)	Minimum fee schedule using State Plan approved rates	Minimum fee schedule for participating FQHCs	Rate Adjustment

There are no additional directed payments in the program for CY 2025 unaddressed in this rate certification. There are no requirements regarding the reimbursement rates the health plans must pay to any providers unless specified in the certification as a directed payment or pass-through payment or authorized under applicable law, regulation, or waiver.

Federally Qualified Health Centers Alternative Payment Model

Effective July 1, 2024, an Alternative Payment Methodology (APM) which provides reimbursement to participating FQHCs on a capitated basis was implemented. For the CY 2025 rating period, two FQHCs have opted into the APM program.

FQHCs are currently reimbursed their PPS rate for each eligible service provided to a Medi-Cal managed care member. This takes the form of health plan's paying an encounter or market rate for each PPS eligible visit that their members make to the FQHC. The State makes a wrap payment to the FQHC representing the difference between the PPS rate to which the FQHC is entitled to and the market rate which the health plan initially reimbursed the FQHC.

The proposed APM would pay FQHCs a monthly capitated payment for each Medi-Cal managed member assigned to the FQHC. This monthly capitation, is developed using actuarial methods, projecting historical member FQHC utilization into the contract period and applying the PPS rate to the utilization to develop this PMPM. Acknowledging some FQHC utilization naturally comes from unassigned/walk-in beneficiaries, the utilization assumed in the APM capitation includes unassigned members, subject to reasonable limitations. If a member is assigned to a clinic, but visits another, different APM participating clinic, no payment for this visit will be made to the rendering clinic as that member would be considered unassigned to the other clinic. In situations where there is no assignment between a health plan and an APM participating clinic, and therefore no APM capitation paid, if a member from the health plan visits said clinic the health plan will reimburse the full PPS rate.

In order to evaluate the impact of this program change for affected health plans, Mercer projected the expected expense that the specific health plan will experience based on historical data. These expenses and utilization were projected for the potential payment scenarios that the health plan could experience and compared to the historical base expenditures at this clinic, projected to the contract period, to develop the add-on PMPM paid to the health plan. A 4% administrative load, representing the increase in variable administrative expense, and a 3% margin/underwriting gain was applied to this add-on PMPM.

The APM includes safeguards to ensure that participating FQHCs receive their full PPS entitlement and will be linked to specific quality metrics that must be satisfied as a condition of continued participation. The APM does not cover dual eligible members or dental services. These populations and services were excluded from this evaluation.

To facilitate CMS rate review for the FQHC APM directed payment, the table below, Table 8, summarizes the directed payment, since it is incorporated into the capitation rates as a rate adjustment.

Table 8

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
FQHC APM	Child, Adult, ACA Expansion, SPD-LTC	See "Sum – Add-Ons Details" tabs in the file titled *CY 2025 Medi-Cal Rate Summaries 2024 12.xlsx*	Described above	No preprint required (minimum fee schedule)	Not applicable

Proposition 56/General Fund Directed Payments

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

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

Prop 56 add-ons are contingent on appropriations of funds being approved by the California Legislature. Currently, all components are effective for the entire CY 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 and Developmental Screening initiatives, listed above with no reference of “Prop 56”, will be funded by State General Fund for the State share in CY 2025.

To facilitate CMS rate review for each of the Prop 56/General Fund payment initiatives, Table 9 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 9

Control Name of the Directed Payment	Rate Cells Affected	Impact	Description of the Adjustment	Confirmation the Rates are Consistent with the Preprint	For Maximum Fee Schedules, Provide the Information Requested
CalAIM Dental Preventive Services	HPSM only — All COAs	Directed payment is reflected in the CY 2023 base data	Minimum fee schedule for specified preventive service codes at the equivalent of 75% above the State’s Schedule of maximum Allowances.	No preprint required (minimum fee schedule).	Not applicable
CA_Fee_Oth2_Renewal_20250101-20251231 — Prop 56 Family Planning	All except SPD-LTC/Full-Dual	See “Sum – Add-Ons Details” tabs in the file titled *CY 2025 Medi-Cal Rate Summaries 2024 12.xlsx*	Adjustment is applied as a PMPM add on to the rates. A description o the data, assumptions and methodology is provided in the narrative below.	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
Control Name TBD — Prop 56 Dental	HPSM only All COAs	See exhibit referenced above	See prior description	Confirmed. The preprint will be submitted to CMS in December 2024.	Not applicable
ACE Screening	All except SPD-LTC/Full-Dual	See exhibit referenced above	See prior description	No preprint required (minimum fee schedule).	Not applicable
Control Name TBD — Developmental Screenings	Child, Adult, ACA Expansion, SPD, and WCM	See exhibit referenced above	See prior description	Confirmed. The preprint will be submitted to CMS in December 2024.	Not applicable

