

Two-Plan, Geographic Managed Care, Regional, and County Organized Health Systems Models

Capitation Rate Development
and 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 capitation rates for use during the rating period of January 1, 2023 through December 31, 2023 (calendar year [CY] 2023). The capitation rates that are the subject of this certification report include those developed for the following models:

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

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

This report describes the rate development process and provides the certification of actuarial soundness required by 42 CFR § 438.4. This report was developed to provide the requisite rate documentation to DHCS and to support the rate review process performed by the Centers for Medicare & Medicaid Services (CMS). This report follows the general outline of the CMS 2022–2023 Medicaid Managed Care Rate Development Guide dated April 2022, which is the applicable version of the guide for CY 2023. The rate development process included the historical practice of developing rate ranges. However, the actuaries are certifying to a final rate within the developed rate ranges as federally required.

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

Multiple attachments are included as part of this rate certification package. These attachments include summaries of the CY 2023 capitation rates (including the final and certified capitation rates), capitation rate calculation sheet (CRCS) exhibits, and stand-alone methodology documents, which provide more detail around various rate setting components. These attachments are referenced throughout the body of this report. The final certified capitation rates by managed care organization (MCO), county/rating region, and category of aid (COA) groupings (synonymous with rate cell), including a comparison to the prior CY 2022 certified capitation rates, can be found in the attached file, *CY 2023 Medi-Cal Detail CRCS Package LB Rate Smry 2022 12.xlsx*.

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

Beginning with the CY 2023 rating period, some significant changes within the Medi-Cal program will occur. Highlights of these changes include the implementation of multiple aspects of the California Advancing and Innovating Medi-Cal (CalAIM) proposal, which is a multi-year initiative by DHCS to improve the quality of life and health outcomes for the Medi-Cal population. Multiple components of this initiative are addressed throughout the body of this report. One notable change effective in CY 2023 is the transition of Full-Dual beneficiaries and beneficiaries residing in long-term care (LTC) facilities into mandatory managed care, so the entire state is consistent in this regard (previously these beneficiaries were only mandatory in COHS and Coordinated Care Initiative [CCI] counties, with minor exceptions).

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

A comparison of the certified CY 2023 capitation rates to the certified CY 2022 capitation rates is also provided in an attachment. Each certified CY 2023 rate (separate for the UIS and SIS populations) is compared to the capitation rates certified within the CY 2022 rating period. However, please note the current CY 2022 capitation rates are developed in total across the UIS and SIS populations and contain all services for the UIS population, and a forthcoming revision is scheduled to occur to the CY 2022 rates that separates them for the SIS and UIS populations. The CY 2022 rates in this comparison are the same previously certified rates for the UIS and SIS population at the county/region, MCO, and COA level as a result. There are instances where there are large changes at the MCO, county/rating region, and COA level in this comparison. This is largely due to the fact that the UIS and SIS populations may have large acuity differences depending on the COA group and the fact that the CY 2023 UIS capitation rates are for federal services only. Further, the impact of the inclusion of members residing in LTC facilities has a large impact on the changes seen as well. An updated comparison to the CY 2022 capitation rates will be provided once the CY 2022 rates are amended and split by the UIS and SIS populations. Additionally, DHCS will provide an updated financial analysis after the CY 2022 rates are updated and finalized.

It should also be noted there will be a future amendment to this certification that will be submitted to CMS. This is due to a new pass-through payment for public Distinct Part

Nursing Facilities pursuant to 42 CFR § 438.6(d)(6), a new State directed payment for the Workforce and Quality Incentive program (WQIP) pursuant to 42 CFR § 438.6(c), and a change in the total amount for the State directed payment Private Hospital Directed Payment (PHDP) program. Other assumptions within the rate setting will be reviewed, such as the end date of the public health emergency (PHE) and the transition of LTC members, but will not necessarily require a capitation rate amendment, unless the certifying actuaries deem an amendment is necessary.

Section 2

General Information

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

- Program history
- MCO participation
- Covered services
- Covered populations
- Rate structure
- Federal Medical Assistance Percentage (FMAP)
- Rate methodology overview

The information provided in this section should be supplemented with the MCO contract information for additional detail.

Program History

California’s Two-Plan, GMC, Regional, and COHS managed care delivery models have been in existence since the 1980s. Managed care was first introduced in California through the COHS delivery model in San Mateo and Santa Barbara counties. Through the years, the COHS model has expanded and there are now 22 COHS counties operating in Medi-Cal managed care. In COHS counties, there is only one plan operating in each county/rating region. The GMC model began operating in Sacramento County in 1994 and in San Diego County in 1998. In the GMC model, there is no limit on the number of MCOs that can operate in these counties. The Two-Plan model was implemented in 1996 in Alameda and San Joaquin counties and expanded to 10 additional counties by 1999. In 2011, the Two-Plan model expanded to include both Kings and Madera counties, bringing the total count of Two-Plan counties to 14. Within the Two-Plan model, two MCOs operate within each county, one a commercial plan and one a Local Initiative health plan. In 2013, California expanded its Medi-Cal managed care program with the Regional model, which consists of 20 counties. Two commercial plans operate within each Regional model county, with the exception of San Benito, which only has one commercial plan.

Pursuant to the Affordable Care Act (ACA) and the subsequent Supreme Court ruling, California elected to expand Medicaid coverage to low-income adults effective January 2014.

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

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

The Two-Plan, GMC, Regional, and COHS models encompass all 58 counties within California (14 counties are part of the Two-Plan model, two counties are part of the GMC model, 20 counties are part of the Regional model and 22 counties are part of the COHS model). For a list of the counties within each model type, please refer to the Excel file titled *CY 2023 Medi-Cal Detail CRCS Package LB Rate Smry 2022 12.xlsx*, which has a tab that lists each model and the applicable counties within each model. For capitation rate payment purposes, different rates are paid to the MCOs for each county in which they operate, with the following exceptions.

- Within the Regional model, there is one rating region that consists of 18 combined counties for which capitation rates are paid.
- Within the Regional model, Kaiser Foundation Health Plan (Kaiser) operates in three of the 18 combined counties, so one capitation rate is developed for Kaiser, which spans all three of these counties.
- For Partnership HealthPlan of California (PHC), there is one rating region for which capitation rates are paid.
- In the following instances, capitation rates were developed at the health plan and county level, but DHCS is taking a further step by paying one single capitation rate by COA for each of these health plans spanning multiple counties. This was also done for the CY 2022 capitation rates. To develop the region rate in each of these instances, the risk-adjusted (where applicable) county rates by COA and MCO were blended together using a weighted average of each risk-adjusted (where applicable) county rate by COA and MCO using projected CY 2023 enrollment.
 - Fresno, Kings, and Madera — CalViva Health and Anthem Blue Cross
 - San Joaquin and Stanislaus — Health Net of California and Health Plan of San Joaquin (HPSJ)
 - Riverside and San Bernardino — Inland Empire Health Plan and Molina Healthcare
 - Santa Barbara and San Luis Obispo — CenCal Health
 - Monterey, Santa Cruz, and Merced — Central California Alliance for Health

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

Managed Care Organization Participation

For CY 2023, there are 23 distinct MCOs that operate in the Two-Plan, GMC, Regional, and COHS managed care programs. Each MCO has different counties in which they operate. Some MCOs only operate in one county while other MCOs operate in multiple counties. For

a complete list of the MCOs and counties in which they operate, please see the rate summary sheets, which can be found in the attached Excel file titled *CY 2023 Medi-Cal Detail CRCS Package LB Rate Smry 2022 12.xlsx*. Capitation rates are shown for each MCO and county/rating region combination.

Covered Services

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

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

Notable services carved out of all managed care programs and counties (with exceptions listed below) include the following:

- Specialty MH services (including IP and OP behavioral health [BH] services, with exceptions noted below):
 - Kaiser in Sacramento County and the Kaiser global subcapitation population in Solano County (PHC globally subcapitates members to Kaiser) covers specialty MH services not covered by any other MCO within the Medi-Cal program. These specialty MH services include psychiatric IP and OP (Sacramento County only).
 - Effective, July 1, 2023, all specialty MH services will be carved out of managed care.
- Alcohol and substance use disorder treatment services.
- Home and Community Based Services (HCBS) (with the exception of CBAS in all counties).
- Dental services (except medically necessary federally required adult dental services and fluoride varnish dental services that may be performed by a medical professional) are carved out, with the exception of members covered by the Health Plan of San Mateo (HPSM) under their pilot dental program.
- Administration of Coronavirus Disease 2019 (COVID-19) vaccines.
- Services covered under the California Children's Services (CCS) program in Two-Plan, GMC, Regional, and Ventura counties. In COHS counties (except for Ventura), CCS services are a managed care covered benefit. CCS-eligible members in these counties make up the WCM rate cell.
- Effective January 1, 2022, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim: covered OP drugs, including physician administered drugs, medical supplies, and enteral nutritional products.

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

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

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

Covered Populations

The program currently covers children, parents/caretakers, adults without dependent children, pregnant women, and seniors and persons with disabilities (SPD), including those dually eligible for Medicare. Individuals served through California's Children's Health Insurance Program (CHIP) are covered under the same managed care contracts. Generally, managed care enrollment is mandatory for the Two-Plan, GMC, Regional, and COHS models, except for members residing in San Benito County (regardless of dual eligibility status). Note, managed care enrollment will be mandatory for dual eligible beneficiaries in non-CCI and non-COHS counties effective January 1, 2023 (previously these beneficiaries were voluntary).

As part of the CalAIM initiative, various additional populations have or will become enrolled in managed care effective throughout CY 2022 and CY 2023. The populations identified to transition January 1, 2022, who were previously non-mandatory in managed care (at least in some counties) and/or enrolled in the fee-for-service (FFS) delivery system are as follows:

- Individuals with other health coverage
- Individuals residing in certain rural zip codes
- Trafficking and Crime Victims Assistance Program (TCVAP)
- Individuals participating in accelerated enrollment (AE)
- Child Health and Disability Prevention Infant Deeming (CHDPI)
- Pregnancy-related Medi-Cal
- Breast and Cervical Cancer Treatment Program (BCCTP)
- Partial Dual beneficiaries in Two-Plan, GMC, and Regional Counties

The populations identified to transition January 1, 2023, who were previously non-mandatory in managed care (at least in some counties) and/or enrolled in FFS are as follows:

- Full-Dual Beneficiaries
- Members previously subject to mandatory managed care, but not in managed care.
- Members residing in a LTC facility beyond the initial month of being institutionalized plus the following month (in non-CCI and non-COHS counties only).

The Intermediate Care Facilities — Developmentally Disabled (ICF-DD) and Subacute (SA) populations will transition July 1, 2023. These populations were previously enrolled in FFS in some counties beyond the initial month of admission plus the following month.

Lastly, the State enrolled members age 50 and above, regardless of immigration status, into managed care effective May 1, 2022. Additional details on the transitioning populations can be found in the “Program Changes” section of this report.

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

Rate Structure

The base data sets used to develop the Two-Plan, GMC, Regional, and COHS CY 2023 capitation rate ranges were divided into cohorts that represent consolidated COA (or Aid Code) or supplemental groupings, which inherently represent differing levels of risk. Rate ranges are developed for each of these cohorts. As noted for the COA and supplemental payment groupings below, there are differences that exist across the various counties. The COA groups for which capitation rates are paid and supplemental payment groupings are listed below (with variations noted as well).

Capitation Rate Category of Aid Groups (Rate Cells)

- Child
- Adult
- ACA Expansion
- SPD
 - This COA consists of SPD members and partial dual eligible members with an ACA Expansion aid code.
- SPD/Full-Dual
 - This COA consists of SPD/Full-Dual members and full-dual eligible members with an ACA Expansion aid code.
- LTC
- LTC/Full-Dual
- WCM (COHS counties only, except Ventura County)

Note, in the development of rates for the COHS counties, the SPD and LTC COA groups will be blended into one capitation rate payable for members in either COA group. Similarly, this will also happen for the SPD/Full-Dual and LTC/Full-Dual COA groups in COHS counties as well.

Additionally, for all counties, the LTC and LTC/Full-Dual COAs will only consist of beneficiaries with an applicable LTC aid code (13, 23, 53, and 63). Other beneficiaries residing in a LTC facility will be classified into the COA consistent with the beneficiaries' aid code.

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

Maternity Supplemental Payment

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

Note, the behavioral health treatment (BHT) supplemental payment from prior years is no longer applicable for CY 2023. These costs will now be included in the development of the CY 2023 capitation rates. Additional details related to base cost development of this benefit are described later in this document.

Federal Medical Assistance Percentage

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

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

In particular, populations that receive a higher FMAP than the regular FMAP include the BCCTP population (now a subset of the SPD population) who meet federal standards, the CHIP population, and the ACA Expansion population. For CY 2023, the BCCTP and CHIP populations receive 65% FMAP. For CY 2023, the ACA Expansion population receives 90%.

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

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

The implementation of the Families First Coronavirus Response Act (H.R. 6021) provides a temporary 6.2 percentage point increase for certain populations effective January 1, 2020, and extending through the last day of the calendar quarter in which the PHE, declared by the Secretary of Health and Human Services for COVID-19, including any extensions, terminates. The 6.2 percentage point increased FMAP 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.

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

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

Rate Methodology Overview

Capitation rates for the Two-Plan, GMC, Regional, and COHS models were developed in accordance with rate setting guidelines established by CMS. As noted previously, the actuaries continued the historical practice of rate range development for the Two-Plan, GMC, Regional, and COHS models. However, the actuaries are certifying to a rate within the developed rate range.

For rate range development for the Two-Plan, GMC, Regional, and COHS model MCO populations, Mercer used July 1, 2020 through June 30, 2021 (state fiscal year [SFY] 2020–2021) MCO-reported encounter data, the SFY 2020–2021 rate development template (RDT) data (from direct contractors with DHCS and also the MCOs' global subcontractors) and other ad hoc claims data reported by DHCS and the Two-Plan, GMC,

Regional, and COHS model MCOs. The most recently available Medi-Cal-specific financial reports submitted to the California Department of Managed Health Care (DMHC) at the time the rate ranges were determined were also considered in the rate range development process.

