MERCER

Rady Children's Hospital

Rate Development and Certification

January 1, 2021–December 31, 2021

State of California
Department of Health Care Services
Capitated Rates Development Division
December 18, 2020

Mercer Government
Ready for next. Together.

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December 18, 2020

Subject: Rady Children's Hospital Pilot Program in San Diego County — Rate Range Development and Certification for January 1, 2021 through December 31, 2021

Dear Mr. Davtian:

The State of California Department of Health Care Services (DHCS) contracted with Mercer Government Human Services Consulting (Mercer), as part of Mercer Health & Benefits LLC, to develop an actuarially sound Medicaid capitation rate range for children with special health care needs receiving care at Rady Children's Hospital (Rady) in San Diego County for use during the calendar year 2021 period (CY 2021). CY 2021 encompasses the time period of January 1, 2021 through December 31, 2021. This pilot is related to the California Children's Services (CCS) initiative, which is aimed at improving care for children with special health care needs. This certification report presents an overview of the analyses and methodology used in Mercer's managed care rate range development for the purpose of satisfying the requirements of the Centers for Medicare & Medicaid Services (CMS).

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.

(Note: Please see page 2 of the Actuarial Standard of Practice No. 49: Medicaid Managed Care Capitation Rate Development and Certification, from the Actuarial Standards Board, http://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049_179.pdf).

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Executive Summary

DHCS contracted with Mercer to develop actuarially sound capitation rates for use during the RCH program rating period of January 1, 2021 through December 31, 2021, CY 2021. This is the first CY rating period since DHCS chose to change from state fiscal year (SFY) rating periods (July through June) to CY rating periods, mainly to enable DHCS and Mercer to evaluate, plan, and adjust for legislative changes affecting managed care that have historically occurred with minimal time prior to the start of the SFY rating periods. The ultimate goal of this change is that legislative changes will be made effective January of each year and will allow enough time for DHCS to implement any new changes and for Mercer to account for these changes prospectively in the rate setting process.

This certification report describes the rate development process and provides the certification of actuarial soundness required by 42 CFR §438.4. This document was developed to provide the requisite rate documentation to DHCS and to support the CMS rate review process. This certification report follows the general outline of the CMS July 2020 through June 2021 Medicaid Managed Care Rate Development Guide, which is the applicable version of the guide for CY 2021. The rate development process included the historical practice of developing rate ranges. However, the actuary is certifying to a final rate within the developed rate ranges as federally required.

Multiple attachments are included as part of this rate certification package. These attachments include summaries of the CY 2021 capitation rates (including the final and certified capitation rate) and a capitation rate calculation sheet (CRCS) exhibit. These attachments are referenced throughout the body of this report. The final capitation rate can be found in the attached file titled *DOC 6 - CA CY 2021 Rating Period (01 01 2021 - 12 31 2021) RCH Rate Detail Package 2020 12 18.xlsx*.

The final CY 2021 capitation rate is a 17% increase when compared to the final capitation rate for the July 1, 2019 through December 31, 2020 rating period (RP 19–20), when prescription drug costs are excluded. This also excludes supplemental payment rates.

One significant change for the CY 2021 rating period is the decision to carve pharmacy out of managed care. This decision was originally made to be effective January 1, 2021, but a three month delay was announced, which resulted in the need to develop a managed care capitation rate for pharmacy for the January 1, 2021–March 31, 2021 period. The development of this pharmacy rate is consistent with other base data and rate development for the CY 2021 period.

Mercer has not trended forward the previous year's rate, but has done a comprehensive exercise of rebasing using more recent program experience. The new base may emerge differently than expected in the prior year's rate development.

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General Information

A capitation rate for the RCH Pilot program was developed in accordance with rate-setting guidelines established by CMS. RCH covers a subset of the CCS eligible population in San Diego County when the member has one of the following five medical conditions:

- Cystic Fibrosis
- Hemophilia
- Sickle Cell
- Acute Lymphoblastic Leukemia
- Diabetes, Type 1 and 2

The information provided in this section should be supplemented with the managed care organization (MCO) contract information for additional detail.