Dental Preventive Services

Consistent with 42 CFR §438.6(c)(1)(iii)(A), DHCS implemented a directed provider payment initiative that imposes a minimum fee schedule for network providers that provide certain dental services under the contract using State Plan approved rates. The minimum fee schedule for these dental procedure codes applies to all eligible providers who perform these services. These payments are included in the CY 2023 dental base data described previously.

Prop 56 Family Planning

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 and non-network providers based on the utilization and delivery of qualifying services for eligible enrollees covered under the contract. The preprints for this payment initiative have been approved for three prior rating periods and the renewal version applicable to the current rating period 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:

- This type of 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 10

Procedure Code [5]	Description	Uniform Dollar Amount
J7294	Contraceptive Vaginal Ring: Segesterone Acetate and Ethinyl Estradiol	$301.00
J7295	Contraceptive Vaginal Ring: Ethinyl Estradio and Etonogestrel	$301.00
J7296	Levonorgestrel — Releasing Iu Coc Sys 19.5 Mg	$2,727.00
J7297	Levonorgestrel — Rls Intrauterine Coc Sys 52 Mg	$2,053.00
J7298	Levonorgestrel — Rls Intrauterine Coc Sys 52 Mg	$2,727.00
J7300	Intrauterine Copper Contraceptive	$2,426.00
J7301	Levonorgestrel — Rls Intrauterine Coc Sys 13.5 Mg	$2,271.00
J7307	Etonogestrel Cntracpt Impl Sys Incl Impl & Spl	$2,671.00
J3490U8	Depo — Provera	$340.00
J7304U1	Contraceptive Patch: Norelgestromin and Ethinyl Estradiol	$110.00
J7304U2	Contraceptive Patch: Levonorgestrel and Ethinyl Estradiol	$110.00
J3490U5	Emerg Contraception: Ulipristal Acetate 30 Mg	$72.00
J3490U6	Emerg Contraception: Levonorgestrel 0.75 Mg (2) & 1.5 Mg (1)	$50.00
11976	Remove Contraceptive Capsule	$399.00
11981	Insert Drug Implant Device	$835.00
58300	Insert Intrauterine Device	$673.00
58301	Remove Intrauterine Device	$195.00

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

Procedure Code [5]	Description	Uniform Dollar Amount
81025	Urine Pregnancy Test	$6.00
55250	Removal Of Sperm Duct(S)	$521.00
58340	Catheter For Hysterography	$371.00
58600	Division Of Fallopian Tube	$1,515.00
58615	Occlude Fallopian Tube(S)	$1,115.00
58661	Laparoscopy Remove Adnexa	$978.00
58670	Laparoscopy Tubal Cautery	$843.00
58671	Laparoscopy Tubal Block	$892.00
58700	Removal Of Fallopian Tube	$1,216.00

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

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

There were relatively complete and credible claims experience data available in the base period, though it is subject to encounter under-reporting and other data issues. Similar to the rate development approach used for the prior period, Mercer leveraged the SFY 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 11 below for detailed impacts for the 12-month period.

Table 11

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
SIS	WCM	390,217	1,537	$0.78	$304,481
SIS	**All COAs**	**19,075,730**	**1,493,555**	**$2.73**	**324,985,297**

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

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

Prop 56 Dental

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

Adverse Childhood Experiences Screening

The ACEs Screening directed payment is a payment arrangement, which directs 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 12

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 add-on. 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 2025 contract period. Note, this service is

primarily intended for children, but adults under 65 are also eligible to receive this service if deemed medically necessary. Therefore, the assumed take-up assumptions are much lower for adults compared to children. Given the assumed utilizations for each group, the age group mix for each COA, and the known unit cost (minimum fee schedule), Mercer then calculated the expected claims PMPM as the benefit cost component of the add-on rates to calculate the percentage of members eligible for this service within each COA. Note, enrollees above age 65 or with Medicare Part B coverage are not eligible for this service. Mercer worked together with the State to develop age group specific take-up assumptions around the percentages of eligible members within each age group who will receive this service within the contract period for the CY 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 13 below for detailed impacts for the 12-month period.

