

Program of All-Inclusive Care for the Elderly

Capitation Rate Development and Amount that Would Otherwise be Paid Certification

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

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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 ¹ capitation rate ranges for the Program of All-Inclusive Care for the Elderly (PACE) and PACE Amount that Would Otherwise be Paid (AWOP), during the calendar year (CY) 2026 rating period. This letter presents an overview of the methodology and analyses used in Mercer's AWOP and experience-based rate range development that complies with the requirements set forth by the Centers for Medicare & Medicaid Services (CMS). The PACE AWOP, as defined by CMS, is “the amount that would otherwise have been paid under the State Plan if the participants were not enrolled under the PACE program” and “takes into account the comparative frailty of participants.” To meet CMS approval, the PACE capitation rates cannot exceed the AWOP.

¹ Actuarially sound/actuarial soundness — Medicaid capitation rates are “actuarially sound” if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital and government-mandated assessments, fees and taxes.

http://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049_179.pdf

Section 2

PACE Program Overview

PACE Eligibility

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

Table 1

Counties/County Combinations	
Alameda	Alameda, Contra Costa, Santa Clara
Alpine, Butte, Colusa, El Dorado, Glenn, Nevada, Placer, Plumas, Sacramento, San Joaquin, Sierra, Stanislaus, Sutter, Tehama, Yuba	Contra Costa
Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo	Fresno, Kings, Madera
Fresno, Kings, Madera, Tulare	Imperial, Riverside, San Bernardino
Kern, Tulare	Los Angeles
Los Angeles, Riverside, San Bernardino	Mariposa, Merced, Monterey, San Joaquin, Santa Cruz, Stanislaus
Marin, Napa, Solano, Sonoma, Yolo	Orange
Sacramento	San Diego
San Francisco	San Joaquin, Stanislaus
Santa Clara	

This certification includes rates for seven new POs, with two expected to be operational on January 1, 2026, and another five on July 1, 2026. AWOPs and experience-based rate ranges developed for these new POs were developed consistent with the methodology described below. Since no current experience exists, the experience-based rates were developed based on cost information submitted by other POs in the same geographic regions, accounting for differences in cost of living between the POs' county/counties and makeup of geographic region.

Covered Benefits

The PACE program encompasses a comprehensive benefit package, including NF, Long-Term Services and Supports (LTSS) including Home and Community-Based Services (HCBS), inpatient hospital, outpatient hospital, physician services, laboratory and x-ray services, pharmacy, transportation, durable medical equipment (DME), and hospice services. A comprehensive list of covered benefits and coordinated access services can be viewed in the State of California PACE State Plan Amendment (SPA).

Section 3

Overview of Medi-Cal PACE Rate Setting

Per California Welfare & Institutions Code 14301.1, PACE capitation rate ranges are developed using an experience-based rate approach, in addition to developing the required AWOP pursuant to the CMS PACE Medicaid Capitation Rate Setting Guide and federal regulation. The PACE capitation rates paid to each PO will be determined by the State, within the experience-based rate range and less than the AWOP. The separate developments of the PACE experience-based rates and AWOPs are consistent, and not in conflict with, the Medicaid State Plan.

AWOP Methodology

The PACE AWOP for CY 2026 was developed in accordance with the CY 2025 CMS PACE Medicaid Capitation Rate Setting Guide. With all institutionalized fee-for-service (FFS) members and Dual FFS members mandatorily enrolled in managed care effective January 1, 2024, the alternative to PACE is primarily managed care; that is Duals and Non-Duals participate in mandatory managed care that include many LTSS. Mercer utilized January through July of 2024 (1H 2024) managed care and FFS data, adjusted for the populations and services covered by the PACE program.

Experienced-Based Rate Ranges Methodology

Actuarially sound PACE experience-based rate ranges for CY 2026 were developed in accordance with generally accepted actuarial principles and practices, consistent with the approach utilized by DHCS in developing reasonable, appropriate, and attainable capitation rates under Medi-Cal. To develop the rate ranges, Mercer collected claims and other data using a rate development template (RDT) at the category of aid (COA) and category of service (COS) level. The final rate ranges were developed separately for each PO and county/county combination. Adjustments and credibility blending were applied as appropriate.