The RDT data used in the development of the rate ranges is data collected from each MCO within the Medi-Cal managed care program separately for each county (or rating region) in which each MCO operates. The data requested from each MCO is completed by the MCOs at the level of detail needed for rate setting purposes, which includes membership, medical utilization, and medical cost data for the most recent time periods (SFY 2020–2021 for the CY 2023 rate ranges) by COA group and by category of service (COS).

Adjustments were made to the selected base data to match the covered population risk and the State Plan approved benefit package for CY 2023. Additional adjustments were then applied to the selected base data to incorporate:

- Prospective and historic (retrospective) program changes not reflected (or not fully reflected) in the base data.
- Budget-neutral relational modeling for smoothing.
- Any observed changes in the population case mix and underlying risk of the MCOs from the base data period.
- Trend factors to forecast the expenditures and utilization to the rating period.
- Administration and underwriting gain loading.

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

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

The above approach has been utilized in the development of the rate ranges for the CY 2023 Two-Plan, GMC, Regional, and COHS models. DHCS will offer the final certified rates within the actuarially sound rate ranges of each MCO, as developed by the actuaries. Each MCO has the opportunity and responsibility to independently review the rates offered by DHCS and to determine whether the rates are acceptable based on their individual financial requirements.

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

Medical Loss Ratio

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

The CY 2023 internal rate ranges utilize a full rebase incorporating the most complete and current data period (SFY 2020–2021). This rebase, along with the non-medical loads, detailed below by model, result in aggregate priced-for effective MLRs greater than 85%.

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

- Two-Plan, GMC, and Regional models:
 - Assumed upper bound MLR: 100% - 13.15% (upper bound non-medical load) = **86.85%**.
 - Assumed lower bound MLR: 100% - 9.35% (lower bound non-medical load) = **90.65%**.
- COHS models:
 - Assumed upper bound MLR: 100% - 13.00% (highest upper bound non-medical load across COHS plans) = **87.00%**.
 - Assumed lower bound MLR: 100% - 9.00% (highest lower bound non-medical load across COHS plans) = **91.00%**.

The State has chosen to not impose remittance provisions related to this MLR for CY 2023.

Rate Ranges

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

The lower and upper bounds of the rate ranges are developed by varying certain assumptions throughout the rate development process. Once the “Mercer estimate” assumptions are determined, the assumptions are then varied by an appropriate amount to reflect a degree of uncertainty and the potential for variability in actual results by MCO. The total variation produced by the varied assumptions is reviewed for reasonableness to ensure the final rate ranges represent reasonable, appropriate, and attainable rates for the covered populations during the rating period.

Section 3

Data

Base Data

The information used to form the base data for the Two-Plan, GMC, Regional, and COHS models rate range development was MCO encounter data, requested MCO RDT data (including global subcontracting MCO RDTs), FFS data for certain transitioning populations, ad hoc claims data, and DMHC-required Medi-Cal specific financial reporting. SFY 2020–2021 served as the base data period. The SFY 2020–2021 encounter and SFY 2020–2021 RDT claims data included utilization and unit cost detail by COA group, by county/region, by MCO, and by 18 consolidated provider types or COS, including:

- IP Hospital
- OP Facility
- ER
- LTC
- Primary Care Physician (PCP)
- Specialty Physician
- Federally Qualified Health Center (FQHC)
- Other Medical Professional (NPP)
- MH-OP
- BHT Services
- Laboratory and Radiology
- Transportation
- CBAS
- Hospice
- Multipurpose Senior Services Program (MSSP)
- In-Home Supportive Services
- Other HCBS
- All Other

A requirement of 42 CFR § 438.3(c)(ii) is that all payment rates under the contract are based only upon services covered under the State Plan to Medicaid-eligible individuals. As described above, MCO RDT and encounter data served as the starting base data for rate setting as well as FFS data in all non-CCI Two-Plan, GMC, and Regional “transitioning”

counties described later in this section. Mercer assessed the quality, timeliness, and completeness of the data per ASOP No. 23, *Data Quality*, to deem the data sufficient to support rate setting. This assessment included reviewing the submitted MCO RDT and encounter data for changes year-over-year, and inclusive of the FFS data, for errors in reporting, overall reasonableness, and consistency across data sources to ensure it was appropriate to incorporate into rate development. The RDT data submissions are thoroughly reviewed, vetted, and discussed with each MCO during the rate setting process. Encounter data undergoes considerable edits within DHCS to ensure quality and appropriateness of the data for rate setting purposes. Base period MCO COA eligibility (described below) and encounter data were pulled consistent with service code mappings from DHCS, including lists of excluded services, such as State-only funded abortion services. Mercer has relied on data and other information provided by the MCOs and DHCS in the development of these rate ranges. Mercer did not audit the data or information, and if the data or information is materially incomplete or inaccurate, Mercer's conclusions may require revision.

The RDT submissions already include incurred but not reported adjustments that are reviewed for appropriateness, and discussed with the health plans as part of the rate development process. If necessary, adjustments were applied to amounts reported by the health plans based on this review. The encounter data did receive adjustments to reflect underreporting and additional runout. These underreporting factors are applied to recognize the encounter data is likely underreported by the MCOs (e.g., encounters from providers who are paid via a capitation arrangement may be understated), and not reflective of all liabilities still outstanding for the base period. Actuarial judgment was used to ensure the factors were reasonable.

Ultimately, the actuaries deemed the RDT data as the most reliable base data source. Therefore the final base data for rate setting is tied back to each MCO's RDT experience, after the adjustments and smoothing process detailed below. Similar to prior rate development periods, there are some exceptions (Kaiser and Aetna Better Health [Aetna] in all counties/rating regions), which are described below.

The final base data, after base data adjustments and smoothing, is further adjusted to reflect the impact of historical program changes, trend applications, and potential managed care adjustments. This is discussed in later sections in the certification report.

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

Base Data Adjustments

The MCO-reported RDT experience was adjusted with a number of utilization and unit cost base data adjustments. As detailed below, these adjustments were necessary to

appropriately reflect reasonable medical cost and utilization for the covered populations and services. The adjustments are explained below.

Hospital Adjustments

Adjustments to MCO reported hospital costs were necessary in some select cases. These adjustments occurred for three MCOs; HPSJ, San Francisco Health Plan (SFHP), and CalOptima. Details for each adjustment are described below.

Health Plan of San Joaquin

In the RDT discussion guide process, HPSJ noted they recognized a particular provider was billing for a higher than normal volume of high cost drugs for dates of service starting in CY 2018 through 2020. Upon review, HPSJ began denying some of these high cost drug claims starting in CY 2019. In further discussions with HPSJ, HPSJ indicated they negotiated a new contract with this particular provider, which would result in lower costs for future periods moving forward. Further, HPSJ reported an ongoing dispute with a separate provider impacting the IP, OP Facility, and ER COS dating back to dates of service starting in Q1 2020.

To appropriately account for this in the base data, DHCS/Mercer worked with HPSJ to identify the anticipated savings from both settlements listed above to develop an appropriate adjustment to apply to the base data. Data provided by HPSJ informed the adjustment. Across all COA groups, approximately \$0.9 million in San Joaquin and approximately \$4.7 million in Stanislaus were removed from the SFY 2020–2021 base data.

San Francisco Health Plan

SFHP communicated to DHCS/Mercer two upcoming contract changes with a large hospital provider in San Francisco. Previously, SFHP and the hospital had a capitation arrangement for provided services. However, the hospital requested a restructuring of the payment arrangement into a FFS contract. As this contract change was known prior to the rating period, DHCS/Mercer elected to make a base data adjustment and worked with SFHP to develop the adjustment.

SFHP repriced the services rendered at the hospital to provide an estimate of the change in base data costs due to the updated contracts. SFHP reviewed SFY 2020–2021 encounters and repriced them to be in line with the contracted FFS rate. DHCS/Mercer met with SFHP to review their analysis and, along with comparison to hospital costs for nearby health plans, found the results reasonable and appropriate. Across all COA groups, this adjustment, accounting for both contract changes increased the SFY 2020–2021 base data costs by approximately \$71.1 million.

CalOptima

In prior rate setting periods, DHCS/Mercer adjusted the reported hospital capitation expenditures for the CalOptima ACA Expansion COA. Following communication with DHCS/Mercer and the downward rate adjustment, CalOptima adjusted their hospital capitation contracting to reasonable and appropriate levels. Given the reporting levels for SFY 2020–2021 were still not reflective of reasonable contracting levels, CalOptima provided the hospital capitation per member per month (PMPM) amounts through the end of CY 2021. This reporting showed, for the ACA Expansion COA, a continued decrease through to the

second half of CY 2021 in PMPM capitation costs. Upon review, Mercer found these more recent reimbursement levels to be reasonable and appropriate and used the reported capitation levels as the best representation of the go-forward reimbursement levels.

To account for this in the base data, Mercer developed the following adjustment. The capitation amounts for the July 2021 to December 2021 period were de-trended, using the trend factors discussed later in the trend section, to the SFY 2020–2021 period. The differences between the reported SFY 2020–2021 levels and the de-trended go-forward amounts were removed in the following amounts for the ACA Expansion COA; approximately \$18.5 million for IP, approximately \$4.5 million for OP, and approximately \$1.7 million for ER. The same analysis showed no adjustment was necessary for other COA groups.

Global Coordinated Care Initiative Capitation Payment Risk Stratification

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

Within CCI counties, some MCOs utilized a blended rate for their globally subcapitated CCI Full-Dual populations, similar to the historical capitation payment structure from DHCS to the MCOs for these members. Consequently, some MCOs reported PMPMs in their RDT that were equivalent (or nearly equivalent) across all of their globally subcontracted CCI Full-Dual COA groups (e.g., Adult, SPD/Full-Dual, and LTC/Full-Dual) and populations (Eligible but not Enrolled [EBNE] and Ineligible [INEL]). In these instances, to appropriately reflect the relative risk of these COA groups, Mercer developed relativity factors based on direct member PMPMs and the population mix of global members for each of these MCOs, effectively shifting dollar amounts between COA groups and the EBNE/INEL populations in a budget neutral fashion.

Long-Term Care Utilizers in non-Long-Term Care Aid Code Adjustment

Experience reported in the RDT submissions for the non-dual/partial-dual LTC COA in CCI counties included experience for both members with LTC aid codes as well as all members with a 90-day stay (or more) in an LTC facility that are age 21 or older, regardless of their aid code. This RDT reporting methodology was done in conjunction with how capitation payments were made from DHCS to the MCOs for these members during the base data time period. In contrast, the LTC COA will strictly be defined by aid code for CY 2023 rate development and payment purposes, which means only members with an LTC aid code will be classified into the LTC COA. Members who reside in a LTC facility but do not have an applicable LTC aid code will be paid a rate based on their actual aid code and not at the LTC COA rate. Mercer reviewed eligibility and encounter data for non-dual/partial-dual members with LTC aid codes or a 90+ day institutional indicator to redistribute the RDT-reported member months, utilization, and cost into the appropriate Adult, ACA Expansion, SPD, and

LTC COAs in a budget neutral fashion. This was done to align the base data with the COA-based rate structure that will be in effect for the CY 2023 time period.

Cal Medi-Connect Base Data Development

The base data starting point for the Cal Medi-Connect (CMC) populations in CCI counties was the combined Medi-Cal, Medicare, and “Unable to Separate” cost and utilization reported by the health plans in the RDT submissions. The CMC adjustment reduces the base data to reflect only the Medi-Cal liability. Similar to the historical CCI rate development process, Mercer reviewed each plan’s reported Medi-Cal expense as a percentage of the total to determine if the plan’s reporting of Medi-Cal liability was reasonable and appropriate for rate setting. If deemed reasonable, Mercer adjusted the total CMC spend to reflect the health plan-reported CMC Medi-Cal expense; otherwise, the CMC base utilization/PMPM was set equal to that of the health plan’s direct member experience for the CMC EBNE population. Note, for health plans with a CMC contract in LA County, that are not also a direct contractor in that county, their CMC member months were assigned to the prime health plan they contract with for other populations (e.g., EBNE), along with a cost/utilization profile equal to that prime health plan’s global EBNE population. This member transition is consistent with the sunset of CCI, and the exclusively aligned enrollment process as CMC health plans transition to D-SNPs.

This adjustment carved approximately \$1.9 billion dollars out of the SFY 2020–2021 base period, representative of the Medicare liability for these CMC members.

Coordinated Care Initiative and Non-Coordinated Care Initiative Base Data Consolidation

To facilitate the transition of CCI Full-Dual members into the non-CCI program after December 31, 2022, RDT reporting for Full-Dual members in CCI counties reflected member assignment consistent with non-CCI COA. The adjusted CCI RDT submission’s member months, dollars, and units by COA were removed from the reported CCI populations (EBNE, INEL, and CMC) and added into the health plan’s respective non-CCI Medi-Cal rate cells on a budget neutral basis. Note, for health plans with a CMC contract in LA County that are not also a direct contractor in that county, their CMC experience was added into the prime health plan they contract with for all other populations, consistent with the exclusively aligned enrollment process as CMC health plans transition to D-SNPs.

UnitedHealthcare Exiting San Diego County

UnitedHealthcare will cease operations within San Diego County in January 2023. As a result of this exit, their existing members will be moved to different health plans within the county. This adjustment was made to the remaining health plans’ base data to account for the acuity differences of these additional members compared to existing SFY 2020–2021 members. Base membership of the remaining health plans was also adjusted assuming a split of the UnitedHealthcare members proportional to the base membership of the remaining plans.

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

For members covered by Kaiser in Solano County, MH services to treat beneficiaries with a serious mental illness (SMI) have historically been included in the subcapitation rate paid by

PHC to Kaiser. This adjustment removed \$3.1 million paid by PHC to Kaiser for SMI services from the Solano County base data leveraged for CY 2023 rate setting. Costs associated with these services will now be included as a capitation rate add-on outside of the base capitation rates.

Pharmacy Carve-Out

Effective January 1, 2022, retail pharmacy services will be carved out of managed care for all populations and covered by the State through the FFS delivery system. Specifically, the following pharmacy benefits, when billed by a pharmacy and on a pharmacy claim, will be carved out of managed care; covered OP drugs (including physician administered drugs), medical supplies, and enteral nutritional products. To remove pharmacy costs from the capitation rates, the pharmacy COS line was zeroed out within the base data for all populations, based on MCO RDT reporting. The RDT data source was reviewed and validated against encounter data for reasonableness. This adjustment removed approximately \$5.8 billion from the SFY 2020–2021 managed care base data.