This certification applies to one final rate that represents a reasonable and appropriate blend of different cost profiles for each condition. Each of these cost profiles can be viewed as two components: 1) utilization and cost experience for CCS-covered services and 2) utilization and cost experience for non-CCS-covered services. At the base data level, the components were blended by condition and reviewed in total to be utilized as the base data for developing the rate range for
CY 2021.

For rate range development, Mercer reviewed six months of CY 2018 fee-for-service (FFS) claims data for both non-CCS and CCS-covered services provided to RCH-eligible members (members residing in San Diego with one of the five conditions that is eligible for the Pilot). Additionally, this year's Rate Development Template (RDT)-reported information for all services and all five conditions was provided by RCH for the second half of CY 2018 and all of CY 2019. Data from these two sources were combined to create a 24-month base data period. Managed care encounter submissions were also reviewed during the base data process, but were not used directly in the base data development.

The most current membership information for prospective members was provided by RCH to DHCS in October 2020. This membership information was validated by DHCS and provided to Mercer. Mercer did not audit this information, but did review for internal consistency. This latest member information informed the ultimate blending of each condition cost profile to form the blended base data.

Adjustments were then made to the selected base data to match the covered population risk and the State Plan approved benefit package for the CY 2021 period. These adjustments included:

- Prospective and historic (retrospective) program changes not reflected (or not fully reflected) in the base data
- Trend factors to forecast the expenditures and utilization to the contract period
- Medical management and care navigation loading
- Administration and underwriting gain loading

Subsequent to these adjustments, DHCS takes three additional steps in the measured matching of payment to risk:

- Application of a Maternity supplemental payment
- Application of a Hepatitis C supplemental payment
- Application of a Behavioral Health Treatment (BHT) supplemental payment

DHCS will offer a final rate within the actuarially sound rate range. This final rate is being certified within this rate report. RCH has the opportunity and responsibility to independently review the rate offered by DHCS and to determine whether the rate is acceptable based on its individual financial requirements.

Additionally, DHCS will include risk corridors in the contract with RCH as a risk mitigation strategy given the relatively small size and the higher risk profile of the covered population (see further details in the risk corridors section below).

Medical Loss Ratio

Mercer confirms that the capitation rate development process and resulting rates, as outlined in this certification and supporting documentation, are reasonable, appropriate, and attainable and that the MCO is assumed to reasonably achieve a Medical Loss Ratios greater than 85%.

Rate Ranges

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

The lower and upper bounds of the rate range are developed by varying certain assumptions throughout the rate development process. Once the "best estimate" assumption is determined, the assumption is then varied by an appropriate amount to reflect a degree of uncertainty and the potential for variability in actual results. The total variation produced by the assumptions is reviewed for reasonableness to ensure that the final rate range represents a reasonable, appropriate, and attainable rate for the covered population during the rating period.

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

Federal Medical Assistance Percentage

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

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

In particular, populations that receive a higher FMAP than the regular FMAP include the Breast and Cervical Cancer Treatment Program (BCCTP) population that meets federal standards, the Children's Health Insurance Program (CHIP) child population and the ACA Expansion population. The BCCTP and CHIP populations receive 65% FMAP, while the ACA Expansion population receives 90% FMAP for CY 2021.

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. 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 implementation of the Families First Coronavirus Response Act (H.R. 6021) provides a temporary 6.2 percentage point increase for certain populations effective beginning January 1, 2020, and extending through the last day of the calendar quarter in which the public health emergency, declared by the Secretary of Health and Human Services for Coronavirus (COVID-19), including any extensions, terminates. The increased FMAP percentage applies to the standard 50% FMAP, and smaller increases apply to the BCCTP and CHIP population FMAPs.

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

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Data

Base Data

The base data is a blend of cost profiles for each condition, where each cost profile includes both CCS-covered services and non-CCS-covered services. The non-CCS services are the standard Medi-Cal managed care benefit package that is covered today by MCOs. The CCS services are the majority of claim cost in the base data and encompass utilization and cost experience specific to the designated conditions that, prior to this program, have been covered by FFS. The non-CCS and CCS services were reviewed in total for the base data development.