Separation of Capitation Rates into Federally Eligible Unsatisfactory Immigration Status and Satisfactory Immigration Status Populations

For CY 2026, separate PACE capitation rates were developed for members with satisfactory immigration status (referred to as the SIS population) and members with unsatisfactory immigration status (referred to as the UIS population). Additionally, for the UIS population, the capitation payment rates have been further split into the rates applicable for services eligible for federal match (namely, pregnancy-related and

emergency services) and into rates applicable for services not eligible for federal match (non-pregnancy-related and non-emergency services).

For each rate cell, UIS acuity factors compared to the SIS population, and a percentage of dollars for UIS members for pregnancy-related and emergency services were developed to separate capitation rates for the UIS and SIS populations and further break the UIS population rates into federal and state-only components. Additional information regarding the factor and percentage development is detailed in Section 6 below.

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

Section 4

AWOP Development

Identification of PACE Eligible Population

The population meeting the PACE eligibility criteria emerged from the institutional and non-institutional populations who are NF certifiable and aged 55 and older. These two broader groups (institutional and non-institutional) were further classified into Dual and Non-Dual, based on Medicare eligibility, for a total of four groups used to develop the CY 2026 AWOPs.

For the purpose of the AWOP development, the institutional members are defined as members with a long-term care (LTC) aid code or indicated as using LTC services for a particular month during the base period.

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

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

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

Category Groupings

The base data sets used to develop the PACE AWOP were divided into initial population groups, which have inherently different levels of risk. The initial population groups for the CY 2026 AWOP are as follows:

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

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

AWOP Methodology

Region-specific FFS claims and managed care plan (MCP)-reported RDT data for the 1H 2024 time period were used to develop the base data for the CY 2026 AWOP. The FFS and managed care data sets are constructed and adjusted in parallel due to the varying considerations and resulting adjustments needed for each population, as described below. The resulting AWOP rate displayed and detailed in the capitation rate calculation sheet (CRCS) is a member-weighted mix of the FFS and managed care populations; the resulting administrative and underwriting gain load assumptions shown in the CRCS exhibits are a product of this, using the non-benefit load assumptions summarized below. A sample calculation using Los Angeles County as an example can be found on the [FFS and MC GME Data – LAN] tab of the accompanying spreadsheet “CY 2026 PACE Additional Exhibits 2025 12.xlsx”. When necessary, adjustments were made to the base data to match the covered population risk and benefit package for the CY 2026 period. These adjustments included the following:

- Completing FFS claims to account for incurred but not reported (IBNR)
- Adjusting MCP-reported data to reflect a PACE-like population
- Smoothing to correct for utilization and unit cost outliers
- Seasonality due to using a half-year base data period

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

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

The projected base data was summarized to obtain the CY 2026 utilization per 1,000, unit cost, and per member per month (PMPM) by initial population group and COS. Lastly, for the Dual population, the resulting PMPMs for the institutional and HCBS populations were blended at 30% and 70%, respectively, to arrive at the CY 2026 AWOP. For the Non-Dual population, the resulting PMPMs were blended at 25% and 75% for the institutional and HCBS populations, respectively. A breakout of 1H 2024 member months by region and rate cell for the population covered by managed care versus FFS in the base data period can be found on the [Enrollment] tab of the accompanying spreadsheet “CY 2026 PACE Additional Exhibits 2025 12.xlsx”. Further, corresponding with the HCBS Acuity adjustment detailed below, Mercer’s analysis has shown that not all members meeting criteria to qualify for programs used in AWOP base data, such as IHSS, MSSP and CBAS, will meet PACE level of care

(LOC) criteria. There is no standard NF LOC definition that spans across the various programs; therefore, the mix within the base data used for rate setting purposes is likely skewed towards a higher mix of community members. Mercer has leveraged this, along with available historical experience, and actuarial judgement to arrive at a 30%/70% and 25%/75% institutional/community assumption for the Dual and Non-Dual populations, respectively. As in prior years, this remains a statewide assumption to minimize volatility, especially in smaller counties where the mix can vary materially year-to-year. The refinement to vary the blend by rate cell was based on the consistency seen across all regions that the Non-Dual rate cell had a lower distribution of institutional members within the base period. A potential variation by region may be considered in the future.