Multipurpose Senior Services Program Carve-Out

MSSP services were no longer a managed care covered benefit effective January 1, 2022. As a result, the MSSP experience for SFY 2020–2021 as reported in the RDT was removed from the base data.

For the SFY 2020–2021 base data period, approximately \$23.5 million of MSSP costs were removed from the base data. This is a significant increase from the prior base period where approximately \$2.1 million of MSSP were carved out of the base, due to the CCI and non-CCI base data consolidation process, as the majority of MSSP costs historically reside within the CCI program.

Global Non-Medical Expense Adjustment

As described previously in the global CCI capitation adjustment description, some MCOs choose to enter into global subcapitation arrangements. As these global arrangements and capitation payments include considerations for administrative duties and underwriting gain, it is necessary to remove these non-medical expenses from the base data. After removal from the medical portion of the SFY 2020–2021 base data, these non-medical data elements are considered when developing the broader non-medical capitation rate loads.

For SFY 2020–2021, the following factors were used to remove non-medical loads from reported global subcapitation payments in the RDT data; 6% for instances where the global subcontractor is Kaiser, 8% otherwise. These assumptions have increased 1% from the prior contract period. Further, Santa Clara Family Health Plan (SCFHP) delegates a large portion of medical services to Valley Health Plan in Santa Clara County (not reported by SCFHP as a global subcontractor within the RDT). In this instance, a 5% adjustment factor was used to remove the non-medical loads from the payments made to Valley Health Plan within the base data development. Mercer arrived at these factors after a review of global subcontractor experience, direct contractor subcapitation payments, encounter data, historical administrative costs, and MCO-reported financials. Across the Two-Plan and COHS models (there are no global arrangements within the GMC or Regional models), this adjustment removed approximately \$316 million from the SFY 2020–2021 base data.

Provider Incentive Adjustments

Within the MCO-submitted RDTs, there is a schedule for MCOs to describe their provider incentive arrangements, in addition to providing the amounts paid in provider incentives separately in the RDT. Through a review of this information, it was determined there were instances of provider incentive arrangements not indicative of expected future cost levels during CY 2023. As a result, base data adjustments were made for two MCOs. The adjustments specific to each affected MCO are described below.

San Francisco Health Plan

Within the RDT, SFHP reported provider incentive dollars within their submission for a Strategic Use of Reserves (SUR) program which runs throughout the base data period. As described by SFHP, the goal of the SUR program is to achieve a margin, which is then distributed back to the provider networks. In the event SFHP has excess reserves of more than two months of capitation revenue, they make payments to providers based on certain performance metrics. Since the SUR program is predicated on only distributing additional funds to providers if SFHP is making a profit and in an excess reserve position, these dollars were removed from the SFY 2020–2021 base data. Profit is already a component of the capitation rate development process (as noted in Section 5 of this certification), and including these dollars would in essence double count any dollars associated with profit built into the capitation rates.

California Health & Wellness

In the California Health & Wellness RDT submission, the plan reported a revenue sharing program specific to Imperial County. This program, while reported under incentives, reflects a local initiative contract with the county, where California Health & Wellness will share 20% of any net profit that exceeds 3% of revenue. Through review of documentation and discussion with California Health & Wellness, it was determined the amounts paid out in incentive payments are solely determined by the net profits by COA and have therefore been removed from the base data and CY 2023 rate development.

Across the Two-Plan and Regional models (no adjustments were made in GMC and COHS counties), approximately \$4.3 million was removed from the SFY 2020–2021 base data due to these adjustments.

Value-Added Services Adjustment

As part of the RDT data submissions, the MCOs were required to report costs for services that were not a part of the State Plan benefit package during the base data period, but were provided as value-added services. Since the use of these value-added services was not defined in the MCO contracts, the costs reported in the RDT were removed from the base data. As noted previously, certain value-added services (known as Community Supports) are now allowable and specified in the managed care contract effective in CY 2022. Any value-added service removed through the base adjustment process was also considered for a program change adjustment if the services aligned with one of the 14 approved Community Supports. The adjustment described here is the base data adjustment that removes all reported value-added services, but some of the services removed through this adjustment are added back as a program change adjustment, described later in that section.

Across all Two-Plan, GMC, Regional, and COHS models, approximately \$41.3 million was removed from the SFY 2020–2021 base data as a result of this adjustment.

Medi-Cal Pharmacy and Durable Medical Equipment Carve-Out

On January 1, 2022, pharmacy benefits designated under Medi-Cal Rx were carved out of Managed Care. On February 8, 2022, DHCS released a Medi-Cal Rx scope document¹, which detailed pharmaceutical benefits impacted by Medi-Cal Rx. In addition, the scope document specifically identifies which pharmacy benefits are (1) subject to full carve-out to FFS under Medi-Cal Rx; (2) partially subject to carve-out; and (3) not subject to the carve-out. Products which are partially carved-out, are products that can be billed and reimbursed on both pharmacy and medical claims, but are only carved-out when billed as a pharmacy claim.

In the rate development process, Mercer addressed the majority of Medi-Cal Rx carve-out costs by removing costs under the Pharmacy COS from the rate setting process, described previously. However, some pharmacy benefits subject to Medi-Cal Rx billed without a pharmaceutical taxonomy or National Drug Code would not be captured in that COS. This adjustment addresses benefits that would be fully carved out on January 1, 2022, but would not be captured in the Pharmacy COS. In order to develop this adjustment, a combination of specific procedure codes were used to identify encounters within the SFY 2020–2021 base period that would be subject to be covered by Medi-Cal Rx, but categorized outside of the Pharmacy COS. These identified costs were then carved out of the base data at the health plan, COA, and COS levels of detail. This adjustment removed approximately \$57.3 million from the SFY 2020–2021 base data.

CalOptima Base Data Adjustment

In addition to the hospital pricing adjustment mentioned above, a further base data adjustment was required for CalOptima. The SFY 2020–2021 RDT reported outlier cost levels for the professional services (a subtotal of the PCP, SP, FQHC, and NPP COS groups) for the ACA Expansion COA group, driven largely by capitation cost levels. Similar to the hospital pricing adjustment, CalOptima provided professional capitation PMPM amounts through the end of CY 2021. Upon review, Mercer found these more recent reimbursement levels to be reasonable and appropriate and used the reported capitation levels as the best representation of the go-forward reimbursement levels. This adjustment resulted in the removal of approximately \$25.7 million from the PCP COS line.

DHCS/Mercer will continue to monitor this item in CalOptima's reporting for future rating periods.

Los Angeles County Cost-Based Reimbursement Clinics

In LA County for the SPD COA and FQHC COS only, in addition to the general base data development of the FQHC COS, the base data includes an additional adjustment to account for the portion of the cost-based reimbursement clinics (CBRC) costs not historically reflected in the base data and not reported in the RDT data. Going back to the original transition of the SPD population from a voluntary managed care COA to a mandatory managed care COA, the full costs associated with CBRCs had been historically included with the Senate Bill (SB)

¹ [Medi-Cal Rx Scope V 5.0 11 22 2021](#)

208 program change adjustments. For CY 2023, these costs are reflected within the base data and were applied after the SIS/UIS considerations described at the end of this section. As a result of this adjustment, a PMPM amount of \$59.98 was added to the SIS base data for LA Care and \$32.42 for Health Net in the FQHC COS line for the SPD COA only. Similarly, a \$2.70 PMPM and a \$1.28 PMPM was added to the federal component of the UIS base data on the FQHC line for SPD members in LA Care and Health Net, respectively.

The data for this adjustment utilized SFY 2020–2021 CBRC experience provided by LA County Department of Health Services. This data reflected the LA Care and Health Net SPD CBRC experience from this period, which aligned with the base data utilized for rate setting. The SFY 2020–2021 RDT information from each of the MCOs was also utilized as it represented the baseline information prior to the subsequent adjustment. The differential between the amounts of LA County Department of Health Services reported experience for each MCO and the underreported MCO experience dictated the needed adjustment.

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

Blue Shield of California Systems Conversion

Through RDT discussions with Blue Shield of California it was identified that a system conversion caused additional and/or incorrect payments to be made to providers through the end of CY 2020, which was reflected in the RDT-reported data. Blue Shield of California provided supplemental data and information related to the incorrect payments made to providers by population, county, COA and COS. An adjustment was applied to remove these costs from the RDT experience. In total, approximately \$5.3 million was removed from the base data across all COA groups for Blue Shield of California.

COVID-19 Temporary Unit Cost Increase Carve-Out

Due to the impact of the COVID-19 pandemic, some health plans made enhanced payments to various providers that otherwise would not have been made. These costs, characterized as temporary and related to the PHE, were collected by quarter on a supplemental schedule of the RDT. Examples of these costs include the 10% per-diem increase to LTC facilities, increased facility payments for COVID-19 isolations, and incentive payments to encourage continued preventive care utilization. A description provided by the health plan was reviewed for each of these costs to confirm they were truly temporary in nature and would not be carried forward to the contract period. All costs from the SFY 2020–2021 period identified to be omitted from the contract period were carved out. In total, approximately \$353.0 million was removed from the base data across all health plans, COA groups, and service categories.

Maternity Base Data Carve-Out

The RDT-reported experience for maternity delivery events was removed from the SFY 2020–2021 base data by COA and COS. This was done since costs for delivery events are covered through a supplemental payment. In prior rating periods, MCOs were only required to report maternity base data in the RDT schedules for the applicable COAs in aggregate without providing COA level details. Maternity supplemental payments were developed from the maternity base data and then carved out of the fully loaded “plan-specific” capitation rates at the end in a revenue-neutral manner. The SFY 2020–2021 RDTs required MCOs to separately report maternity utilization and cost data for each of the COAs (Child, Adult, ACA Expansion, and WCM) that are subject to the maternity supplemental payment. MCOs with global subcontract arrangements continued to report any maternity supplemental payments made to their global subcontractors for these applicable COAs. The maternity supplemental payments net of administrative expenses for the global members were further allocated to each COS based on the MCO’s direct members’ maternity cost distribution. The combined SFY 2020–2021 RDT-reported maternity experience for direct members and global members formed the maternity base data, and was also used in the carve-out of maternity services from the base data. This adjustment removed \$953.5 million from the SFY 2020–2021 base data.

Kaiser and Aetna Base Data Development

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

Kaiser Foundation Health Plan

Consistent with prior rating periods, Kaiser’s RDT-reported information was not deemed fully credible to use in the development of base data.

For the SPD/Full-Dual COA, 100% credibility was given to the data reported in Kaiser’s RDTs. For the LTC and LTC/Full-Dual COAs in San Diego County, 100% credibility was placed on the county/region average due to low Kaiser base membership. For every other COA, to develop Kaiser base data for CY 2023, a 50% weight was given to a risk-adjusted county/region average and a 50% credibility was given to a repriced version of Kaiser’s RDT data. The risk-adjusted county/region average data is established for all other MCOs within Sacramento, San Diego, and the regional counties separately. Then Medicaid-Rx risk score information was reviewed for Kaiser versus the average of the other MCOs within each respective county/region. This risk adjustment process is performed on the county average without maternity as it is removed in a prior adjustment. The remaining 50% of the base data is comprised of Kaiser’s RDT data with adjustments. The adjustments were required as the reported unit cost levels for some service categories are clear outliers and not representative of the costs associated with the Medi-Cal population. For the professional COS (PCP, Specialty Physician, FQHC, Non-Physician Practitioner, and MH–OP) and laboratory/radiology services, Kaiser’s reported utilization was used, but the unit cost was repriced using the county/region average unit cost. The PMPM for each service category was then calculated from reported utilization and repriced unit cost. All other service categories utilize Kaiser reported experience with no adjustments.

Aetna Better Health

Consistent with prior rating periods, Aetna’s RDT-reported information alone was not deemed fully credible to use in the development of base data. To develop Aetna’s base data for CY 2023, a 50% weight was given to a risk-adjusted county average, and the remaining 50% weight was given to a pure county average, similar to the approach taken in the CY 2022 rating period. The risk adjusted county/region average data is established for all other MCOs within Sacramento and San Diego separately. Then, Medicaid-Rx risk score relativities were reviewed for Aetna versus the average of the other MCOs within each respective county. Fifty percent of Aetna’s base data is then calculated as the ratio of their risk score relativity factor compared to the average of the other MCOs multiplied by the county average base data PMPM based on the other MCOs in each county. This risk adjustment process is performed on the county average without maternity. The remaining 50% of the base data is comprised of a pure county average within each respective county, which is the same as the risk-adjusted county/region average data except Medicaid-Rx risk scores were not applied to any MCO data. The process described above was done for the Child, Adult, ACA Expansion, and SPD COAs. For the SPD/Full-Dual COA in both counties and the LTC and LTC/Full-Dual COAs in San Diego County alone, the base data is based on a 100% pure county average within each respective county.

Behavioral Health Treatment Unit Cost Adjustment

Health Plan of San Mateo and Santa Clara Family Health Plan

HPSM exclusively uses a capitation method to reimburse BHT providers. Similarly, SCFHP delegates approximately 70% of BHT services to Valley Health Plan in Santa Clara County. In both instances, the capitated amounts paid by HPSM and SCFHP in SFY 2020–2021 were not supported by observed utilization of the underlying populations. Therefore, the SFY 2020–2021 cost levels for these MCOs were deemed unreasonable and were adjusted accordingly. For HPSM, their overall utilization was repriced using a regional average unit cost. For SCFHP, their utilization with Valley Health Plan was repriced using their FFS experience, which consequently was in line with the regional average unit cost. Across the entire base data period, the adjustment resulted in the following impacts:

- HPSM
 - Child 8.0% decrease
 - SPD 7.5% increase
- SCFHP
 - Child 19.3% decrease
 - SPD 20.5% decrease

Kaiser Foundation Health Plan

Kaiser reported BHT unit costs that were vastly higher than the other MCOs within their respective regions. This is likely due to Kaiser’s business model and accounting system, which for pricing purposes does not distinguish members across their various lines of business; therefore, Kaiser’s unit cost levels are unable to be used for rate setting. However, Kaiser’s overall data reporting with respect to utilization is credible and was maintained in

their base experience. Kaiser's BHT service units were repriced using observed historical unit cost levels in their respective regions to produce the overall cost level per utilizer to establish Kaiser's base experience. Across the entire base data period, the adjustment resulted in the following impacts for Kaiser across all counties in which they operate:

- Child 31.2% decrease
- SPD 20.6% decrease

Data Smoothing

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

Smoothing and Data Credibility Adjustment Process

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

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

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

The credibility factors can be different for each MCO, COA, and COS. Depending on the member months for the base data year (SFY 2020–2021) for an MCO and COA combination, base factors are established, giving credibility to the plan-specific RDT data, plan-specific encounter data, smoothed RDT data, and smoothed encounter data. Given the reliance on plan-reported RDT data, the encounter data used to develop the SFY 2020–2021 base was adjusted to reflect the fully completed RDT PMPMs, at the COA group and COS detail level. With the gradual improvements seen over the years in encounter reporting, encounter unit costs were retained and encounter utilization was adjusted in this process to create resulting PMPMs that were in alignment with the RDT PMPMs.