The data used to form the 24-month base data period for the RCH program rate range development is a combination of FFS claims data and RDT-reported information provided by RCH. FFS claims data for covered services provided to RCH eligible members during the first half of CY 2018 (January 1, 2018 through June 30, 2018) was combined with RDT-reported information provided by RCH for the remainder of CY 2018 and CY 2019 (July 1, 2018 through December 31, 2019). Managed care encounter submissions were also reviewed during the base data process, but were not used directly in the base data development.

Claims data for both of these data sources included utilization and unit cost detail by the consolidated provider types or category of service (COS), including:

Inpatient Hospital	Federally Qualified Health Center (FQHC)	Community-Based Adult Services
Outpatient Facility	Other Medical Professional	Hospice
Emergency Room Facility	Mental Health — Outpatient	Home- and Community-Based Services — Other
Long-Term Care (LTC) Facility	Pharmacy	All Other
Physician Primary Care	Laboratory and Radiology	
Physician Specialty	Transportation	

RCH is enrolled in the 340B Drug Pricing Program and shall dispense drugs priced at the appropriate 340B level when possible. The RDT data provided by RCH for the second half of CY 2018 and CY 2019 already reflected 340B pricing and thus required no further adjustment. The pharmacy FFS data used in the base for the period January 1, 2018–June

30, 2018 was adjusted, consistent with the prior analysis and assumption, to reflect 340B pricing. For the first half of CY 2018 FFS data, a factor of 0.86 was applied to the pharmacy per member per month (PMPM) for non-cystic fibrosis drugs, and a factor of 0.84 was applied to the pharmacy PMPM for cystic fibrosis drugs (cystic fibrosis drugs were assumed to have a higher portion filled under 340B).

Utilization and unit cost information was reviewed at the COS detail level for reasonableness. Due to the size of the program, a rate range was developed for all RCH eligible conditions combined, based upon the most current member mix as reported by RCH and validated by DHCS/Mercer (October 2020).

No disproportionate share hospital payments or adjustments for FQHC or Rural Health Center reimbursements were necessary to include in the base data. FQHC costs considered in rate development are the costs incurred by the MCO, net of any wrap-around payment by DHCS to reimburse the FQHC at their Prospective Payment System rate. Information on catastrophic claims is reported separately by RCH and is available through analysis of FFS data. No adjustments to the base data were deemed necessary. The RCH experience includes incurred but not reported (IBNR) adjustments. This information was reviewed for appropriateness. No IBNR adjustments were applied to the CY 2018 and CY 2019 base data as sufficient run out was deemed appropriate.

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. FFS claims data contains no non-State Plan services and the RCH data contained only State Plan services. Mercer has relied on data and other information provided by DHCS in the development of this rate range. Mercer has reviewed the data and information for reasonableness, and Mercer believes the data and information utilized in the rate development to be free of material error and suitable for rate range development purposes for the populations and services covered under the RCH contract. Mercer did not audit the data or information and, if the data or information is materially incomplete or inaccurate, Mercer's conclusions may require revision. However, Mercer did perform alternative procedures and analysis that provide a reasonable assurance as to the data's appropriateness for use in capitation rate development under the State Plan.

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

Maternity Supplemental Payment

To further enhance the measured matching of payment to risk, DHCS utilizes a maternity supplemental payment. Given the specialized nature of the RCH population, birth events are not anticipated, but a maternity event and its related cost could result in significant variance to the projected population risk. Costs for pregnant women are 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 in rates, DHCS is including a maternity supplemental payment, which represents costs for the delivery event (pre-natal and post-partum care costs are not part of the supplemental payment). RCH receives the lump sum maternity supplemental payment when one of its current members gives birth and DHCS is appropriately notified that a birth has occurred. Note that 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 2021 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. The Medi-Cal CY 2021 San Diego county maternity kick payment was deemed a reasonable and appropriate rate for the contract period.