AWOP Base Data Sources and Analysis

The 1H 2024 Medi-Cal FFS and managed care claims for the four initial population groups were collected and segmented into the 20 COS shown in the table below. In addition to the Medicaid paid amount, the coinsurance amount, patient liability, and copayment amount were included in the base data such that the AWOP would include the full cost of providing State Plan services.

Table 2

COS				
Inpatient Hospital	Physician Primary Care	Mental Health Outpatient	CBAS	Community Supports (CS)
Outpatient Facility	Physician Specialty	Pharmacy	Hospice	Enhanced Care Management (ECM)
Emergency Room	FQHC	Laboratory and Radiology	MSSP	HCBS Other
LTC	Other Medical Professional	Transportation	IHSS	All Other

These COS are consistent with the grouping used to develop the capitation rates for other Medi-Cal programs. Additional Medicaid covered services (such as pharmacy, MSSP, and dental) primarily covered under FFS were added to ensure the base data was complete and reflective of the services otherwise covered for a PACE member in the CY 2026 rating period.

Managed Care Claims

The 1H 2024 time period was used in the development of the CY 2026 AWOP PACE base data. For the managed care population, both FFS claims and MCP-reported RDT information were used to form the AWOP base. Specifically, the SPD-LTC and SPD-LTC/Full-Dual COA base from the Medi-Cal managed care program was

leveraged as a starting point to form the AWOP managed care-paid base. This was then adjusted by comparing encounters of the managed care population to encounters of the PACE-like population and applying the resulting factor to the MCP-reported RDT information. Additional details on the MCP-reported RDT information, along with any further details on adjustments made to this data, can be found in the Medi-Cal Managed Care Rate certification “CA CY 2026 (01 01 2026 -12 31 2026) Rate Cert Report 2025 12 Redacted.pdf”, provided as supporting documentation to this certification. Further, the MCP-reported, managed care-paid information was supplemented with FFS claims for services covered by FFS and not the managed care delivery system, to make up the base for the managed care, PACE-like population.

Base Data Completion

For the FFS claims, IBNR was estimated and added to the base to reflect the fully incurred services and payments. The IBNR factors, provided on the [IBNR] tab of the accompanying spreadsheet “CY 2026 PACE Additional Exhibits 2025 12.xlsx”, were developed using lag triangles of the FFS data.

With the approach of leveraging MCP-reported RDT information, no further completion was necessary for the managed care paid portion of the base as MCPs were instructed to estimate IBNR to reflect fully incurred services and payments.

Non-Federal Share Costs in Designated Public Hospitals

The FFS claims for designated public hospitals (DPHs) in California are processed through a Certified Public Expenditures methodology in which the federal government covers the Federal share, and the county covers the non-federal share of costs. The FFS hospital claims in the base data contained only Federal share costs for DPHs, so adjustments to account for the non-federal share of costs for DPHs were included in the CY 2026 AWOP development. This impacts the FFS Non-Dual population only.

Data Smoothing

In certain situations, unit cost, or utilization data for certain counties and COS, was deemed to be an outlier. In those situations, the unit cost or utilization was smoothed to be more reasonable. Reasonableness was based on comparison to other surrounding counties' data and actuarial judgement. The smoothing adjustment is budget neutral at the statewide level.

Seasonality

A seasonality adjustment was applied to the base data, since the base data is a six-month time period. Quarterly Medi-Cal managed care RDT data from CY 2019, CY 2021, CY 2022, and CY 2023 were reviewed to help inform the seasonality adjustment applied to the 1H 2024 base. A positive adjustment was applied to the IHSS and LTC COS across all rate cells, accounting for the average number of days per month during the 1H 2024 base period relative to the CY 2026 rating period. With

the exception of members with dual eligible coverage, Mercer did not identify any consistent and material seasonality patterns when comparing claims experience for the first half of the calendar year with the second half of the calendar year. For the dual population, seasonality patterns were observed likely due to the cost sharing provisions for Medicare services, with higher Medicaid liability observed in the first half of the calendar year as deductibles are being met. Statewide seasonality assumptions by COS were applied with variation by region for the number of partial duals within HCBS and Institutional Non-Dual populations. In general, there were slight reductions applied to the dual rate cells due to this adjustment.