Larger member month counts correspond to more credibility given to the plan-specific RDT and encounter data and less to the smoothed amounts. For example, for a fully credible plan based on member months exceeding 25,000, these amounts would be 70% plan-specific RDT data, 20% plan-specific encounter data, 7.5% smoothed RDT data, and 2.5% smoothed encounter data. For a smaller COA, having less than 5,000 but greater than 2,500 member

months, these amounts would be 58% plan-specific RDT data, 14% plan-specific encounter data, 21% smoothed RDT data, and 7% smoothed encounter data.

Another component of this process includes having the plan-specific RDT and encounter data run through smoothing ranges, based on reasonable ranges of PMPM and unit cost. These smoothing ranges were based upon the prior rating period's base, which had undergone a similar smoothing and data credibility adjustment process, which was trended and adjusted to align with the SFY 2020–2021 base data period. These ranges, based on each MCO's prior base, at the COA group and COS detail level, helped account for plan-specific nuances, and takes a more tailored approach to the smoothing ranges. If the plan-specific data (separate by COA and COS) is not deemed reasonable (i.e., does not fit into the smoothing ranges), that plan-specific data element is replaced with the closest bound of the smoothing range. For example, if the plan-specific encounter data was not deemed reasonable, but the RDT was reasonable, these amounts would be 70% plan-specific RDT data, 20% plan-specific encounter data that has been replaced by the upper or lower bound of the smoothing range, 7.5% smoothed RDT data, and 2.5% smoothed encounter data for a fully credible COA. In prior years, in the case where a data source was deemed unreasonable, more weight would have been put to smoothed values. Instead, replacing the outlier data points with the corresponding closest bound of the smoothing range allows for more specificity to the MCOs own data over the region average.

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

This smoothing and credibility process was applicable for all COS listed above with the exception of the following; BHT services and CBAS. For these remaining COS, below is a description of the process used to develop the base data:

- **CBAS:** CBAS services vary widely by county within the Medi-Cal managed care program. Some counties have many CBAS facilities while other counties may have none. Due to these differences, both RDT and encounter utilization and cost data were reviewed separately for each MCO and county and ultimately, the base data solely relied on the RDT reported information for this COS.
- **BHT Services:** The RDT-reported amounts for the BHT Services COS line were retained with no smoothing and credibility adjustment, after the plan-specific unit cost adjustments described previously. Subsequent adjustments to the BHT COS lines were made in the COVID-19 adjustment, which is described later in this Section.

Relational Modeling

The Two-Plan, GMC, Regional, and COHS model programs are very large, covering millions of beneficiaries. In aggregate, each MCO has a fully credible population base for rate setting purposes. However, there are a number of MCO COA groups for which there is concern over specific COA group credibility. In those instances, Mercer analyzed data and information on

a more aggregate level and, from this, developed factors, or relativities, to overcome any excessive variation brought on by small membership, or extraordinary (high or low) utilization or unit costs. Adjustments were made via a budget-neutral smoothing and relational modeling process. In general, no dollars were gained or lost in this process.

COVID-19 Adjustment

Acknowledging the CY 2023 rate year leverages a SFY 2020–2021 base data period, a time with experience heavily influenced by COVID-19, extensive analyses were done to ensure utilization and unit cost anomalies (compared to years past) retained in the base data were appropriate and indicative of expected and assumed CY 2023 experience. This analysis leveraged the prior base data period, CY 2019, as a benchmark given that it reflected a pre-COVID-19 period and in turn, experience. This prior CY 2019 base was smoothed, trended, and adjusted for known data nuances, programmatic changes, along with having efficiencies applied to reflect our best estimate of SFY 2020–2021, “clean” of COVID-19 influences. This benchmark served as a guide, while still using SFY 2020–2021 as the base data period, to inform a “return to normal” (or the “new” normal) — a sentiment voiced by the MCOs and backed by a review of quarterly RDT reporting and encounters.

Another factor that necessitated this adjustment in the base was the approach taken for the development and application of trend. Trends as applied in the CY 2023 rate development process and described in sections below, do not adjust for lower levels of utilization due the influences of COVID-19. Hence by bringing utilization and unit cost up (or down) to levels typically within the range of historical experience, the trends applied and the rates downstream, should align better with anticipated CY 2023 experience. At the COA group and COS detail level, this comparison of the SFY 2020–2021 base (which had some preliminary smoothing to remove any extreme outliers) to the trended and adjusted CY 2019 showed consistently lower PMPMs in the base across many COS lines as compared to the benchmark. Where appropriate, base utilization and unit cost were adjusted towards the trended and adjusted CY 2019 benchmark. This was done by leveraging relationships between the base and the benchmark at plan-specific, county, model, and statewide levels.

This COVID-19 “prop up” of the base data specifically impacts the IP (Child and WCM only), ER, PCP, Specialty Physician, FQHC, NPP, MH-OP, BHT, and Transportation COS lines. With the exception of Laboratory and Radiology and Hospice (SPD only) COS lines, no reductions to the base were made. For Laboratory and Radiology, consistent increases in the base were noted, when compared to the trended and adjusted CY 2019 indicating increased testing likely associated with COVID-19. Similarly, in just the SPD COA group, hospice utilization was noticeably higher during the base data period warranting the downward adjustment specific to this COS and COA group.

Similar to other service categories, BHT experienced a drop in utilization at the beginning of the COVID-19 pandemic, and this was observed consistently statewide. While the other “prop up” adjustments considered PMPM levels, BHT adjustments leveraged utilization levels. To offset the dampened utilization, a benchmark utilization statistic was created by simulating the BHT utilizer counts during the SFY 2020–2021 base period by COA group, using historical trends from the pre-pandemic era (i.e., prior to March 2020). Similar to other COS lines, this benchmark was then compared to the actual utilizer counts during the base period.

Finally, after the application of this adjustment, the final smoothing process as described in the previous section, was applied. In total, across all COA groups and service categories, this adjustment added approximately \$898.2 million to the base.

Long-Term Care Fee-For-Service Transitioning Population Base Data

Effective January 1, 2023, the LTC and LTC/Full-Dual COAs will become managed care eligible in all non-CCI Two-Plan, GMC, and Regional “transitioning” counties. These populations were already covered in managed care in CCI and COHS counties; hence, this subsection does not apply in these cases. Since MCO RDT data does not currently exist for these members in transitioning counties, the base data for these COAs is comprised of county-wide SFY 2020–2021 FFS data. The FFS data included utilization and unit cost detail by the same 18 COS noted in the beginning of this section. Note that the base data pulled for this population was only for members with an applicable LTC aid code (13, 23, 53, and 63), as members residing in a LTC facility but without an LTC aid code will be classified into the COA consistent with the beneficiaries’ aid code.

All selected base data was adjusted (as appropriate) to reflect the impact of program changes between the base and contract periods as well as managed care payment levels. These items are discussed further in the *Program Changes* and *Population Adjustments* sections below.

As described above, FFS data served as the base data for rate setting. FFS data undergoes a substantial number of edits to ensure quality and the appropriateness of the data for rate-setting purposes. Base period member eligibility and FFS data were pulled consistent with service code mappings from DHCS, including lists of excluded services, such as State-only funded abortion services. The FFS base data was limited to only services covered through the federal-specific managed care contracts, with the exception that all services for UIS beneficiaries were included at this step (state only services are removed at a step described later in this Section). Mercer has reviewed the data and information utilized for reasonableness, and at the time the rates were developed, we believed the data and information to be free of material error and suitable for rate development purposes for the populations and services covered under this transition.

Maternity Supplemental Payment

To further enhance the measured matching of payment to risk, DHCS utilizes a maternity supplemental payment for all health plans. Pertaining to gender, the primary issue that could result in significant variance among the MCOs’ enrolled population and hence their risk, is the event of maternity and its related cost. Costs for pregnant women are on average substantially higher than the average medical cost of care for men and non-pregnant women with similar demographic characteristics. To mitigate the maternity risk issue within the rates, DHCS includes a maternity supplemental payment, which represents costs for the delivery event. Prenatal and postpartum care costs are not part of the supplemental payment, but remain within the capitation rates for their respective COA. An MCO receives the lump sum maternity supplemental payment when one of its current members within the Child, Adult, ACA Expansion, or WCM COA groups gives birth, and DHCS is appropriately notified a birth event has occurred. Note, 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 2023 maternity supplemental payments. This results in non-live birth expenses being included in the base capitation rates rather than being included in the supplemental payment. Separate maternity supplemental payments enhance matching payment to risk in large part because they mitigate potential adverse selection effects across plans for the non-COHS models and protect the COHS plans from the impact of changing delivery prevalence.

Maternity Supplemental — Design

- Payment made on delivery event that generates a state vital record.
- One supplemental payment per delivery regardless of number of births.
- One blended supplemental payment combining caesarean and vaginal deliveries.
- Supplemental payment varies by county/region, but not by MCO within a county/region.
- Supplemental payment reflects cost of delivery event only (mother and baby, excluding prenatal and postpartum care).
- Supplemental payment is for the entire CY 2023 time period.
- Same supplemental payment is utilized for the Child, Adult, ACA Expansion, and WCM COA groups if a delivery event occurs.

Maternity Supplemental — Base Data Development Approach

In general, a similar process used for the development of the base data by COA group is utilized in the development of the base data for the maternity supplemental payment. The RDT data for direct members is used as the main 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 SFY 2020–2021 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.
- 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. It is our experience that from year-to-year the majority of plan-reported data would fall within an acceptable range conducive to matching payment with risk. However, in some instances when it is clear data quality might compromise the soundness of the rate, Mercer deems it necessary to adjust the ratio to a more normalized level. Once this process was complete, a final factor was applied across all COS so that the resulting per member per delivery cost is the same as the amount carved out of the MCO's base data.

Satisfactory Immigration Status/Unsatisfactory Immigration Status Considerations

Up to this point in the base data development process, all data processing and adjustments were done using combined SIS and UIS data in total (with the lone exception of the CBRC adjustments noted earlier). The final step in the base data development process was to split the base data out by UIS and SIS populations at the MCO, COA, and COS level, and limit to only federal services for the UIS population. This subsection describes the process that was utilized.

For each MCO, COA, and COS, the following metrics were developed to separate the base data for the UIS and SIS populations, and further break the UIS population rates into federal and state-only components. Additionally, a description of how each metric was used to derive the base data is described as well.

- UIS acuity factor compared to the total population
 - This factor represents the expected PMPM cost relativity of the UIS population compared to the total population (UIS and SIS combined). This factor was calculated separately for each MCO, COA, and COS. To derive the total base data PMPM across federally eligible and state only services for the UIS population, the original combined base data were used as the starting point, and multiplied by the UIS acuity factor. This created the total base data PMPM values for the UIS population by health plan, COA, and COS.
 - To derive the updated base data for the SIS population by MCO, COA, and COS, the base SFY 2020–2021 member months and the original base data (UIS and SIS combined) were used as the starting point, and the base UIS member months and UIS base data were backed out of the combined base data.
- Percentage of dollars for UIS members for pregnancy-related and emergency services
 - As previously noted, only pregnancy-related and emergency services are eligible for federal match for the UIS population. As a result, it was necessary to estimate the percentage of PMPM spend for services that are pregnancy-related or emergency specific to the UIS population. Metrics were calculated to estimate the percentage of the capitation rates that are for pregnancy-related and emergency services, separately. This process was done for each MCO, COA, and COS. To derive the federally eligible UIS capitation rates, the percentage of PMPM spend assumed to be federally eligible (sum of pregnancy-related and emergency percentages) were multiplied by the total UIS capitation rates. The remaining services not eligible for federal match will be funded in full by the State, and are not part of this certification.

Acuity Factor and Federal Percentage Development

Within this subsection, the data, assumptions, and methodology used to derive both the UIS acuity factors and percentage of services that are pregnancy-related and emergency are described.

Acuity Factor Development

In the development of the UIS acuity factors for each MCO, COA, and COS, enrollment, MCO-submitted encounter data, and FFS data from SFY 2020–2021 (the base data year) was reviewed. At the MCO, COA, and COS level, SFY 2020–2021 member months and costs from the encounter and FFS data were grouped separately for the UIS population and for the population in total. Encounter and FFS data were the only available data sources to review UIS PMPM spend versus the total populations' PMPM spend. This analysis created PMPM values by MCO, COA, and COS for the UIS population compared to the total population. Note that encounter data was used for the managed care population in SFY 2020-2021, while FFS data was used for the LTC populations in transitioning counties.

To derive the UIS acuity factors, a credibility adjustment and smoothing process was performed. Credibility adjustments were needed because in many instances, the UIS population for a certain MCO, COA, and COS was small. The first step in this process was to run each PMPM through smoothing ranges for the total population by MCO, COA, and COS. If the PMPM value for the total population passed the smoothing ranges, all data for that MCO, COA, and COS were deemed credible (both the total population data and the data specific to the UIS population). By COA and COS, all credible MCO PMPM values that passed the smoothing ranges were aggregated to create statewide average PMPMs for the UIS and total populations, separately.