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 county/region, but not by MCO within a county/region (this maternity payment is consistent with other San Diego maternity payments for the same rating period)
- Supplemental payment reflects cost of delivery event only (mother and baby, excluding pre-natal and post-partum care)
- Supplemental payment is for the entire CY 2021

Maternity Supplemental — Base Data Development Approach

In general, a similar process used for the development of the base data by category of aid (COA) group is utilized in the development of the base data for the maternity supplemental payment. The RDT data is used as the main base data source for this base data development. The general process for the development of the maternity base data is described below:

- Calculate per delivery costs and utilization from CY 2018 MCO 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 MCO and delivery type (caesarean and vaginal)

- Develop smoothed data points to replace missing or unreasonable data and blend with plan-specific data
- Blend reported and smoothed base costs from the MCOs to generate base data by MCO, delivery type and COS
- Aggregate base data across county/region and delivery type

In the final step of the base data development process, the MCO-specific data (after smoothing and credibility adjustments) is blended together across MCOs in each county/region and across caesarean and vaginal deliveries. As part of this process, the caesarean and vaginal ratios reported by each MCO 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. Mercer's experience is that from year-to-year the majority of plan-reported data would fall within an acceptable range that is conducive to matching payment with risk. However, in some instances when it is clear that data quality might compromise the soundness of the rate, Mercer deems it necessary to adjust to a more normalized level.

Hepatitis C Supplemental Payment

To enhance the measured matching of payment to risk, DHCS is utilizing a Hepatitis C supplemental payment for the CY 2021 rating period for the first three months of the year (January 1, 2021 – March 31, 2021). Effective April 1, 2021, pharmacy will be carved out, including Hepatitis C drugs. It should be noted that any Hepatitis C pharmaceutical therapy costs were removed from the base experience as a program change to allow the supplemental payment to cover the anticipated pharmaceutical therapy costs associated with Hepatitis C. Please see the following attachment (*DOC 4 – CY 2021 Hepatitis C Supplemental Payment Methodology December 2020.pdf*) for further details on the Hepatitis C supplemental payment methodology and subsequent rate development.

Since DHCS utilizes a supplemental payment to reimburse the MCOs for costs associated with Hepatitis C drug therapies, it is necessary to remove Hepatitis C drug costs from the capitation rates. Mercer reviewed the base data elements for Hepatitis C drug spend and found none associated with the RCH population that formed the two-year base.

BHT Supplemental Payment

Effective September 15, 2014, MCOs became responsible for BHT services to address autism spectrum disorder. Effective July 1, 2018, the MCOs' responsibility to cover these services expanded to include children who are not diagnosed with autism. These benefits are available for beneficiaries, ages 0 to 20 years old, who are eligible for the Early and Periodic Screening, Diagnostic Treatment (EPSDT) program and meet medical necessity criteria for

the service. To further enhance the measured matching of payment to risk, DHCS is utilizing a BHT supplemental payment for the CY 2021 rating period. It should be noted that BHT services were removed from the base experience to allow the supplemental payments to cover the anticipated costs for these services. Effective July 1, 2019 Comprehensive Diagnostic Evaluations (CDE) are no longer covered under the BHT supplemental payment, and instead are covered under the capitation rate. Therefore, CDE base costs remain in the base data used for the capitation rates and were not used in the development of the BHT supplemental payment. The autism spectrum disorder gross medical expense used to develop the BHT supplemental payments for RCH was the San Diego County average.

Please see the following attachment (*DOC 3 - CY 2021 BHT Supplemental Payment Methodology Letter December 2020.pdf*) for further details on the BHT supplemental payment methodology and subsequent rate development.

Data Smoothing

As the size of the RCH program in San Diego County is considered small, covering approximately 350 lives with five medical conditions, data was considered in aggregate. The use of a two-year base period and aggregation of various data sources provided an appropriate population base for rate setting purposes. DHCS will include a risk corridor in the contract with RCH as a risk mitigation strategy given the relatively small size and the higher risk profile of the covered population (see further details in the risk corridor section below).