Pharmacy Rebates

The FFS pharmacy data used to inform the base was adjusted downward by 50% to account for pharmacy rebates. While the State collects and retains rebates in Medi-Cal Rx, POs have also indicated claiming pharmacy rebates within the RDT and attest to reporting pharmacy costs net of rebates, where applicable.

Third Party Liability

The base data was net of third-party liability (TPL); therefore, TPL amounts were excluded from the base data pull.

Patient Liability/Share of Cost

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

Federally Qualified Health Centers/Rural Health Clinics Wrap-Around Payments

Medi-Cal managed care reimbursements to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are not required to be at least the Prospective Payment System (PPS) rate. In the event the MCP reimbursement is below the PPS rate, wrap-around payments are made to FQHCs/RHCs to gross up to the PPS level. These wrap-around payments occur in FFS. Mercer identified these wrap-around payments for managed care members in the 1H 2024 AWOP FFS data where procedure code is T1015 and the procedure code modifier is SE. An adjustment was calculated to remove these dollars from the base.

Glucagon-Like Peptide-1 Drugs for Weight Loss

Effective January 1, 2026, the Medi-Cal Rx program will eliminate the coverage of Glucagon-Like Peptide-1 (GLP-1) drugs for weight loss. While this program change does not apply to PACE, PACE-like members will no longer have access to these drugs for weight loss through Medi-Cal. GLP-1 drugs for weight loss were identified

using National Drug Codes (NDCs) for the brand name drugs Wegovy, Saxenda, and Zepbound. The data was summarized, and an adjustment was created by removing the dollars and units from the 1H 2024 base data.

Adjustments to Develop the AWOP

Once the base data was adjusted, the CY 2026 AWOP was obtained by applying the following components to the adjusted base data:

- Program changes (covered below with the experience-based rates methodology).
- Trend factors to project the expenditures and utilization to the contract period (covered below with the experience-based rates methodology).
- A 1.40 acuity adjustment factor was applied to the HCBS population to reflect the assumed frailty difference between the actual PACE-eligible population and the PACE-like population used to develop the AWOPs. As most HCBS programs under Medi-Cal used in the AWOP development do not require a member to meet NF LOC criteria (for example, IHSS is a personal care-like service, but is available through the State Plan), the only services where a member is required to be NF LOC in the same way as PACE are waiver programs. Further, not all MSSP members meet the same LOC criteria as PACE, necessitating the application of the 1.40 acuity adjustment factor to bring the overall costs of the base population up to the levels of a HCBS population that better represent true NF LOC members eligible for PACE. Mercer intends to revisit this assumption, leveraging available data, and evaluate reasonableness on an ongoing basis.
- Administration and underwriting gain (not applied to FFS portion of the AWOP) loads (covered below with the experience-based rates narrative).

Section 5

Development of Experience-Based Rate Ranges

Base Data

The data and information used to form the base data for the PACE experience-based rate ranges was CY 2023 and CY 2024 PO-submitted RDT data and financial reporting. The CY 2023 and CY 2024 RDT data includes utilization and unit cost detail by rating group, county, and 19 consolidated provider types or COS, including:

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

Claims/expense experience for PACE Center Services were collected in the RDT separately, with additional detailed breakouts for Social Services, Routine and

Episodic Nursing, Recreational Therapy, Personal Care, Chore Services, Meals, Escort and Transportation, Nutritional Counseling, and Physical/Occupational/Speech Therapy. This data was reviewed for reasonableness and to provide confirmation that PACE Center Services were not included with other medical services/COS. For final base data development and all adjustments, PACE Center Services were consolidated into a single service category.

The experience-based rates utilized a CY 2023 and CY 2024 base data period, applying an even 50%/50% weighting to either year. Credibility, as described below, was developed based on 24 months.