As a result of this process, two different UIS acuity factors were calculated for each MCO, COA, and COS; one calculated as the MCO-specific UIS PMPM divided by the MCO-specific total population PMPM, and the other calculated as the statewide average UIS PMPM divided by the statewide average total population PMPM. Using these two UIS acuity factors for each MCO and COA, a credibility percentage was assigned to the MCO-specific UIS acuity factor, dependent on the data point passing the smoothing ranges and the size of the MCO/COA combination. If the MCO/COA's UIS population size was at least 25,000 member months for the base year, the MCO and COA combination was given full credibility. If the MCO and COA's UIS population size was less than 25,000 member months in the base year, the MCO was given a credibility factor calculated as the square root of the MCO's base year member months divided by 25,000. Further, all MCO-specific credibility factors were dampened by a 0.75 factor, so that the maximum credibility given to any one MCO/COA's UIS acuity factor was 75%. All remaining credibility was given to the statewide average UIS acuity factor by MCO, COA, and COS. If a given MCO's data did not pass the smoothing ranges, 100% credibility was given to the statewide average acuity factor. This credibility adjustment process created the UIS acuity factors applicable for each MCO, COA, and COS combination.

Federal Percentage Development

In the development of the percentage of the UIS base data that are for federally eligible services, SFY 2020–2021 encounter data for the UIS population was utilized by analyzing both pregnancy-related and emergency services PMPM spend as a percentage of total UIS

PMPM spend. As previously noted, the percentage of UIS dollars for pregnancy-related services and the percentage of UIS dollars for emergency services were analyzed and developed separately. However, the total of the two components make up the total federal percentage that drives the base data calculation. Within the coding logic, various flags in the data were derived and services were flagged as either pregnancy-related or emergency using a hierarchy logic so each encounter or FFS claim only flagged once as either pregnancy-related or emergency. No encounters or FFS claims were flagged twice in the event that a service was flagged as both pregnancy-related and emergency related. The coding logic used to derive the federal percentages (both emergency and pregnancy-related services) is consistent with the logic provided in the July 1, 2019 through December 31, 2020 certification revision dated June 24, 2022.

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

The result of this was PMPM amounts by MCO, COA, and COS for the UIS population for pregnancy-related and emergency services, as a percentage of the total UIS PMPMs, separately. In the development of the percentages utilized for the federal capitation rate development, smoothing ranges were developed at the COA and COS level separately for pregnancy-related and emergency services. The smoothing ranges were developed based on a review of each MCO's data points for the same COA and COS combination. In the smoothing process, if a plan-specific percentage fell within the smoothing range, this value was accepted and used in the calculation of a statewide average percentage of total UIS dollars. This was done separately for pregnancy-related and emergency percentages. The result of this was a statewide average percentage of total UIS PMPM spend that is for pregnancy-related and emergency services, by COA and COS. These statewide federal percentages (the sum of pregnancy-related and emergency percentages) were then applied to the UIS base data in total by MCO, COA, and COS to derive the UIS base data for federal services only. Remaining services for the UIS population are included in the state-only rates that are not part of this certification.

Other Considerations

Acuity factors were developed for all applicable MCO, COA, and COS combinations using the process described above. However, there were small COAs where the acuity factors are assumed to be 1.0 for all MCOs and COS'. In particular, all acuity factors are 1.0 for the LTC, LTC/Full-Dual, and WCM COAs in all applicable counties. The analysis described above was performed for these COAs, but no discernable difference in acuity was noted. Further, the UIS population in these COAs is very small, which contributed to the decision to assume 1.0 acuity factors in these instances.

Further, the acuity factor for the maternity supplemental payment was also assumed to be 1.0 for each county, COA, and COS. This was based on a review of the C-section ratios for UIS beneficiaries compared to the total population. Within this review of historical C-section ratios, it was observed that the mix of C-section delivery events was relatively similar for the UIS, SIS, and total populations. Further, in some counties with a smaller UIS population, it is expected that the C-section delivery mix to be volatile over time and not credible to use in the

development of a separate maternity supplemental payment. Additionally, the maternity supplemental payments are assumed to be 100% federally claimable, since the maternity supplemental payment is reflective of the delivery event only.

Finally, unit cost differences were also reviewed for the UIS population compared to the total population, as well as federal versus state only services. Within this review, no consistent material differences were noted in unit costs by COA and COS. As a result, unit cost statistics for the SIS and UIS populations were assumed to be the same by MCO, COA, and COS. As data is collected up front at the UIS and SIS level in future rate setting years, any differences in unit costs for UIS and SIS populations will be seen at that time based on differences in the data up front.

Section 4

Projected Benefit Costs and Trends

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

- Trend from SFY 2020–2021 to CY 2023
- Program Changes
- Population Adjustments
- CBRC in LA County
- Maternity Supplemental Payment Rate Development

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

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

Trend

Trend is an estimate of the change in the overall utilization and cost of medical services over a finite period of time. Trend factors are necessary to estimate the expenses of providing health care services in a future period. As part of the CY 2023 rate range development for the Two Plan, GMC, Regional, and COHS model programs, Mercer developed trend rates at the COA level and for the maternity supplemental payment for each provider type or COS separately by utilization and unit cost components. Notably, Mercer selected the same trends for the SIS and UIS populations for each COA. This was done, as it is Mercer's expectation that utilization or unit cost trends will not differ substantially between the populations on a service category basis. Though Mercer did not vary trend selections between SIS and UIS, the exhibits contained in this section are created using the aggregated SIS population (without Maternity services), where the large majority of program costs are associated. For all COA group cohorts in the CY 2023 rating period, the SFY 2020–2021 base data was trended forward 30 months from the mid-point of SFY 2020–2021 to the mid-point of CY 2023.

Mercer reviewed and utilized multiple sources of data and information for trend development. These include recent MCO encounter and RDT data, MCO Medi-Cal-only financial statements, Medi-Cal specific hospital IP and OP payment data, Consumer Price Index, National Health Expenditures updates, and multiple industry trend reports including the CMS

Medicaid actuarial report². Each of these data and information sources has strengths and challenges, and those strengths and challenges may change over time. Hence, no one, or combination of data and information source(s), was utilized within a prescribed formula. Rather, each was reviewed for its potential applicability and utilized collectively with other data and information via actuarial judgement in order to inform the final trends.

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

There were three notable changes from the CY 2022 rate development process. Specifically, there were trends set explicitly for the BHT and MH-OP COS groups, as well as all COS groups for the maternity supplemental payment.

For BHT services, the approach to develop trend was largely consistent with the approach described above for all other COS, with one notable addition. For the utilization trend two separate components were considered; the trend in the number of BHT service users, and the number of BHT service hours per user. For both utilization components, Mercer leveraged observed MCO-reported experience over time, as well as actuarial judgement.

Trends were newly set for MH-OP services for the CY 2023 rates. For the CY 2022 rates (and prior), MH-OP services were adjusted, through a base adjustment, to projected PMPM levels for the contract year. Therefore, no trend was explicitly displayed on the CRCS for this service to project to the contract period for CY 2022 rates. For CY 2023 rates, the base adjustment was deemed not necessary; therefore, utilization and unit cost trends were developed to project the service PMPM into the contract period.

Trends were newly set for the maternity supplemental payment for CY 2023 rates. For the CY 2022 rates (and prior), trends were applied to the Child, Adult, ACA Expansion, and WCM base data, inclusive of maternity event service cost and utilization, with a maternity carve-out occurring post-trend in the rate development process. For CY 2023 rates, maternity services were carved out of the base data as a base adjustment, leaving the Child, Adult, ACA Expansion, and WCM base data net of maternity, and leading to a set of base data for the maternity supplemental payment. The newly set maternity trends were then applied to the maternity base data, with maternity unit cost trends set equal to the Adult and ACA Expansion population trends. Utilization trends for maternity were selected to be 0.0% given that utilization changes in delivery events will be accounted for by the nature of the

² <https://www.cms.gov/files/document/2018-report.pdf>

supplemental payment, and there are no expected changes in service utilization per delivery event from the base period of SFY 2020–2021 to the CY 2023 contract period.

There are 12 COS where significant changes in annual claim cost trends took place to reflect the more recent trend experience. In these instances the annual PMPM trend factors changed more than 0.50% and at least one of the incremental changes to utilization and/or unit cost trend factors changed more than 0.25% from CY 2022 to CY 2023. These large changes from the prior year are a result of reviewing newer and emerging information (as described above) to appropriately align prospective payment levels, with additional detail regarding BHT and MH-OP provided above, and additional CBAS detail provided following the table. Please see the table below for detailed changes of trend assumptions by COS for the indicated COA groups.

Annual Trend Factors — All COAs			
COS	CY 2022	CY 2023 (SIS, Non-Maternity)	Change
Primary Care Physician	2.04%	1.44%	-0.60%
Specialty Physician	2.92%	2.12%	-0.80%
FQHC	2.04%	1.42%	-0.62%
Non-Physician Professional	2.02%	4.01%	1.99%
MH-OP	0.00%	4.93%	4.93%
BHT ³	3.26% ¹	5.73%	2.47%
Laboratory and Radiology	4.03%	5.06%	1.02%
Transportation	3.01%	5.01%	2.00%
CBAS	4.01%	0.55%	-3.46%
Hospice	2.25%	2.75%	0.50%
Other HCBS	4.03%	3.02%	-1.01%
All Other	4.03%	3.02%	-1.01%

The largest decrease in trend assumptions year-over-year listed above is for the CBAS COS. This change in trend selection is a reflection of shifting the base year forward from CY 2019 to SFY 2020–2021. For CY 2022 rates, the base year of CY 2019 did not reflect higher utilization of CBAS services related to the temporary alternative services (TAS) flexibilities for delivery of CBAS services granted by DHCS in tandem with the PHE. Through the TAS, CBAS facilities (which traditionally meet in congregate settings) were granted the authority to provide services remotely in order to enhance patient safety; with this flexibility, members who utilized CBAS have received these services more frequently than in the pre-pandemic base period. Though the TAS flexibilities expired after September 30, 2022, the California Department of Aging has developed a replacement service flexibility that began October 1,

³ CY 2022 BHT Trend was on a supplemental payment (per user) basis

2022 called CBAS Emergency Remote Services (ERS), which will continue indefinitely. Through the CBAS ERS application and approval process, Medi-Cal beneficiaries can continue to receive remote CBAS services, allowing for a heightened level of CBAS utilization in the contract period similar to that of the SFY 2020–2021 base period. As a result, Mercer decreased the utilization trend for the large majority of CBAS service cost in the rates to be reflective of a more stable state with mid-point utilization trend at 0.25%. The exception to this trend selection are for the Adult and ACA Expansion COA groups. For these populations, Mercer selected a lower (compared to CY 2022 rates) mid-point utilization trend of 3.25%.

Note, trends for the LTC provider type are displayed as 0.0% for both utilization and unit cost. Due to the relatively high level of legislatively mandated changes surrounding LTC, Mercer has handled LTC unit cost trends through the program changes section of the methodology.

After the mid-point/best estimate trends were determined, a trend range was created by adding 0.25% to each of the utilization and unit cost components as the upper bound, and subtracting 0.25% as the lower bound, with the exception that no range was created for the LTC COS, where the best estimate trends were determined to be zero and handled through other rate setting components. In aggregate, the annualized lower bound claim cost trends for the SIS population, across all MCOs, all COA groups, and all COS, average 0.8% for utilization and 1.8% for unit cost, or 2.7% PMPM. This represents a decrease of 0.4% over the aggregate trend figures at the lower bound from those developed for the CY 2022 capitation rates.

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

Program Changes

Program change adjustments recognize the impact of benefit or eligibility changes that took place during or after the base data period. The program changes incorporated in the development of the rates were based on information provided by DHCS staff as of December 1, 2022. The program changes detailed below were viewed to have a material impact on capitation rates and were reviewed, analyzed, and evaluated by Mercer with the assistance of DHCS.

The next several subsections are the program changes adjustments explicitly accounted for within the CY 2023 capitation rates. A summary showing the managed care impact by county/region, MCO, and COA group can be found within the program change charts provided within the Excel file titled *CY 2023 Medi-Cal Detail CRCS Package LB Rate Smry 2022 12.x/sx*. Additionally, the program change adjustments identified below are applied in columns (F) and (G) of the CRCS, unless otherwise indicated.

Ground Emergency Medical Transportation Fee Increase

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

In order to develop the GEMT program change adjustment, the managed care population was first split into two subpopulations (by COA group, MCO, and county):

- Non-dual members and dual members only eligible for Medicare Part A.
- Members fully eligible for Medicare and members eligible for Part B only.

This split was done because Medicaid is the primary payer for GEMT services for non-dual/Part A only members, while Medicare is primary for Full-Dual/Part B only members (with Medi-Cal the payer of last resort).

For the non-dual/Part A subpopulation, SFY 2020–2021 health plan-submitted encounter data limited to the GEMT codes affected by the fee increase (A0225, A0427, A0429, A0433, and A0434) was utilized.

Based on review and analysis of the data, utilization per 1,000 statistics were developed for the non-dual/Part A subpopulation (by health plan, COA, county, and immigration status). These 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 for non-dual/Part A only members.

For the Full-Dual/Part B subpopulation, the impact of this adjustment is much smaller since Medicare is the primary payer for GEMT services. The first step for the dual eligible members was to evaluate each GEMT code after the Medi-Cal fee increase to see if any crossover Medi-Cal liability existed by code. To do this, the Medicare ambulance fee schedule was reviewed for the applicable codes (A0225, A0427, A0429, A0433, and A0434). Based on this review, it was determined crossover Medi-Cal liability would only exist for code A0429 and only in certain counties, since 80% of the Medicare fee schedule fell below the Medi-Cal fee schedule in certain counties for this code only.