Table 13

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	**All COAs**	**119,075,730**	**1,141,247**	**$0.28**	**$34,833,901**

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

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

Developmental Screening

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

Table 14

Procedure Code	Description	Uniform Dollar Amount
96110	Developmental Screening (absent modifier “KX”)	$59.90

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

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

Mercer was able to rely on experience data available in the SFY 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 0–2 and age group 3–20) by COA across all model types to calculate the percentage of members eligible for this service within each COA. Note, only children under age 20 and without Medicare Part B coverage

are eligible for this service. Mercer developed age group specific take-up assumptions around the percentage of eligible members who will receive this service within the contract period. In conjunction with prior take-up assumptions used for historical rating periods, Mercer also relied on actual experience data for the Developmental Screening code within the SFY 2022–23 base period to inform the take-up assumptions used for the CY 2025 contract period. This service is primarily intended for younger children under age three, though older children ages three through 20 are also eligible to receive this service if deemed medically necessary. Given the assumed utilizations for each group, the age group mix for each COA, and the known additional unit cost (uniform dollar increase), Mercer then calculated the expected claims PMPM as the benefit cost component of the add-on rate. This benefit cost PMPM is developed on a combined basis for all SIS and UIS populations. Acuity factors as well as percentages of pregnancy-related and emergency services for the UIS population were developed using code level SFY 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 Developmental Screening services was found to meet the criteria as a pregnancy-related or emergency service. As a result, no portion of the UIS rates specific to this directed payment is part of this certification. Lastly, the PMPM amount of each rate component was adjusted to include half of the plan-specific administrative load, which provides for the variable component of the administrative costs of the program while the fixed administrative costs are covered in the base capitation rates, and an underwriting gain of 2.0%. Further detail of these components, including MCP-specific amounts are provided in the accompanying rate development exhibits in Excel format.

See Table 15 below for detailed impacts for the 12-month period.

Table 15

Developmental 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	731,896	$0.90	$46,081,804
SIS	Adult	17,430,799	4,550	$0.02	$348,616
SIS	ACA Expansion	42,730,795	2,786	$0.00	$0
SIS	SPD-LTC	7,293,000	6,888	$0.06	$437,580
SIS	WCM	390,217	5,575	$0.90	$349,723

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

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

Hospital Directed Payments

The following directed payments outlined below are paid as separate payment terms, apart from MOT, and the actual payments associated with these directed payments will be paid in the future. A summary of the separate payment term directed payments is provided in Table 16 below.

Table 16

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

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.OPH.Oth_Renewal_20250101-20251231 — 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 and revised on December 20, 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 on December 11, 2024.	Confirmed.
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 on December 11, 2024.	Confirmed
CA_VBP_IPH.OPH_Renewal_20250101-	$178.52 million	The actuary certifies the incorporation of the	See exhibit referenced above	Confirmed. The preprint was submitted to	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)
20251231 — DMPH QIP		separate payment term		CMS on December 11, 2024.	

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 in December 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.

Children's Hospital Supplemental Payment

The CHSP preprint was submitted to CMS on December 11, 2024 and revised on December 20, 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, 30% is designated to IP services and 70% 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 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.

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.

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

Fee-For-Service Uniform Dollar Increase

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

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

Capitation Uniform Percentage Increase

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

with the methods discussed in this certification and the 42 CFR § 438.6(c) preprint.

The total impact of the EPP directed payment across the classes is targeted to be approximately $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.

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.

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 in December 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 Medi-Cal MCP contracts. Each region 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 region-specific basis for the regions with DMPHs. Each 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 region, which formed the basis for creating uniform percentage increases that would total the intended directed payment maximum allowable payment target for each DMPH region.

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.

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 17 below summarizes the directed payment, since it is incorporated into the capitation rates as a rate adjustment.

Table 17

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	Child, Adult, ACA Expansion, SPD-LTC, SPD-LTC/Full-Dual	$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 18 below summarizes the directed payment.

Table 18

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

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).