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

Rate Category Groupings

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

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

Medi-Cal Versus Medicare Cost Distribution

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

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

Credibility Blending and Regional Base Data

POs vary in size, as well as in years of operation. Due to this, a blend of PO-specific base data with a regional base based on the PO's credibility during the base period is used for POs that are not deemed fully credible. Historically, credibility percentages were calculated and applied by combining the Dual and Non-Dual member months for a given PO/region. New to CY 2026 PACE experience-based rates, credibility was determined and applied separately for each Dual and Non-Dual rate cell. This is

a refinement to the process as the PACE market grows and more credibility can be assigned to each rate cell. Full credibility can be defined as 18,000 member months for the 24-month base period, subject to actuarial judgment, with consideration of the populations and services involved.

Similar to CY 2025 PACE experience-based rate setting, the credibility weighted base for POs who do not reach full credibility comprises of a weighting on the PO's own experience and experience from a regional base. For each PO, a PO-specific geographic adjustment factor was also applied to the regional base to further recognize cost differences within a region ².

The regions for the regional base are as follows: Bay Area, North Non-Coastal, South Non-Coastal, and SoCal. Appendix A outlines these four regions and the counties within each. PO counties were grouped based on geographical proximity and market characteristics and then used to develop a regional rate.

In some instances, an adjustment to the calculated credibility was made to mitigate large year-over-year changes in base costs. These outlier costs are often due to, but not limited to, prolonged high start-up costs which are outliers to other POs within the same county or base region, rapid member growth from year-to-year, or large swings in base PMPMs due to the refined methodology of calculating credibility at the rate cell level.

New PO Adjustment

To account for the assumed somewhat relatively higher acuity and operational costs in a new PACE Center, Mercer applied a “New PO factor” to POs in operation for less than two years. This factor begins at 3.0% for POs starting in CY 2026 and decreases to 1.5% at the start of the second year of operation, prorated as necessary. For example, POs beginning July 1, 2025, received a 2.25% increase for CY 2026, the average of the first- and second-year factors, 3.0% and 1.5%. This adjustment factor was applied to the final gross medical expense, prior to non-medical loading, and across all COS. Mercer developed this factor by comparing available PO encounter data and PO-submitted RDT data for POs that became effective within the past three years.

Other Adjustments

After considering feedback from OnLok Senior Health Services (OnLok) following the delivery of draft base data to the POs, a managed care adjustment was applied to the Home Health service category for all OnLok Dual rate cells. This managed care adjustment increases the Home Health PMPMs for this population to account for the higher-than-average Home Health Medi-Cal percentage allocations OnLok calculated and reported in their RDT submissions.

² The geographic adjustment factors used to adjust the regional rate leveraged multiple sources, including cost-of-living, wage data from the Bureau of Labor Statistics (BLS), Medicare Hospital Wages, and CMS Medicare Physician Geographic Cost Factor (GCF).

Retrospective Eligibility Periods

POs are not required to cover retrospective eligibility periods for their enrollees. These periods are covered in the Medi-Cal FFS program. Since RDT data serves as the base data for the rate ranges, retrospective eligibility periods are not part of the capitation rate development process. No further adjustments are necessary.

Section 6

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

UIS Acuity Factor and Federal Percentage Development

As briefly described in Section 3, separate PACE capitation rates were developed for the SIS and UIS populations. To establish separate payment rates, SIS and UIS-specific experience-based rates as well as AWOPs were developed. The acuity factors and percentages of pregnancy-related and emergency services applied do not vary in the experience-based and AWOP development process.

UIS Acuity Factor Compared to the SIS Population

Analysis of RDT information specific to the SIS and UIS populations concluded the acuity of members for these two populations were not materially different therefore, the aggregate UIS rates (across federally eligible and state-only services) are equal to the SIS rates.

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

As noted previously, only pregnancy-related and emergency services have been confirmed as eligible for federal match for the UIS population. As a result, it was necessary to estimate the percentage of PMPM spend for services that are pregnancy-related or emergency specific to the UIS population. Given the age demographic of the PACE population, it was assumed that little to no pregnancy-related services would be rendered in the PACE program. As such, the UIS Federal percentage applied to the UIS population only represents emergency services. Leveraging COA and COS-specific managed care emergency percentages, the resulting Federal share (3.0% for the Dual population; 12.0% for the Non-Dual population) was aggregated by PACE-specific COS mix and applied uniformly across all COS.