The next step in the adjustment for Full-Dual/Part B only members was to estimate the total number of GEMT trips for dual eligible members billed with code A0429. Note, Medi-Cal-specific data (i.e., encounter and SDR data) for dual eligible members is likely under-reported as providers will not necessarily submit a record to Medi-Cal after being reimbursed in full by Medicare. To do this, the total GEMT trips in Medicare (across all Medicare members, regardless of Medi-Cal eligibility) were estimated using provider submitted data DHCS had collected, which included a breakout by payer. Based on this data, 1.1 million total Medicare GEMT trips were assumed (across all codes). Since this was a total Medicare trips number, regardless of dual eligibility, the next step was to estimate the

number of trips for dual eligible members. Based on an eligibility and literature review, it was assumed 25% of Medicare eligible members were also dually eligible for Medi-Cal. Based on this; it was assumed 275,000 total GEMT trips would exist for dual eligible members (1.1 million times 25%). Next, using encounter data split by code across Medi-Cal, it was assumed approximately 34% of these trips were billed with code A0429. The resulting number of A0429 trips was then converted into a statewide-assumed utilization per 1,000 statistic for code A0429 for Full-Dual/Part B only members. Due to the county-specific Medicare fee schedules, the unit cost add-ons varied by county and resulted in county-specific GEMT PMPM amounts for these Full-Dual/Part B only members.

The final step in the GEMT PMPM calculation was to blend the non-dual/Part A GEMT PMPMs with the GEMT PMPMs for the Full-Dual/Part B PMPMs by COA group, since COA groups are comprised of members with differing dual statuses (in particular, SPD). The final adjustment PMPMs were developed by MCO, county/region, COA group, and immigration status and applied in the transportation COS within the CRCS.

An update for CY 2023 states this policy change is only applicable to GEMT providers not publicly owned, as public GEMT providers are now subject to a different add-on amount. Based on GEMT provider information provided by the State, a percentage of GEMT trips split by public and non-public providers was developed and applied at the health plan-county level. As this GEMT QAF add-on only applies to non-public GEMT providers as required by State law, only the percentage of non-public provider GEMT trips received this add-on. Within the base data in future rating periods, plans are expected 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.

Ground Emergency Medical Transportation Rate Increase AB 1705

Effective January 1, 2023, AB 1705 will establish the Public Provider GEMT program, resulting in a per trip rate increase for GEMT public service providers. Based on the data, assumptions, and methodology described in the previous subsection pertaining to the GEMT QAF add-on, a separate rate increase of \$946.92 was applied to the percentage of assumed public GEMT provider trips. Specific to the duals population, this per trip add-on puts all GEMT trips for the applicable codes above the Medicare fee schedule. As such, all Full-Dual/Part B only public provider GEMT trips have been adjusted to only reflect Medi-Cal's liability of the total GEMT payment rate inclusive of the AB 1705 add-on.

AB 97 Buybacks

Effective July 1, 2022, Medi-Cal restored the 10% AB 97 FFS payment reductions previously applied for various provider types that will now be exempt from AB 97 payment reductions, including the following:

- Air Ambulance Transportation Services
- Alternative Birth Centers-Specialty Clinics — services provided to adults
- Assistive Device and Sick Room Supply Dealers (Durable Medical Equipment)
- Audiologists
- Chronic Dialysis Clinics — services provided to adults

- Community Clinics — services provided to adults
- Hearing Aid Dispensers
- Nurses, including certified nurse-midwives, nurse anesthetists, certified pediatric nurse practitioners, certified family nurse practitioners, and group certified pediatric nurse practitioners.
- Occupational Therapists
- Optometrists
- Orthoptists
- Portable X-Ray
- Psychologists
- Rehabilitation Clinics — services provided to adults
- Respiratory Care Practitioners
- Speech Therapists
- Surgical Clinics — services provided to adults

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

- Podiatrists
- Prosthetists

Adjustments were developed using encounter data, by COA and separated for SIS and UIS beneficiaries, for the provider types listed above during the period of July 1, 2020 to June 30, 2021. This adjustment accounts for pricing pressures based on FFS payment increases which managed care plans are anticipated to pay.

Psychiatric Collaborative Care Management Services

Effective January 1, 2021, Medi-Cal began to cover three Psychiatric Collaborative Care Management (Psych CoCM) services using current procedural terminology (CPT) codes (99492, 99493, 99494) for treatment of MH or substance abuse use conditions billed by the treating physician or other qualified health professional. Emerging Medi-Cal claims experience specific to the Psych CoCM codes available in SFY 2020–2021 was reviewed but deemed not credible. Therefore, a PMPM adjustment by COA for adding coverage of these new codes was derived based on various assumptions, detailed below.

- The proportion of the population with BH conditions, which was estimated based on pharmacy records submitted for the Medicaid Rx risk adjustment analysis.
- The proportion of the eligible population that would utilize the Psych CoCM services during CY 2023, which was based primarily on review of another State's Medicaid experience, consultation with clinical resources, and actuarial judgement.

- FFS reimbursement rate for each CPT code provided by DHCS.

A projected PMPM for the Psych CoCM services was derived using the assumptions noted above, which are the same for SIS and UIS members. No adjustments were made to the UIS Federal rates as these services are generally not pregnancy-related nor emergent.

CalAIM Community Supports

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

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

Managed Care Organization Voluntarily Covered In Lieu of Services Adjustment

The “MCO Voluntarily Covered ILOS Adjustment” specifically adjusts for value-added services dollars reported in the RDT that align with one of the newly covered Community Supports services. These were services voluntarily provided by the MCOs within the SFY 2020–2021 base data period that were removed within the “Value-Added Services Adjustment” base data adjustment. If a value-added service reported in the CY 2020 or CY 2021 RDTs was deemed by DHCS and Mercer to align with one of the 14 Community Support services, then those dollars were carved into the rates in the form of a program change adjustment. As these services were reported by COS and COA by each MCO, this

adjustment is COS, COA, and MCO specific. The data used to apply the adjustment was based on the RDT data reported by the MCOs.

Whole Person Care Adjustment

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

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

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

Remote Patient Monitoring

Remote patient monitoring (RPM) services became a managed care covered benefit effective July 1, 2021. RPM will be included as an allowable telehealth modality in managed care delivery systems. RPM treatment management services are provided when clinical staff use the results of remote physiological monitoring devices to manage a patient under specific treatment plans.

To develop a rate adjustment for this program change, an assumption driven methodology was used, with actuarial judgement as well as clinical input. First, total monthly eligibles were identified for all managed care programs, and the percentage of potential users was estimated (using disease prevalence statistics from risk-adjustment analysis by COA group). Of the members assumed to be eligible for RPM in this process, a penetration rate was assumed for members who would ultimately utilize the benefit. Mercer then estimated the average duration (the months of use per year) per user for each RPM service. The specific services covered under this program change are the following, listed by procedure code:

- 99453: Initial set-up and patient education of equipment — One unit per user month.
- 99454: Remote monitoring — One unit per user month.
- 99457: Remote monitoring treatment or 99091 — Collection and interpretation of data — One unit per user month.
- 99458: Remote monitoring treatment — Additional 20 minutes.

The assumptions noted above, in conjunction with the unit cost assumptions provided by DHCS (based on Medi-Cal fee schedule information by code), produced the total projected dollars for RPM. However, it is not expected that all of the estimated RPM utilization will occur in CY 2023 as the service began July 1, 2021, and a ramp up assumption was used. To assist in the ramp up assumption, Mercer reviewed encounter data for the benefit from July 2021 through December 2021, but ultimately actuarial judgement with clinical input was

used. The final RPM dollars were distributed to the Specialty Physician and PCP COS. This service will be monitored for potential capitation rate adjustments in subsequent rating years.

Doula Benefit

Doula services will become a Medi-Cal covered benefit effective January 1, 2023. Doula services encompass the health education, advocacy, and physical, emotional, and nonmedical support provided before, during and after childbirth or end of a pregnancy, including throughout the postpartum period.

No Medi-Cal claims experience specific to doula services were available at the time the adjustment was derived. Therefore, various assumptions were used to develop a PMPM adjustment for the Child, Adult, ACA Expansion, and WCM COAs, detailed below:

1. Projected CY 2023 live birth counts and abortion counts based on the distributions by COA from SFY 2020–2021 Medi-Cal managed care data. Assumptions of pregnancies resulting in different birth outcomes (live births, stillbirths, miscarriages) were based on national statistics published by the Centers for Disease Control and Prevention (CDC)⁴, the Mayo Clinic⁵, and various other sources.
2. The proportion of the eligible beneficiaries that would utilize the doula services during CY 2023, ramp-up assumptions, and the percentage of pregnancies and delivery events under each birth outcome scenario, were based on discussions with DHCS, consultation with clinical resources, and actuarial judgement.
3. The projected reimbursement rates for eligible doula services are based on information provided by DHCS.

A projected PMPM for doula services was derived using the assumptions noted above, which are the same for SIS and UIS members. The portion of the cost for postpartum care was estimated to be 10% of total costs of all doula services. As such, the program change adjustment for UIS Federal rates was assumed to be 90% of the program change adjustment for SIS rates.

Community Health Worker

Effective July 1, 2022, community health worker (CHW) is an addition to the group of skilled and trained individuals who are currently able to provide clinically appropriate Medi-Cal covered benefits and services to Medi-Cal beneficiaries. While CHWs are also providers of ECM, this program change is separate from the ECM add-on detailed later in this certification.

Leveraging research on CHW staffing and using a build-up similar to the ECM model in identifying potential CHW utilizers, approximately 3.5% of the Medi-Cal managed care population were estimated to be utilizers of CHW services.

An average number of service hours per month was then developed, taking into account elements such as contact types (i.e., face-to-face, telephonic, etc.), frequency and duration

⁴ <https://www.cdc.gov/ncbddd/stillbirth/facts.html>

⁵ <https://www.mayoclinic.org/diseases-conditions/pregnancy-loss-miscarriage/symptoms-causes/svc-20354298>

of contacts, CHW enrollee program tenure, and level of need for members receiving CHW services. Ultimately, 2.0 service hours per month was assumed for the CHW program. This assumption was then multiplied by a California-specific CHW provider cost per hour to price this adjustment. The methodology used to develop the CHW cost per hour is consistent with that used in the ECM rate development for the same provider type. We project the CHW program to be fully ramped up by CY 2027. Given the emphasis on staffing the ECM program with CHWs for the CY 2023 rating period, a 7.5% ramp-up of this program benefit is assumed for CY 2023.

Rapid Whole Genome Sequencing

Rapid whole genome sequencing became a managed care covered benefit effective January 1, 2022. This benefit is available to infants age one year old and younger receiving IP hospital services in an intensive care unit and covers individual sequencing, trio sequencing for parent(s) and their child, and ultra-rapid sequencing.

This adjustment was priced based on managed care intensive care unit utilization of the eligible population and an assumed mix of tests (individual or trio sequencing; rapid or ultra-rapid sequencing) seen from a previous state-funded rapid whole genome sequencing program. Further, this benefit is covered as a CCS covered service when case review confirms the study is warranted and when the test relates to a CCS eligible condition. As a result, this program change only impacts the WCM COA in managed care.

Dyadic Services

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

New Benefits from Dyadic Services Policy:

- Dyadic Visit
 - Note, DBH visits occur on the same day, or close to the same day, as the medical well-child visit.
- General BH Integration

Existing Benefits Impacted by Dyadic Services Policy:

- Case Management Services
- Psychiatric Diagnostic Evaluation

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

General Methodology

In order to determine the impact of this program change on the capitation rates, Mercer calculated the aggregate dollar impact based on the anticipated utilization of impacted services and their prospective unit costs. The starting point for anticipated utilization was to determine the average number of monthly members with BH needs through clinical assumptions and SFY 2020–2021 eligibility; furthermore, how many of those members would utilize dyadic visits during their well-child visits. The assumed dyadic visits vary by age groups that align with the suggested well-child visits from the Bright Futures Periodicity Schedule⁶. Using this utilization of dyadic visits, Mercer estimated the number of additional services provided (for both new and existing benefits) as a result of the dyadic services policy. This expected new utilization of the impacted benefits was analyzed based on the following three categories:

- During the Dyadic Visit
 - In addition to the new utilization of the dyadic visit itself, Mercer analyzed the remaining impacted services for the likelihood of them also being provided during the dyadic visit on a by service basis. Based on these likelihoods, Mercer calculated the total utilization of all services (both new and existing) that would be performed during dyadic visits throughout the calendar year. Per DHCS' policy, all services provided during the dyadic visit are billable under the child's Medi-Cal ID. As such, this new utilization during the dyadic visit is mostly attributable to the Child and WCM COA groups, with smaller amounts impacting the SPD COA (for disabled children ages 0–20) and the Adult and ACA Expansion COAs (for children ages 19–20 years old).
 - After the Dyadic Visit (Downstream Services)
- Given that referrals for certain services are an expected outcome of dyadic visits, it was necessary to include an estimate for the increase in existing services beyond the dyadic visit resulting from the dyadic services policy in the calculation of new utilization. For the estimate of this increase, Mercer analyzed managed care encounters to determine baseline utilization levels of the specific impacted services in the CY 2019 base period.

⁶ https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

Mercer then assumed a growth percentage of 10% for these existing services as a result of the dyadic services policy, and included this growth within the expected new utilization from this program change. Per DHCS' policy, only services provided during the dyadic visit are billable under the child's Medi-Cal ID. Given this category of new utilization occurs outside of the dyadic visit, this increased utilization of existing services was allocated to the various COA groups according to the baseline amounts initially determined in the SFY 2020–2021 data.

- General BH Integration
 - This new benefit covers case management services for MH conditions and includes initial assessments, follow-up monitoring, BH care planning, facilitating and coordinating treatment, and ensures continuity of care with a designated member of the care team, billable up to once a month for recipients of all ages when delivered by medical providers. In contrast to the other two categories that are based on the number of members utilizing dyadic services, the estimated utilization impact associated with general BH integration was instead based on the number of members with a BH need. Similar to downstream services, the utilization associated with the general BH integration benefit are allocated to the various COA groups consistent with the assumed number of members within those groups with a BH need, rather than being assigned to the child's Medi-Cal ID.

To calculate the financial impact associated with this expected new utilization of services, Mercer relied upon CY 2023 reimbursement rates provided by DHCS for certain services, where available, supplemented by aggregate Medi-Cal managed care unit cost data (for applicable procedure codes). Using these various unit costs and the expected new utilization of services, Mercer determined a fully ramped-up prospective impact of the dyadic services program change for CY 2023. To account for the January 1, 2023 effective date and an anticipated ramp-up of the use of these new services, the estimated annual dollars were adjusted downward. Ultimately, an adjustment was applied for the following five COA groups: Child, Adult, ACA Expansion, SPD, and WCM.