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

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

Table 19

Control Name of the Directed Payment	Rate Cells Affected	Impact	Description of the Adjustment	Confirmation the Rates are Consistent with the Preprint	For Maximum Fee Schedules, Provide the Information Requested
CA_VBP_NF.Oth_New_20230101-20251231 — LTC Directed Payment	All	See Program Change charts referenced in Section 4	Adjustment is applied in the base capitation rates and is a portion of the LTC COS.	Confirmed.	See description above.

Children and Youth Behavioral Health Initiative

Effective January 1, 2024, CYBHI is a policy change and State directed payment that implements a universal fee schedule for school-linked behavior health services. The CYBHI directed payment is described further within Section 4 of this report.

To facilitate CMS rate review for CYBHI, Table 20 below summarizes the directed payment, since it is incorporated into the capitation rates as a rate adjustment.

Table 20

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_Oth3_New_20240101-20261231 – CYBHI	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 reference in Section 4	Confirmed	Not Applicable.

Equity and Practice Transformation Directed Payment

The Equity and Practice Transformation (EPT) State directed payment will require MCPs to reimburse selected network providers a uniform dollar add-on payment, modified based on performance on designated measures, for the first contracted service for each assigned member seen in the rating period. The add-on payment is based on the following 23 Classes and assigned lives ranges:

Table 21

Class	Assigned Lives Range
A	600–700
B	701–800
C	801–1,000
D	1,001–1,250
E	1,251–1,500
F	1,501–1,700
G	1,701–2,000
H	2,001–2,500
I	2,501–3,000
J	3,001–4,000
K	4,001–5,000
L	5,001–6,000
M	6,001–7,000
N	7,001–8,000
O	8,001–10,000
P	10,001–14,000
Q	14,001–20,000
R	20,001–25,000
S	25,001–30,000
T	30,001–40,000
U	40,001–50,000
V	50,001–100,000
W	100,001–150,000

The total impact of the EPT directed payment across the classes is targeted to be approximately $41.6 million.

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 22 below summarizes the directed payment, since it is incorporated into the capitation rates as a rate adjustment.

Table 22

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

Pass-Through Payments

Pass-through payments, as described below, are applied in the Mainstream 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 aforementioned private pass-through PMPM adjustments are added to the post risk-adjusted rates.

Included attachments labeled *Exhibit A CY 2025 Private Hospital IP HQAF Pass-Through 2024 12.pdf* and *Exhibit B CY 2025 Private Hospital OP ER HQAF Pass-Through 2024 12.pdf* contain the detailed components behind these calculations. The resulting PMPM add-on rates by rate cell are provided in the “Sum – Region Add-Ons” tabs within the attached spreadsheet *CY 2025 Medi-Cal Rate Summaries 2024 12.xlsx*.

These pass-through payments are paid to private hospitals.

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 ultimately necessary for the payments will not be known until after the rating period has ended. The amount of HQAF revenue collected by the State will follow the

CMS-approved fee model and is independent of the final amount of pass-through payments.

Martin Luther King Jr. Community Hospital in Los Angeles Region

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

The estimated share of IP revenue for MLK was applied to the capitation IP GME PMPM by rate cell. These calculations produced estimated MLK PMPMs by rate cell and in total. It should be noted, the GME amounts utilized to produce the baseline amounts are inclusive of projected maternity costs. This approach was taken so these adjustments did not impact the maternity supplemental payments (this is consistent with historical practice). A uniform percentage increase for the MLK component of the IP COS was established to provide the needed adjustments to reflect the required costs. The development of these adjustments also includes a 3.30% 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 – Region Add-Ons” tabs within the attached spreadsheet *CY 2025 Medi-Cal Rate Summaries 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.

Benioff Children’s Hospital Oakland in Alameda Region

Historical base data adjustments for Benioff Children’s Hospital Oakland (BCHO) in the Alameda region for the Child and SPD rate cells are being presented as pass-through payments based upon the definition of a pass-through payment within 42 CFR § 438.6(d). As described in prior certifications, the payment levels incorporated within the base data utilized for rate development did not reflect the

costs the hospital was incurring to serve the Medi-Cal population. Based upon a review of the cost information provided from the MCPs and the hospital, adjustments have been introduced to produce add-on PMPM amounts reflecting the difference between costs included in the base capitation rates and the actual costs.