Trend

Trend is an estimate of the change in the overall cost of medical services over a finite period. Trend factors are necessary to estimate the expenses of providing health care services in a future period. As part of the CY 2026 AWOP and rate range development for the PACE program, Mercer developed trend rates for each provider type or COS separately by utilization and unit cost components.

Trend information and data were gathered from multiple sources, including RDT data, PO financial statements, Medi-Cal MCP trend data, Medi-Cal FFS experience, Consumer Price Index, and the National Health Expenditure Projections 2024–2033 Forecast Summary³. 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 the Medi-Cal managed care program, as well as prior rate periods, as a combination of “top down” and “bottom up” claim cost trend development. Mercer, as part of the Medi-Cal managed care program’s trend development, 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 in 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. These trends, developed for the Medi-Cal managed care program, are seen as appropriate for use in both PACE experience-based rate range and AWOP development. Where service categories, such as PACE Center Services, Pharmacy, and IHSS, are not applicable to the Medi-Cal managed care program but are pertinent to PACE rate development, the same overarching trend development approach as described was used.

Effective October 16, 2024, California Senate Bill (SB) 525 established an increased minimum wage schedule for covered healthcare employees, varying based on the employer’s size and entity type. Many covered employers will be required to pay covered employees \$25.00 per hour by June 2026, though the minimum wage schedule is tiered by employer entity type and increases over multiple years. An adjustment for SB 525 was incorporated into the prospective unit cost trend assumption, varying by service category to reflect the specific workforce composition.

In alignment with CY 2025 rates, the ECM and CS service categories are only present in the AWOP development for CY 2026 rates. The trends used in rate development for the ECM and CS service categories are reflective of strong expected growth in service experience and, like all other service categories, are consistent with those selected in the mainstream managed care rate development.

³ <https://www.cms.gov/files/document/nhe-projections-forecast-summary.pdf>

For the experience-based rate ranges, the CY 2023 and CY 2024 base data were trended forward 30 months to the mid-point of CY 2026 with POs starting July 1, 2026, receiving an additional three months of trend. The 1H 2024 AWOP base was membership-weighted and trended 27 months to the mid-point of CY 2026.

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

The specific lower bound trend levels by utilization and unit cost for the 19 COS are displayed in columns (G) and (H) of the experience-based CRCS, respectively. These annual trend figures are applied for the number of months represented in the time periods section in the upper right corner of the CRCS. The number of trend months is determined by comparing the mid-point of the modeled CY 2023 to CY 2024 base period to the mid-point of the rating period, CY 2026.

Annual lower bound claim cost trends, across all COS range (varying by PO), from 4.4% to 7.6% for Duals and 5.0% to 6.8% for Non-Duals on a PMPM basis. For the AWOPs, upper bound claim cost trends were used and across all COS range (varying by AWOP) from 1.1% to 2.9% for Duals and 3.9% to 6.7% for Non-Duals on a PMPM basis (Institutional and HCBS combined). Note the trend figures exclude unit cost changes associated with the program changes listed below.

Program Changes

Program change adjustments recognize the impact of benefit, eligibility, and/or reimbursement changes that have become effective since the beginning of the base period or will become effective by the end of the contract period. The program changes incorporated in the development of the rates were based on information provided by DHCS staff. The following program changes were accounted for in the development of the CY 2026 AWOP and capitation rates:

- **LTC Rate Increase** — This increase to LTC and NF unit costs accounts for rate increases to Assembly Bill (AB) 1629 facilities and other LTC facilities. LTC program changes are based on the historical increases of LTC daily rates and the projected increase for CY 2026. The county-specific percentage program change is calculated by comparing the average cost level in the respective experience-based (CY 2023 and CY 2024) and AWOP (1H 2024) base data periods to the contract period (CY 2026).
- **IHSS Wage Increase** — The IHSS wage increase is an increase to unit costs for the Personal Care COS from the base period to CY 2026 wage levels. The county-specific program change was developed by comparing the average IHSS hourly rate in the respective base data periods to the projected average hourly rate in the contract period. As Medicare does not cover IHSS services, the change in hourly rate affects both the Non-Dual and Full-Dual populations.
- **Hospice Rate Increase** — The hospice adjustment considers annual rate increases to hospice services and room and board. An adjustment was applied to

all populations, consistent with the managed care rates. 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 January 1 of each year. Note that the room and board increases were historically updated on August 1 of each year; however, starting January 1, 2024, these increases are now effective January 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.