4
Projected Benefit Costs and Trends

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

- Trend from the midpoint of CY 2018 and CY 2019 (January 1, 2019) to CY 2021 (July 1, 2021)
- Program changes

The adjustments listed above are shown within the various columns of the CRCS. The exact columns are noted within each subsection below.

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

Trend

Trend is an estimate of the change in the overall cost of medical services over a finite period of time. Trend factors are necessary to estimate the expenses of providing health care services in a future period. As part of the CY 2021 rate range development for the RCH program in San Diego County, 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 MCO encounter and RDT data, MCO financial statements, Medi-Cal FFS experience, Consumer Price Index, National Health Expenditures updates and multiple industry reports. Mercer also relied on professional judgment based upon experience in working with the majority of the largest Medicaid programs in the country. The claim cost trend assumptions being used are consistent with the CY 2021 Two-Plan/Geographic Managed Care assumptions used for the seniors and persons with disabilities (SPDs) population with the exception of pharmacy. Upon analysis, the pharmacy trend was further informed and refined for CCS populations that reflect different utilization of therapeutic classes relative to a non-CCS population. Mercer modeled an annual pharmacy PMPM trend of approximately 5.22% at the lower bound. The components associated with this PMPM trend are a utilization trend of -0.50% and a cost per script of 5.75%. The cost per script trend is mainly driven by brand cost inflation and high cost drugs associated with the RCH eligible conditions.

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

Persons with Disabilities			
COS	**2019 (over 2018)**	**2020 (over 2019)**	**2021 (over 2020)**
Inpatient Hospital	-9.3%	-8.1%	-7.0%
Prescription Drugs	-4.1%	-3.6%	-3.0%

Child Enrollees			
COS	**2019 (over 2018)**	**2020 (over 2019)**	**2021 (over 2020)**
Inpatient Hospital	-5.1%	-3.1%	-3.1%
Prescription Drugs	-3.3%	-1.9%	-1.9%

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

For the January 1, 2021 through December 31, 2021 rating period, the CY 2018 and CY 2019 base data used was trended forward 30 months to the mid-point of CY 2021. Separately, for the pharmacy component effective January 1, 2021 through March 31, 2021, the CY 2018 and CY 2019 base data used was trended forward 25.5 months to the mid-point of CY 2021

Given the most recent financial information available at the time the rate ranges were developed, the range for the claim cost trend component is +/- 0.25% per year for each of the utilization and unit cost components, or roughly +/- 0.5% PMPM per year for all services (the +/- 0.25% does not apply to a zero value). Over the 30-month period from the mid-point of the CY 2018 and CY 2019 base period to the mid-point of CY 2021, this contributes approximately +/- 1.2% to the lower and upper bounds of the rate ranges.

The specific lower bound trend levels by utilization and unit costs for the COS are displayed in columns (D) and (E) of the CRCS, respectively. These annual trend figures are applied for the number of months represented in the time periods section in the upper right hand corner of

[1] https://www.cms.gov/files/document/2018-report.pdf, pages 48–49.

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.

Annual lower bound claim cost trends, across all COS with the exception of pharmacy, average -0.1% for utilization and 2.9% for unit cost or 2.9% PMPM.

Program Changes

Program change adjustments recognize the impact of benefit or eligibility changes that took place during or after the base data period. The program changes incorporated in the development of the rate ranges were based on information provided by DHCS staff. The program changes detailed below were viewed to have a material impact on capitation rates and were reviewed, analyzed and evaluated by Mercer with the assistance of DHCS. Per DHCS, there are no current known amendments that will be provided to CMS in the future.

The next several subsections are the program changes adjustments that were explicitly accounted for within the CY 2021 capitation rates. Additionally, the program change adjustments identified below are applied in columns (F) and (G) of the CRCS, unless otherwise indicated.