The estimated share of revenue for BCHO was applied to the capitation GME PMPM by rate cell and applicable COS. These calculations produced estimated BCHO PMPMs by rate cell and in total. It should be noted the GME amounts utilized to produce the baseline amounts are inclusive of projected maternity costs. This approach was taken so these adjustments did not impact the maternity supplemental payments (this is consistent with historical practice). A uniform percentage increase across all applicable COS was established to reflect the needed adjustments to reflect total costs. The development of these adjustments also includes a 3.30% administrative load that aligns with administrative costs assigned to the maternity supplemental payment as well as the administrative load included with the Prop 56 directed payment add-on payments. An underwriting gain of 2.00%, 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 $25.77 million across CY 2025 based upon enrollment projections.

The detailed build-up of these adjustments is included in the attachment labeled *Exhibit D CY 2025 BCHO Pass-Through 2024 12.pdf*. The resulting PMPM add-on rates by rate cell are provided in the “Sum – Region Add-Ons” tabs within the attached spreadsheet *CY 2025 Medi-Cal Rate Summaries 2024 12.xlsx*.

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

The non-federal share of this payment arrangement will consist of voluntary IGTs from eligible public entities. For this payment, the entity transferring funds is University of California, San Francisco, a state entity that does not have general taxing authority. The IGT for the non-federal share of the payments is voluntary, and the State solicits a letter of intent from University of California, San Francisco that will identify the approximate amount of IGTs they plan to provide. As the non-federal share of the final payments will be based upon actual member months realized by MCPs, the total amount of IGTs that ultimately will be necessary for the payments will not be known until after the rating period has ended. To the best of our knowledge, the entity has not received State appropriations specific to this program at this time. As stated above, the non-federal share of this payment will consist of a voluntary IGT for which the transferring entity will certify the transferred funds qualify for federal financial participation. The State has yet to enter into any written agreement with the funding entity relating to the non-federal share of this payment arrangement. The State is not aware of any additional written agreements currently existing between healthcare providers and/or related entities to finance the non-federal share specific to this payment arrangement. If approved, the State intends to enter into a separate agreement with the transferring entity regarding the provision of IGTs for this purpose, including a mechanism whereby the transferring entity certifies that the

funds transferred are public funds and eligible for federal financial participation pursuant to applicable federal regulations.

Distinct Part Nursing Facilities

This pass-through payment is for public DP-NF services for facilities in Alameda and San Francisco regions that transitioned from the FFS delivery system to the managed care delivery system under 42 CFR § 438.6(d)(6). The pass-through payment transitions existing State Plan-approved supplemental payments for DP-NF services that were covered for the first time under a MCP contract following the carve-in of LTC services from the FFS delivery system on January 1, 2023. The supplemental payments were made during the 12-month period immediately two years prior (CY 2021) to the first year of the transition period (CY 2023).

The approach for making these adjustments within the capitation rates are being addressed through 42 CFR § 438.6(d)(6). The pass-through components of the DP-NF adjustments are paid as a PMPM add-on amount by rate cell, included within the certified rates.

For purposes of spreading the pool amount across all applicable health plans and regions where DP-NF services are transitioning to managed care, the approach was to develop an estimated uniform dollar increase and PMPM impacts, similar to the approach utilized for the hospital and SNF WQIP directed payments. The estimated contracted share of LTC days and unit cost differentials for the DP-NF class were applied to the GME PMPM component of the capitation rate by rate cell for the LTC COS. These calculations were performed separately for the Alameda and San Francisco regions. These calculations produced estimated DP-NF 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 pass-through payment target amount.

The total target impact of $110.9 million is projected across the Alameda and San Francisco regions, in which DP-NF services transitioned from FFS to managed care and where a public DP-NF facility exists. The development of these add-on amounts did not impact the underlying data or assumptions associated with the regular development of the capitation rates. No additional administrative load or underwriting gain is included within these add-on amounts for DP-NF.

The DP-NF pass-through PMPM adjustments are added to the post risk-adjusted rates.

Included is an attachment labeled *Exhibit E CY 2025 DP-NF Pass-Through 2024 12.pdf* containing 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 *FINAL CY 2025 Medi-Cal Detail CRCS Package LB Rate Smry 2024 12.xlsx*.

Hospital 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 3.24% 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, PDHP, and DHDP. 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.