- **Part A Buy-in** — Effective January 1, 2025, DHCS began paying the Medicare Part A premium for eligible Medicaid members with Medicare Part B coverage. Upon this change, the eligibility information for the qualified members within the Non-Dual rate cell will become reflective of the Full-Dual rate cell characteristics. This adjustment is to account for the movement of members from Non-Dual to Full-Dual, as well as the reduction in costs associated with these members that will now be covered by Medicare Part A. Eligibility data from the SFY 2023–24 time period was used to develop member month impacts for members switching out of Non-Dual to Full-Dual rate cells. Cost relativities (based on 1H 2024 encounter data for AWOPs and CY 2023 and CY 2024 RDT data for experience-based rates) were used to calculate the PMPM impacts of removing these members from the Non-Dual rate cell. Further, these membership impacts and cost relativities were then used to calculate the PMPM impacts of adding these members to the Full-Dual rate cell, while applying reductions to Medicare Part A covered services consistent with the new benefit coverage these members will have.

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

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

- **SB 523 and AB 1705 Ground Emergency Medical Transportation (GEMT)** — SB 523 established the GEMT Quality Assurance Fee (QAF) program, which provides for an annual GEMT QAF rate that will be imposed on each eligible emergency medical transport provided by each non-public GEMT provider subject to the QAF. The QAF collected will be used to provide increased reimbursement in the form of an add-on to the FFS fee schedule rate for the appropriate current procedural terminology codes. AB 1705 established the Public Provider GEMT

(PP-GEMT) program resulting in a per trip rate increase for public GEMT providers. Both State law (Welfare & Institutions Code § 14129.3[b]) and approved SPAs establish the combination of the State's FFS fee schedule rates and the add-on payments constitute the Rogers rates MCPs must pay to non-contracted GEMT providers serving Medi-Cal managed care enrollees for those years in which the GEMT add-on is effective. The amount included in the AWOP was consistent with rate setting for other Medi-Cal programs.

An assumed add-on increase of \$1,518.61 is applied in the CY 2026 rates versus the prior approved add-on rate of \$1,049.98. SPA 25-0030 was submitted to CMS on September 30, 2025, for the proposed add-on increase and is currently under review by CMS.

With the exception of the IHSS wage increase program change, which is specific to PACE experience-based and AWOP development, all program changes listed above were developed in line with the Medi-Cal Managed Care program and are further described in *Section 4: Projected Benefit Costs and Trends, Program Changes*, in the accompanying document “CA CY 2026 (01 01 2026 - 12 31 2026) Rate Cert Report 2025 12 Redacted.pdf”.

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

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

Administration

The administration loads for the POs were developed in aggregate across all rate groupings. This factor is expressed as a percentage of the capitation rate (i.e., percent of premium). For the experience-based rate ranges, this mid-point percentage was developed from a review of the POs' historical reported administrative expenses, which are submitted as part of their attested RDTs on an annual basis. The administrative costs are reviewed to ensure they are appropriate and reasonable for the Medicaid eligible PACE members. Mercer also utilized its experience and professional judgment in determining the mid-point and lower/upper bound percentages to be reasonable. Similar to CY 2025, the mid-point administration load was established at 12% across all POs. The range for the administrative component is +/- 3% at the lower/upper bounds from the mid-point value. This PACE wider range reflects the unique nature of POs in terms of member size and operating model, as well as a wide range of actual PO results.

The AWOPs were developed to include a provision for the State's administrative costs for the FFS portion of the base data. Similarly, an appropriate managed care factor was included for the managed care portion of the base. FFS also includes a

2.0% load factor (as a percent of the total AWOP) to reflect the State's administrative costs. Managed care administrative costs across all counties were assumed to be between 4.1% and 5.5%, consistent with other capitated rate setting assumptions for similar populations under Medi-Cal at the upper bound.