Non-Medical Transportation

Non-Medical Transportation (NMT) became a managed care covered benefit effective July 1, 2017. NMT refers to non-emergent transportation to and from medical appointments for beneficiaries where the mode of transportation has no medical component associated with it. This includes modes of transportation such as taxicabs and public transportation and does not include modes of transportation such as non-emergent ambulance transportation or transportation via a wheelchair van (which are referred to as non-emergent medical modes of transportation). Supplemental transportation data was provided by the MCOs by three grouped modes of transportation (emergent, non-emergent medical and non-medical), by COA and by quarter for CY 2018 and CY 2019. The data was provided by quarter to evaluate the ramp up of the NMT benefit through the most recently available quarter of data prior to the January 1, 2021 rating period start date. Additionally, data existed from other state Medicaid programs to assist in developing benchmark NMT PMPMs by COA. However, neither of these data sources were specific to the CCS population alone.

Project NMT PMPMs for CY 2021

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

Calculate NMT Costs Assumed in the CY 2021 Rates

NMT data as reported by the MCOs in the CY 2018 and CY 2019 base data time period were used as the basis for the NMT amounts assumed in the rates. These amounts reported by the MCOs were trended to CY 2021 (using the trend factors developed for the Transportation COS line).

Calculate NMT PMPM Adjustment

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

In the development of these amounts, the data supplied by the MCOs was reviewed both at the NMT-specific level and at the total transportation level. This was done to control for instances where the NMT PMPMs may look like they were increasing at high levels, but the total transportation PMPMs were not increasing at similar levels.

To develop a rate adjustment for this program change specific to the RCH population, both of these data sources were reviewed and ultimately a PMPM adjustment was based on an expectation that these high needs children would be more "SPD-like". As a result, SPD NMT levels were reviewed from both data sources and this drove the PMPM assumption for the RCH population. Because the RCH members are all children eligible for EPSDT services, it was assumed that NMT was already provided for covered services. Therefore, an adjustment was made only for services not covered under the managed care contract as referenced above. At the lower bound, prior to non-medical loads, this program change resulted in a $2.72 PMPM increase.

Ground Emergency Medical Transportation Fee Increase

Pursuant to approved State Plan Amendment 18-0004, and subsequent continuances in approved State Plan Amendments 19-0020 and 20-0009, DHCS makes add-on payments to Ground Emergency Medical Transportation (GEMT) providers in the State's FFS program that meet specified requirements using proceeds from a GEMT provider qualify assurance fee. Both State law (Welfare & Institutions Code § 14129.3(b)) and the approved State Plan Amendments establish that the combination of the State's FFS base and add-on payments constitutes the Rogers rates that MCOs must pay to non-contracted GEMT providers serving Medi-Cal managed care enrollees for those rating periods in which the GEMT add-on is effective. A program change adjustment has been included in the certified capitation rates to account for this MCO obligation.

Two data sources were utilized (CY 2018 and CY 2019 dates of service were compiled for both data sources):

1. Supplemental Data Requests (SDRs) sent out to the health plans to report on their transportation utilization and claims cost information, separated by mode of transportation (emergent, non-emergent medical and non-emergent non-medical)

2. Health plan-submitted encounter data limited to the ground emergency transportation codes affected by the fee increase (A0225, A0427, A0429, A0433 and A0434)

Based on review and analysis of these two data sources, utilization per 1,000 statistics were developed (by health plan, COA and county). This utilization per 1,000 statistics were then applied to the GEMT unit cost add-on amount, to develop the COA, county and plan-specific GEMT PMPM amounts.

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

The program change was developed by determining a reasonable estimate for emergent transportation for the RCH population during the contract period and applying the enhanced payment to those projected trips. To derive the PMPM adjustment factors for this program change, both encounter data and supplemental transportation data provided by the MCOs were utilized. From this data, utilization per 1,000 statistics were developed and the applicable GEMT add-on was assumed for each applicable trip. At the lower bound, prior to non-medical loads, this program change resulted in a $1.97 PMPM increase.

Other Items

Health Care-Acquired Conditions

Section 2702 of the Affordable Care Act of 2010 required CMS to establish regulations prohibiting federal Medicaid payments to states for amounts expended for Health Care-Acquired Conditions. On June 30, 2011, CMS published the final rule implementing the requirements set forth in Section 2702 of the Affordable Care Act, 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 inpatient hospital facility is excluded, including out-of-state facilities.