Mercer reviewed data and methodology results for the SIS and UIS populations separately, as well as in total, and determined that there was no need to vary the PMPM assumptions between the two populations. However, as the dyadic services adjustment is not related to any emergency or pregnancy-related services, no projected dollars are attributed to the UIS Federal rates, leaving only an impact on the SIS rates.

Long-Term Care Fee-Service Equivalent Directed Payment Adjustment

With the carve-in of LTC services in Two-Plan/GMC/Regional non-CCI "transitioning" counties effective January 1, 2023 for skilled nursing facilities and July 1, 2023 for all other institutional LTC services, DHCS is implementing a delivery system reform State directed payment under 42 CFR § 438.6(c) for the facility per diem reimbursement of LTC services for health plans operating in "transitioning" counties. All Plan Letter (APL) 22-018[1] provides further detail regarding these requirements, in accordance with Welfare and Institutions Code § 14184.201(b) and (c). Health plans that operate in Two-Plan/GMC/Regional non-CCI counties are required to reimburse network LTC providers at, and those providers are required to accept, the payment rate that would otherwise have been paid in the FFS delivery system (e.g., Medi-Cal FFS per diem rate). This requirement applies to all LTC services, both

for services transitioning from FFS and all LTC services previously covered by the health plans in these counties.

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

It is notable, that within the APL listed above, as part of the delivery system reform State directed payment, requirements were also set forth by DHCS within Two-Plan/GMC CCI and COHS “non-transitioning” counties that MCOs are required to pay a minimum of the Medi-Cal FFS per diem rate, rather than exactly the FFS per diem rate. RDT discussion guide conversations with these MCOs revealed that none of them were paying under 100% of the FFS rates. As such, Mercer did not apply any adjustments to the LTC portion of the rates within Two-Plan/GMC CCI counties or COHS counties for this consideration⁷.

Populations Transitioning from Fee-for-Service to Managed Care

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

The populations that transitioned from FFS to managed care on January 1, 2022, designated as part of CalAIM — Phase I, are as follows:

1. TCVAP, excluding the share of cost population
2. Accelerated Enrollment (AE)
3. CHDPI
4. Pregnancy-related Medi-Cal
5. BCCTP
6. Beneficiaries with Other Healthcare Coverage (OHC)
7. Beneficiaries in rural zip codes (Rural)

⁷ <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-018.pdf>

8. Partial Dual beneficiaries in Two-Plan, GMC, and Regional counties

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

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

1. Full-Dual beneficiaries
2. Populations previously subject to managed care, but not transitioned
3. Beneficiaries residing in a LTC facility

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

1. ICF-DD and SA beneficiaries

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

General Methodology

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

Members and their associated claims were identified in the SFY 2020–2021 FFS data by aid code, dual status, LTC accommodation codes, zip code, and enrollment indicators for OHC and waiver status. LTC utilizers were also identified using a 90 day look back logic to identify members with LTC stays, not in an LTC aid code. Note, for beneficiaries with an applicable LTC aid code, the claims and enrollment associated with these beneficiaries was produced as its own set of base data for its own specific rate cell, described previously in the Data section.

Once the appropriate members and claims were identified, the following adjustments were made to make FFS claims more appropriate for these analyses:

1. Repriced FQHC FFS units to managed care costs, which do not reflect wrap-around payments made by DHCS
2. Excluded claims for services that would remain FFS paid.
3. Excluded delivery claims for the Child, Adult, and ACA Expansion COAs

Each population was pulled and analyzed separately by county, COA, and immigration status (SIS/UIS).

The following populations were evaluated separately, but combined and applied as an aggregate rate adjustment, referred to as Populations Transitioning from FFS to Managed Care (CalAIM — Phase I).

1. TCVAP, excluding the share of cost population

2. AE
3. CHDPI
4. Pregnancy-related Medi-Cal
5. BCCTP
6. Beneficiaries with OHC
7. Rural

The following populations were developed and applied as separate rate adjustments:

1. Partial Duals
2. Full-Duals
3. Populations previously subject to managed care, but not transitioned
4. Beneficiaries residing in a LTC facility, but in non-LTC COAs
5. ICF-DD and SA LTC beneficiaries

More details for each adjustment are provided below.

Populations Transitioning from Fee-For-Service to Managed Care (CalAIM — Phase I)

For each of the populations listed above, as part of this aggregate adjustment, the identified FFS data for each population was analyzed in order to compare the expected PMPM cost profile of this population in FFS compared to the appropriate managed care population. In this review, expected managed care cost levels were assumed in combination with the FFS utilization. From this analysis, PMPM relativity factors were developed for the transitioning populations compared to the base population already in managed care.

The PMPM relativity factors for each population were weighted by the membership volume for each population (at the county level) and aggregated to develop rate adjustments for this transition.

Trafficking and Crime Victims Assistance Program

The TCVAP provides eligible non-citizen victims of human trafficking, domestic violence, and other serious crimes services such as cash assistance, food benefits, employment, and social services. This population was identified to be in the Child and Adult COAs. When this transitioning population was analyzed, the volume of members transitioning into managed care was very small compared to their corresponding COAs. As a result of this significantly low volume, the transition of the TCVAP population to managed care was assumed to have no material rate impact.

Accelerated Enrollment

The AE population refers to the Medi-Cal population where enrollment is expedited as acceptance into Medi-Cal is deemed likely. This population was identified to be in the Child, Adult, and WCM COAs. For SIS members, the volume of members transitioning into

managed care were very small compared to their corresponding COAs. As a result of this significantly low volume, the AE SIS population was assumed to have no material rate impact.

For the identified transitioning members within the UIS population, the volume of members transitioning into the Adult COA was very small compared to their corresponding COAs. As a result of this significantly low volume, the AE UIS Adult population was assumed to have no material rate impact. For the Child COA, there was approximately a 0.9% statewide membership impact to managed care. Using the aforementioned methodology, Mercer analyzed the identified FFS population data and developed PMPM relativity impacts by model and COA. The developed factors were then used when calculating this population's impact in the aforementioned aggregate rate adjustment.

Child Health and Disability Prevention Infant Deeming

The CHDPI program is a preventive program that delivers periodic health assessments and services to low income children and youth in California. This population was identified to be in the Child and WCM COAs.

For SIS members, the volume of members transitioning into managed care were very small compared to their corresponding COAs. As a result of this significantly low volume, the CHDPI SIS population was assumed to have no material rate impact.

For UIS members, the volume of members transitioning into COAs in COHS models was very small compared to their corresponding COAs. As a result of this significantly low volume, the COHS UIS population was assumed to have no material rate impact. In the Two-Plan, GMC, and Regional models, there was approximately a 20% membership impact to the UIS Child COA. The two counties that drove this membership increase were LA and Riverside (representing approximately 87% of the transitioning UIS population).

Using the aforementioned methodology, Mercer analyzed the identified FFS population data and developed PMPM relativity impacts by COA for LA, Riverside, and other combined Two-Plan, GMC, and Regional counties (excluding LA and Riverside counties) separately. The developed factors were then used when calculating this population's impact in the aforementioned aggregate rate adjustment.

Pregnancy-related Medi-Cal

The pregnancy-related Medi-Cal population refers to the Medi-Cal members whose income is within 138%–213% of the Federal poverty level. As mentioned before, members who are currently in FFS in this population prior to January 2022 will remain in that delivery system. Only new pregnancy-related Medi-Cal members were enrolled in managed care starting January 1, 2022.

This population was identified to be in the Child and Adult COAs in all model types. For the Child COA, the volume of transitioning members is expected to be very small, and as a result, no rate impact was assumed in this COA for all model types.

For the Adult COA, the membership volume impact of the members transitioning into managed care are shown in the table below.

Model	SIS	UIS
COHS	0.3%	0.6%
Two-Plan/GMC/Regional	0.2%	0.4%

Using the aforementioned methodology, Mercer analyzed the identified FFS population data and developed PMPM relativity impacts by model and COA. The developed factors were then used when calculating this population's impact in the aforementioned aggregate rate adjustment.

Breast and Cervical Cancer Treatment Program

The BCCTP provides urgently needed cancer treatment coverage to individuals diagnosed with breast and/or cervical cancer. This population moved into the SPD COA group. For the COHS model, this population was already covered under managed care, and as a result, no rate impact is assumed for both UIS and SIS populations.

For the Two Plan, GMC, and Regional models, the membership volume impact of the members transitioning into managed care in the SPD COA are shown in the table below.

Model	SIS	UIS
Two-Plan/GMC/Regional	0.2%	1.9%

Using the aforementioned methodology, Mercer analyzed the identified FFS population data and developed PMPM relativity impacts by model and COA. The developed factors were then used when calculating this population's impact in the aforementioned aggregate rate adjustment.

Beneficiaries with Other Healthcare Coverage

Beneficiaries with OHC are FFS members who were previously blocked from entering into managed care because of their OHC status. This population was identified to be in the Child, Adult, ACA Expansion, SPD, and WCM COAs.

For SIS members, the membership volume impact of the members transitioning into managed care for each relevant COA are shown in the table below.

COA	COHS	Two-Plan, GMC, Regional
Child	0.0%	0.8%
Adult	0.3%	1.4%
ACA Expansion	0.1%	1.1%
SPD	0.0%	1.6%

For UIS members, the membership volume impact of the members transitioning into managed care for each relevant COA are shown in the table below.

COA	COHS	Two-Plan, GMC, Regional
Child	0.3%	0.3%

COA	COHS	Two-Plan, GMC, Regional
Adult	4.5%	3.0%
ACA Expansion	0.0%	0.9%
SPD	0.0%	0.1%

Using the aforementioned methodology, Mercer analyzed the identified FFS population data and developed PMPM relativity impacts by model and COA. The developed factors were then used when calculating this population's impact in the aforementioned aggregate rate adjustment.

Beneficiaries in Rural Zip Codes

This population consists of FFS beneficiaries in rural zip codes who have been previously blocked from entering into managed care because of their zip code. These members transitioned into the managed care delivery systems in San Bernardino, Riverside, Kern, and LA counties. This population can fall into any COA group within the Two-Plan model.

In LA County, the volume of the members transitioning into managed care regardless of immigration status is expected to be very small, and as a result, no rate impact was assumed.

For SIS members, in Kern, Riverside, and San Bernardino counties, the membership volume impacts for each county compared to the base managed care population are shown in the table below.

COA	Kern	Riverside	San Bernardino
Child	3.4%	0.8%	5.1%
Adult	3.9%	0.9%	6.4%
ACA Expansion	4.1%	0.9%	7.2%
SPD	3.9%	1.2%	5.2%

For UIS members, in Kern, Riverside, and San Bernardino counties, the membership volume impacts for each county compared to the base managed care population are shown in the table below.

COA	Kern	Riverside	San Bernardino
Child	1.5%	0.5%	2.4%
Adult	1.6%	0.5%	2.9%
ACA Expansion	1.6%	0.4%	2.4%
SPD	1.6%	0.2%	1.3%

Using the aforementioned methodology, Mercer analyzed the identified FFS population data and developed PMPM relativity impacts for Kern, San Bernardino, and Riverside by COA. The developed factors were then used when calculating this population's impact in the aforementioned aggregate rate adjustment.

Partial Duals Transitioning from Fee-For-Service to Managed Care (CalAIM — Phase I)

This population consists of FFS beneficiaries with either Medicare Part A or Medicare Part B only in Two-Plan, GMC, and Regional counties. This population transitioned from voluntary managed care status to mandatory managed care status on January 1, 2022. The identified population found in the SFY 2020–2021 FFS data was primarily impactful to the SPD COA.

The membership volume impact, in aggregate, for Two-Plan, GMC, and Regional counties was 3.6% to the SIS population and 0.8% to the UIS population. For this population, the associated FFS data was used to derive the assumed PMPMs by county across all services. Additionally, an adjustment was made to recognize the MCOs' obligation to provide utilization management/quality assurance/care coordination (UM/QA/CC) services, which inherently does not exist within the FFS data utilized. Existing managed care enrollment distributions by MCO and COA per county were then used to determine an appropriate mix of transitioning members per MCO within any specific rating county/region and COA group.

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

Full-Duals Transitioning from Fee-For-Service to Managed Care (CalAIM — Phase II)

This population consists of FFS beneficiaries with both Medicare Part A and Medicare Part B coverage in Two-Plan, GMC, and Regional counties. This population will transition from voluntary managed care status to mandatory managed care status on January 1, 2023. The identified population found in the SFY 2020–2021 FFS data was primarily impactful to the SPD Full-Dual COA.

The membership volume impact, in aggregate, for Two-Plan, GMC, and Regional counties was 40% to the SIS population and 30% to the UIS population, with larger percentage impacts in non-CCI counties and smaller percentage impacts in CCI counties. In the development of the assumed PMPMs for this population across all services, FFS data for the Full-Dual transitioning population was utilized to set PMPMs for each county.

For the SIS population, the identified FFS population data was reviewed for reasonability and directly utilized to set utilization and unit cost profiles by county and COS. Two main adjustments were made to this data in the development of the data attributable to this transitioning population:

1. An increase to the All Other COS was applied to recognize the MCO's obligation to provide UM/QA/CC services for these members, which inherently does not exist in the FFS claims data.
2. Adjusting the transportation COS to reflect managed care levels of utilization and unit cost by county. This accounted for increases in expected transportation utilization due to expanded access to non-emergency medical transportation services in managed care, as the FFS claims showed little experience related to non-emergency medical transportation services.

For the UIS population, given the relatively low volume of membership, utilization and PMPM relativities were developed separately for CCI and non-CCI counties at a statewide level.

Relativity impacts were set separately for the LTC COS line, the CBAS COS line and all remaining COS lines combined. This was done since it was observed that the LTC and CBAS COS lines had significantly different factors for the UIS population than other COS lines.

Existing managed care enrollment distributions by MCO and COA per county were then used to determine an appropriate mix of transitioning members per MCO within any specific rating county/region and COA group. The adjustment pertaining to this population is shown separately in the program change documentation provided within the attached capitation rate documentation.