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

Underwriting Gain

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

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

Pass-Through Payments and State Directed Payments

Pass-through Payments (PTPs) and State Directed Payments (SDPs) are only applicable to the AWOP development. The PTPs and SDPs applicable to the AWOP members are the hospital PTPs and SDPs. While the CY 2026 AWOP development includes the estimated PMPMs for the hospital PTPs, the hospital SDPs are not included as the estimated SDP PMPMs were not available at the time of AWOP development. The lack of SDP PMPMs included in AWOP development is consistent to prior years.

The Hospital PTP PMPMs included in CY 2026 rate development are those included in the CY 2026 Medi-Cal managed care program. Please see the managed care program certification for more details. The PTP PMPMs were only included for the managed care population.

Withhold Arrangements

There are no PO withhold arrangements in place. For the purpose of AWOP development, the Medi-Cal managed care program implemented the Quality Withhold and Incentive (QWI) program beginning in CY 2024. Any withhold dollars not earned back by MCPs under the quality withhold will be paid out through the quality incentive.

The QWI program will withhold 0.78% from the final certified rates across all MCPs for CY 2026. The withhold will apply to both SIS and UIS rates across all rate cells.

However, of the total withheld amount, 0% is not reasonably achievable under the QWI program. Therefore, no adjustment is made to the managed care population in the AWOP development for withhold arrangements.

Risk-Sharing Mechanisms

There are no risk-sharing mechanisms for POs in place.

Risk-sharing mechanisms as leveraged within the Medi-Cal Managed Care program had no impact on AWOP development as the development of each risk-sharing related component reflects Mercer's best estimate of the anticipated costs associated with each. Details on risk-sharing mechanisms as related to the Medi-Cal Managed Care program can be found in *Section 7: Special Contract Provisions Related to Payment, Risk-Sharing Mechanisms* of the accompanying document “CA CY 2026 (01 01 2026 - 12 31 2026) Rate Cert Report 2025 12 Redacted.pdf”.

Incentive Arrangements

There are no PO incentive arrangements in place.

For the purpose of AWOP development, the Medi-Cal managed care program implemented the QWI program beginning in CY 2024. Any withhold dollars not earned back by MCPs under the quality withhold will be paid out through the quality incentive.

The QWI program will withhold 0.78% from the final certified rates across all MCPs for CY 2026. The withhold will apply to both SIS and UIS rates across all rate cells. However, of the total withheld amount, 0% is not reasonably achievable under the QWI program. Therefore, no adjustment is made to the managed care population in the AWOP development for incentive arrangements.

Rate Ranges

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

Section 7

Rate and Rate Range Certification

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

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

Mercer certifies that the PACE model rate ranges for the CY 2026 time period, January 1, 2026 through December 31, 2026, were developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medi-Cal covered populations and services under the managed care contract. The undersigned actuary is a member of the American Academy of Actuaries and meets its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

AWOPs and rate ranges developed by Mercer are actuarial projections of future contingent events. All estimates are based upon the information and data available at a point in time and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely, and potentially wide, range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use. Actual PO costs will differ from these projections. Mercer has developed these rates and rate ranges on behalf of DHCS to demonstrate compliance with the CMS requirements identified in the CMS PACE Medicaid Capitation Rate Setting Guide and are appropriate for the populations and services covered under the PACE

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

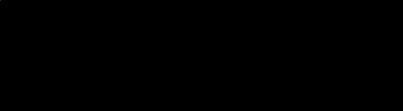
POs are advised that the use of these rates and rate ranges may not be appropriate for their particular circumstance, and Mercer disclaims any responsibility for the use of these rate ranges by POs for any purpose. Mercer recommends that any PO considering contracting with DHCS should analyze its own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

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

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

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

Sincerely,


Ethel Tan, ASA, MAAA
Principal

Copy:

Sean Barber, DHCS
Brandon Lee, DHCS
Daniel Thorne, DHCS
Jon Jolley, Mercer
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Appendix A

Geographic Region Groupings

Region	County
Bay Area	Alameda Contra Costa Marin Napa San Francisco Santa Clara Solano Sonoma
N. Non-Coastal	El Dorado Humboldt Merced Placer Sacramento San Joaquin Stanislaus Sutter Yuba
S. Non-Coastal	Fresno Imperial Kern Kings Madera Riverside San Bernardino Tulare
SoCal	Los Angeles Orange San Diego