As such, Mercer initially reviewed potential encounter data information for making an appropriate adjustment. Unfortunately, the required information (a present on admission indicator, for example) is not currently part of the encounter data. This is an ongoing process without any current information available for a program change adjustment. Other studies and

other state experience have shown limited needed adjustments related to these types of conditions. This issue will continue to be reviewed. No adjustments have been included within these rates.

Graduate Medical Education

With regard to Graduate Medical Education (GME) 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 that there are no provisions in the existing managed care contract regarding GME. RCH will not pay specific rates that contain GME costs or other GME related provisions. As existing MCO data and non-GME FFS costs serve as the base data, GME expenses are not part of the RCH capitation rate development process.

Third-Party Liability

The MCO experience used to develop the base data was reported net of any third-party liability; therefore, no adjustment was necessary in the capitation rate development process.

Member Cost Sharing

The Medi-Cal program requires no member copayments or other cost sharing. Therefore, cost sharing considerations do not impact rate development.

Retrospective Eligibility Periods

MCOs in the Medi-Cal managed care program are not required to cover retrospective eligibility periods for their enrollees. These periods are covered in the Medi-Cal FFS program. For the selected FFS and RCH data used as the base data for the rate, retrospective eligibility periods are not part of the capitation rate development process. No adjustments are necessary.

Mental Health Parity and Addiction Equity Act

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

In Lieu of Services

No adjustments were made for In Lieu of Services. These types of services will continue to be monitored in future base data and rate setting periods.

Institution for Mental Disease

Covered benefits associated with these capitation rates do not include services that would be associated with an Institution for Mental Disease (IMD). In addition, if a managed care

member is in an IMD in a given month, the state does not pursue federal match for that individual for that month. Therefore, the only potential rate impact from a federal perspective for members utilizing an IMD for more than 15 days in a given month would be associated with the potential impact of those members experiencing significantly higher costs than other non-IMD utilizing members. The consideration of this potential limited impact was viewed as immaterial and no adjustments were made to the base data. This element of the rate-setting process will continue to be monitored in future rate setting periods.

Provider Overpayments

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

Coronavirus Disease 2019

The impact of Coronavirus Disease (COVID-19) was considered for the CY 2021 rating period. Because of the very changing and emerging nature of COVID-19 and the relative uncertainty of the disease prevalence, timing and cost of a vaccine during the CY 2021 rating period, estimates were based on limited available data. Cost data for COVID-19 testing performed during CY 2020 was collected specific to the RCH population. This data was used to determine the add-on amount for expected testing that was including for the CY 2021 rating period. Because of the acute nature of the conditions present in RCH members, no delayed or canceled services were assumed during the CY 2021 rating period. There was no prevalence of COVID-19 among members based on available CY 2020 data as reported by RCH. Given this, no additional cost adjustment, other than the expected cost of testing, was included in the base data.

Managed Care Adjustments

For the CY 2021 contract period, no managed care adjustment factors were applied. Given the special health care needs of the eligible population, Mercer decided it was reasonable and appropriate to not apply efficiency adjustments or assume other managed care adjustments.

Pharmacy Add-On

One significant change for the CY 2021 rating period is the decision to carve pharmacy out of managed care. This decision was originally made to be effective January 1, 2021, but a three month delay was announced which resulted in the need to develop a managed care capitation rate for pharmacy for the January 1, 2021–March 31, 2021 period. The development of this pharmacy rate is previously described and consistent with other base data and rate development for the CY 2021 period. A 2% administration and 1.5% underwriting gain were assumed for the pharmacy add-on.