DP-NF Pass-Through Payment Base Amount Calculation

There are three components of the calculation to determine the aggregate amount of the pass-through payment: actual supplemental paid amounts for the 12-month period immediately 2 years prior to the rating period, ratio of services transitioning to managed care, and fee schedule adjustments for the applicable DP-NF facilities.

The actual supplemental paid amounts for the 12-month period two years prior (CY 2021) in the Alameda and San Francisco regions was $112.4 million. The actual supplemental payments are based on the total payments made for dates of service in CY 2021 paid by in the FFS Supplemental Payment Rate Year (August–July) 2020–2021 and 2021–2022. The FFS Supplemental payments are made in accordance with SPA 4.19-D pages 18–21a.

Actual utilization was extracted from the DHCS Management Information System/Decision Support System for dates of service in CY 2021 and January 2024 through June 2024 based on NPIs for all applicable Public Distinct Part Nursing Facilities where Medi-Cal was the primary payor.

Prior to January 1, 2023, MCPs operating in these regions covered medically necessary SNF services for members from the time of admission into a SNF and up to one month after the month of admission into the SNF. Members were disenrolled from the MCP to Medi-Cal FFS after this time.

Utilizing this FFS data provided by DHCS, Mercer annualized the available 2024 utilization and reviewed the difference in the volume of FFS bed days between the CY 2021 and CY 2024 time periods. This volume difference for FFS was then used to determine the percentage of DP-NF supplemental payment-eligible days that remained in FFS in CY 2024 (and expected to remain in FFS for CY 2025), and the remainder had transitioned to managed care in CY 2024. Mercer assumed a level (e.g., equivalent) volume of bed days between the two time periods. As such, the difference between FFS days in CY 2021 and expected FFS days in CY 2025 yielded the number of managed care days assumed for CY 2025.

These managed care days were the numerator of the ratio of services transitioning to Medi-Cal managed care, with the denominator being total DP-NF supplemental payment-eligible days in CY 2025 (i.e., equivalent to FFS days in CY 2021). This resulted in a ratio of 98.1% that was applied as a reduction factor to the total DP-NF pool amount (i.e., 1.9% of days remained in FFS in CY 2025). In addition, 10.9% of the payments in CY 2025 were assumed to be for State-only services for members with UIS. An additional factor of 89.1% (or 1–10.9%) was applied.

These two factors combined yielded the final ratio of services transitioned from payment in an FFS delivery system to federally-eligible services covered under the MCP contract; 87.4%. The application of this ratio reduced the CY 2021 pool amount to $98.3 million.

Consistent with direction given by CMS, Mercer adjusted the CY 2021 pool amount forward to represent CY 2025 dollars through the application of DP-NF fee schedule adjustments. The fee schedule adjustments were developed consistent with other LTC rate changes that are applied as a program change within the rate-setting process and described in Section 4 of this certification.

More specifically, legislatively mandated annual FFS rate increases between the CY 2021 and CY 2025 time periods for all DP-NF, Level B facilities were compounded together to yield a four-year percentage increase to apply to the CY 2021 DP-NF pool amount. Given that the DP-NF pool amount reflected the FFS equivalent in the base period, the DP-NF rate increases adjust these payment levels to reflect the DP-NF FFS equivalent in the prospective rating period. The accumulative impact of these fee changes was 12.8% The application of these fee schedule adjustments increased the DP-NF pool amount to $110.9 million for the CY 2025 rating period.

Section 8

Certification and Final Rates

This certification assumes items in the Medicaid State Plan or Waiver, as well as the MCP 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 Mainstream 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 MCP 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, and collectively do 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 Rodney Armstrong at rodney.armstrong@mercer.com, Katharina Katterman at katharina.katterman@mercer.com, Jim Meulemans at james.meulemans@mercer.com, Robert O'Brien at robert.j.o'brien@mercer.com, or Timothy Washkowiak at timothy.washkowiak@mercer.com.

Sincerely,

[redacted]

Rodney Armstrong, ASA, MAAA
Principal

[redacted]

Katharina Katterman, ASA, MAAA
Principal

[redacted]

James J. Meulemans, ASA, MAAA, FCA
Partner

[redacted]

Robert J. O'Brien, ASA, MAAA, FCA
Principal

[redacted]

Timothy Washkowiak, 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 2022–23 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 ED 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