5
Projected Non-Benefit Costs

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

- Administration
- Underwriting gain
- Medical Management/Care Navigation

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

Administration

The administration loading for RCH was developed in aggregate. The administration load factor is expressed as a percentage of the capitation rate (i.e., percent of premium). The mid-point percentage was developed in part based on a review of the health plan-reported data for the WCM program and previous CCS administrative costs. Mercer also utilized its experience and professional judgment in determining the final mid-point and lower and upper bound percentages to be reasonable. The lower bound administration load is 5.75%. The range for the Administration component is +/- 0.9% (lower and upper bound) from the mid-point value.

For the three month pharmacy add-on, a 2% administration load was assumed.

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

Underwriting Gain

The lower bound underwriting gain was established at 1.5%, which is a change from 2.0% set for the prior rating period. The range for the underwriting gain component is +/- 1.0% at the upper/lower bounds from the mid-point value. Mercer has implicitly and broadly considered the cost of capital within Mercer's rating assumptions. Mercer's conclusion is that Mercer's assumptions surrounding underwriting gain, as well as the income a risk taking entity generates from investments, are sufficient to cover at least minimum cost of capital needs for the typical MCO.

Medical Management and Care Navigation

RCH is required to provide Medical Management/Care Navigation (MM/CN) for the appropriate management of the five RCH eligible conditions. In order to appropriately account for these services, a MM/CN load was developed as part of the rate range development process. The cost for MM/CN was originally based on county allocations provided by DHCS for services provided to similar populations. Mercer reviewed the impact of this rating component relative to the total rates with consideration for the specific RCH population.

The MM/CN PMPM of $37.67 is 2% of the capitation rate at the lower bound.

Health Insurance Providers Fee

The Health Insurance Providers Fee does not apply to the RCH program.

6
Special Contract Provisions Related to Payment

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

- Incentive arrangements
- Withhold arrangements
- Risk-sharing mechanisms
- Pass-through payments
- Delivery system and provider payment initiatives

Incentive Arrangements

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

Withhold Arrangements

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

Risk-Sharing Mechanisms

Risk-sharing mechanisms, as described below, are applied to the RCH rate and are implemented outside of the capitation rate development process.

Risk Corridor

Given the relatively small size and the higher risk profile of the covered population, a risk corridor is included in the contract with RCH in order to mitigate risk. The risk corridor includes medical and prescription drug expenses. It excludes care coordination and administrative costs. There is an initial band where RCH is fully responsible of +/- 2% in the first rating period and +/- 5% in the second and third rate periods inclusive of the CY 2021 rating period.

Pass-Through Payments

There are no pass-through payments between DHCS and RCH. This subsection is not applicable to this rate certification.

Delivery System and Provider Payment Initiatives

There are no delivery system and provider payment initiatives between DHCS and RCH. This subsection is not applicable to this rate certification.

7
Certification and Final Rates

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

Capitation rates developed by Mercer are actuarial projections of future contingent events. All estimates are based upon the information and data available at a point in time, and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely, and potentially wide, range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use. Actual MCO costs will differ from these projections. Mercer has developed these rates on behalf of DHCS to demonstrate compliance with the CMS requirements under 42 CFR 438.4 and in accordance with applicable law and regulations. There are no stop loss, reinsurance, or incentive arrangements in these rates. Use of these rates for any purpose beyond that stated may not be appropriate.

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

DHCS understands that Mercer is not engaged in the practice of law, or in providing advice on taxation matters. This report, which may include commenting on legal or taxation issues or regulations, does not constitute and is not a substitute for legal or taxation advice. Accordingly, Mercer recommends that DHCS 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 report assumes the reader is familiar with the Medi-Cal program, Medi-Cal eligibility rules and actuarial rating techniques. It has been prepared exclusively for DHCS and CMS, and should not be relied upon by third parties. Other readers should seek the advice of actuaries, or other qualified professionals competent in the area of actuarial rate projections, to understand the technical nature of these results. Mercer is not responsible for, and expressly disclaims liability for, any reliance on this report by third parties.

DHCS agrees to notify Mercer within 30 days of receipt of this certification 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 certification 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, please feel free to contact Marcie Gunnell at marcie.gunnell@mercer.com.

Sincerely,

[redacted]

Marcie S. Gunnell, ASA, MAAA, FCA
Principal

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