Members Transitioning from Fee-For-Service to Managed Care Who Were Previously Subject to Managed Care Transition (CalAIM — Phase II)

This population consists of FFS beneficiaries who were enrolled in aid codes that should have been in managed care, but were not in managed care for various operational reasons in Two-Plan, GMC, and Regional counties. This population will transition to mandatory managed care status on January 1, 2023.

The membership volume impact for Two-Plan, GMC, and Regional counties was approximately 3% across both the SIS and UIS populations.

Within the development of the PMPM cost profile for this transitioning population, FFS claims were analyzed for these members. However, it should be noted, some of these beneficiaries will still stay in FFS even after the transition. For example, some members can opt out of managed care if they have a medical exemption to do so. Within the FFS claims analyzed for this broader population, members with a medical exemption could not be separately identified, which likely skewed the PMPMs seen in the FFS data. Additionally, newly enrolled Medi-Cal beneficiaries will remain in the FFS delivery system until they are either eligible for managed care or choose a managed care health plan. Therefore, there will always inherently be FFS member months for members with a mandatory managed care enrollment status. While logic was refined to exclude these first months of enrollment for newly enrolled beneficiaries, it is still likely some member months that should stay FFS were included within the data. Based on the challenges associated with the data for this population, the transitioning beneficiaries were assumed to have a PMPM relativity factor of 1.0 compared to the base population already within managed care.

Existing managed care enrollment distributions by MCO and COA per county were then used to determine an appropriate mix of transitioning members per MCO within any specific rating region/county and COA group. The adjustment pertaining to this population is shown separately in the program change documentation provided within the attached capitation rate documentation.

Beneficiaries with an Applicable LTC Aid Code

As noted previously, beneficiaries with one of the four LTC aid codes (13, 23, 53, or 63) will transition into Medi-Cal managed care effective January 1, 2023 (along with members without an LTC aid code). Beneficiaries with an LTC aid code will be classified within the LTC and LTC/Full-Dual COAs for rate setting and capitation payment purposes. As a result, there is no program change adjustment specific for this population. Rather, this population's base data was SFY 2020-2021 FFS data, as described in the Data section of this certification.

Additional rate setting assumptions such as trend, program changes, and non-medical loads apply to this population on its own, since this population has its own applicable rate cells.

Long-Term Care Utilizers in Non-LTC Aid Codes (CalAIM — Phase II)

The LTC utilizers in non-LTC COA population consists of members in FFS that reside in an institutional setting, as identified via accommodation codes, that do not have one of the four Medi-Cal LTC aid codes (13, 23, 53, or 63). Prior to CY 2023 in Two-Plan/GMC/Regional non-CCI counties, MCOs would dis-enroll members to FFS that become institutionalized and have a length of stay of at least one full month plus the month of admission, consistent with the DHCS policy of excluding these members from managed care in these counties. Starting January 1, 2023, these beneficiaries who reside in a LTC facility will become a managed care covered population statewide (aside from ICF-DD and SA populations described in the next section). Further, DHCS intends to pay capitation rates for these beneficiaries based on their aid code. As such, these LTC utilizers in non-LTC COA groups will transition to managed care and merge with the existing Child, Adult, ACA Expansion, SPD, and SPD/Full-Dual COA groups for CY 2023.

The SFY 2020–2021 data used to inform the program change adjustment for this population was FFS data specific to this population. This data was reviewed for reasonableness for rate-setting on a county-wide basis by COA, COS, and split by SIS and UIS populations. This data was then adjusted with the following two items:

1. Since the data was separated by COA, there were inherently differing unit cost levels within the same county for different COAs. In review of the data, it was noted, IP unit costs were drastically different for some COAs within the same county in some instances. This was not unexpected given some of the populations can be relatively small. To address the IP unit cost inconsistencies across COA, IP dollars were shifted among non-dual COA groups in a budget neutral manner so that the resulting IP unit costs were consistent for each COA.
2. An increase to the All Other COS was applied to recognize the MCO's obligation to provide UM/QA/CC services for these members, which inherently did not exist in the FFS claims data.

For the SIS population, Mercer then calculated relativity factors by COA and COS (for utilization per 1,000, unit cost, and PMPM statistics) by comparing the transitioning group of LTC utilizers in non-LTC COA groups to the initial base data. Existing managed care enrollment distributions by MCO and COA per county were used to determine an appropriate mix of transitioning members per MCO within any specific rating county/region and COA group.

For the UIS population, there was a low volume of transitioning UIS members related to these populations; to account for this non-credible volume, Mercer utilized statewide average utilization per 1,000, unit cost, and PMPM statistics from the SIS transitioning data to form credible cost profiles. These statewide averages were done separately for all non-dual (Child, Adult, ACA Expansion, SPD, and LTC) and Full-Dual (SPD/Full-Dual and LTC/Full-Dual) COA groups. These aggregate cost profiles were then used in conjunction with county and COA specific UIS transitioning member months to determine the rate adjustments for the UIS rate cells.

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

Intermediate Care Facilities–Developmentally Disabled and Subacute Long-Term Care Populations (CalAIM — Phase II)

The ICF-DD and SA populations consist of members in FFS that reside in either type of these two institutional settings, as identified via accommodation codes. ICF-DD members were carved out of managed care in all Two-Plan/GMC/Regional counties prior to CY 2023, while SA beneficiaries were carved out of managed care in only Two-Plan/GMC/Regional non-CCI counties. As such, historically MCOs would disenroll these members to FFS that become institutionalized in these settings and had a length of stay of at least one full month plus the month of admission. Starting July 1, 2023, ICF-DD and SA beneficiaries will transition to mandatory managed care in all counties in which they were carved out. As such, these ICF-DD and SA groups will merge with the existing Child, Adult, ACA Expansion, SPD, SPD/Full-Dual, LTC, and LTC/Full-Dual COA groups for CY 2023 rates upon the transition to managed care.

The SFY 2020–2021 data used to inform the program change adjustment for this population was FFS data specific to this population. This data was reviewed for reasonableness for rate-setting on a county-wide basis by COA, COS, and split by SIS and UIS populations. This data was then adjusted with the following two items:

1. A budget neutral adjustment to IP costs between COA groups within a county was applied in order to achieve reasonable and appropriate IP unit cost levels for every COA group, similar to the adjustment notes for the prior item.
2. An increase to the All Other COS for all non-LTC COA groups was applied to recognize the MCO's obligation to provide UM/QA/CC services for these members, which inherently did not exist in the FFS claims data. For the LTC and LTC/Full-Dual COA groups where the base data was FFS-based, a similar adjustment was applied as a unit cost managed care adjustment in column (L) of the CRCS.

Due to the low volume of transitioning members related to these populations, Mercer utilized statewide average utilization per 1,000, unit cost, and PMPM statistics from the transitioning data to form credible cost profiles. These statewide averages were done separately for all non-dual (Child, Adult, ACA Expansion, SPD, and LTC) and Full-Dual (SPD/Full-Dual and LTC/Full-Dual) COA groups, as well as separately for ICF-DD and SA members. These aggregate cost profiles were then used in conjunction with county and COA specific ICF-DD and SA transitioning member months to create a single blended cost profile for each county and COA for use when adjusting the CY 2023 rates for these populations.

For the SIS population, relativity factors were calculated by COA and COS for utilization per 1,000, unit cost, and PMPM statistics by comparing the transitioning group of ICF-DD and SA members to the initial base data. Existing managed care enrollment distributions by MCO and COA per county were used to determine an appropriate mix of transitioning members per MCO within any specific rating county/region and COA group. Further, given that ICF-DD and SA members will be carved into managed care halfway through the CY 2023 contract period, half of the SFY 2020–2021 ICF-DD and SA member months were used to develop an appropriate adjustment for the CY 2023 rates.

For the UIS population, there was a low volume of transitioning members related to these populations. To account for this non-credible volume, Mercer utilized the statewide SIS ICF-DD and SA cost profiles in conjunction with the UIS member months identified as transitioning, split by ICF-DD and SA, to create a single blended cost profile for each county and COA when adjusting the CY 2023 UIS rates. These blended cost profiles were then used to determine the relativity factors in the development of the rate adjustment specific to the UIS rates.

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

The resulting relativity factors for all transitioning populations listed in this subsection titled “Populations Transitioning from Fee-for-Service to Managed Care” were ultimately aggregated across all transitioning population adjustments to arrive at the final adjustment applied for all transitioning populations. This was done by MCO, COA, and COS for both the SIS and UIS populations separately.

UIS Population Aged 50 and Older

Effective May 1, 2022, the State transitioned Medi-Cal members aged 50 and older to full-scope Medi-Cal and moved them into managed care, regardless of the member’s immigration status. This population was identified to be in the Adult, ACA Expansion, and SPD COAs. For the CY 2023 rating period, this adjustment was applied to the UIS rates only, with no adjustments applied to SIS rates.

The UIS membership volume impacts for each model and COA compared to the corresponding SFY 2020–2021 managed care UIS population are shown in the table below.

COA	COHS	Two-Plan/GMC
Adult	45.0%	35.4%
ACA Expansion	48.2%	67.0%
SPD	81.1%	152.8%

Prior to May 1, 2022, this populations was enrolled in the FFS delivery system and only eligible for restricted scope services, namely pregnancy and emergency related services. As this population is restricted scope, Mercer pulled multiple data points to understand the potential cost profile of this population.

1. SFY 2020–2021 managed care encounter data was reviewed for the age 50 and older population currently in managed care compared to encounter data for the total UIS population in managed care by COA group.
2. SFY 2020–2021 managed care encounter data was reviewed for the age 50 and older population currently in managed care, but were identified as the covered managed care population without SIS. This data was compared to encounter data for the total population by COA group.
3. SFY 2020–2021 FFS data for the actual population transitioning was also reviewed. However, since this population was restricted scope in SFY 2020–2021, the comparison to managed care encounter data for the base population by COA was done for the IP

Hospital and ER services categories. This is because restricted scope eligibility means members are only eligible for emergency and pregnancy-related services. These two service categories provide for a more apples to apples comparison.

Using the two data sources described above, Mercer developed PMPM relativities by COA and by county/region. Relativities were developed using a blend of county/region specific and model average data, with varying weights applied to each based on transitioning UIS population size in each county/region. It should be noted, the PMPM relativity factors were developed in total, which created a total UIS PMPM for the transitioning population. This PMPM was then split into federal and state-only components, based on percentages derived in the existing managed care populations. These PMPMs were then used in combination with the expected increase in managed care enrollment by plan to derive the program change adjustment applied for this transitioning population.

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

Long-Term Care Rate Changes

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

Historically, FFS rate increases for all LTC facilities typically occurred August 1 of each year. Beginning CY 2021, rate increases for Assembly Bill (AB) 1629 LTC facilities occur January 1 of each year, while rate increases for non-AB 1629 LTC facilities continue to occur on August 1 of each year. The LTC rate increase factors are developed separately for each county (or rating region) within the Two-Plan, GMC, Regional, and COHS model programs. To calculate the adjustment factors for each county, costs and rate increases by the different LTC facility types are analyzed by county/region, and the final adjustment factor is developed using this information. LTC rate change factors also reflect the 10% fee schedule increase for ICF-DD, Freestanding SA Facilities, and SNF — Level B that will be included as part of the cost-base rates during the CY 2023 rating period. During the PHE, all LTC facilities were subject to a 10% payment level increase. DHCS has made a policy decision to extend the 10% increase to these specific facilities regardless of the end date of the PHE.

Long-Term Care Per Diem Add-on Rates

For ICF-DD and Free Standing Pediatric Subacute facilities, further adjustments were applied to the LTC service category to account for per diem fee schedule rate increases.

Effective August 1, 2022, the former Proposition 56 (Prop 56) Supplemental Payments will be transitioned to be included as part of the fee-for-service cost-base rates. This adjustment accounts for pricing pressures related to these FFS increases that managed care plans are anticipated, but not obligated, to pay. These per diem rate increases were formerly included within the LTC rate changes adjustment for CY 2022. For the CY 2023 the per-diem add-on adjustments were developed using a consistent methodology as CY 2022 and are now displayed as separate adjustments for CY 2023.

Hospice Rate Increase

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

Program Changes Applied as Add-ons to the Rate

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

Major Organ Transplants

CY 2023 capitation rates include PMPM add-ons to reflect the impact of MOT becoming a managed care covered benefit effective January 1, 2022 in Two-Plan, GMC, and Regional counties. MOTs were already a covered benefit within the COHS model. Add-on rates were developed for the following transplant types; bone marrow, liver, heart, lung, intestine, and pancreas. Kidney and cornea transplants are already covered in all managed care models.

For the PMPM add-on development, Mercer reviewed historical CY 2020 and CY 2021 FFS data and identified individuals who received a MOT by each transplant type listed above through All Patients Refined Diagnosis Related Groups (APR-DRG) and/or surgical codes. Mercer then reviewed eligibility to establish, by individual, the pre- and post-transplant periods. The pre-transplant period was identified when an individual disenrolled from an MCO to FFS prior to a MOT surgery event. The post-transplant period was identified as the period where, after a MOT surgery, the average number of months before an individual re-enrolled into an MCO. Costs for the transplant event itself were reviewed and defined as costs incurred during the IP stay of the transplant surgery. Average costs for these transplant periods (pre, event, and post) were then converted to per utilizer per month figures.

Except in WCM counties, individuals enrolled in the CCS program will continue to have their transplant costs covered through FFS when the transplant is related to their CCS-eligible

condition, which is nearly always anticipated to be the case. As such, Mercer excluded their historical costs from the base data.

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

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

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

Adjusted base period unit costs and utilization per 1,000 statistics were trended from the midpoint of the base period (January 1, 2021) to the midpoint of the contract period (July 1, 2023) for a total duration of 30 months. Further, county-specific historical prevalence of transplant events were reviewed to develop PMPM add-ons that vary by county. Annual trends by service category are consistent with lower bound trends used for the broader rates. Add-on rates reflect a full administration load consistent with lower bound assumptions used for the broader capitation rates. The fully loaded rates have an impact of approximately \$297 million for the CY 2023 rating period, limited to the SIS population only. This is an increase from CY 2022 driven by the phase-in element present for CY 2022 rate development that was removed for CY 2023. MOT encounter data for UIS and SIS members were separated for CY 2023 and MOT capitation rates are calculated separately for both populations. MOT for UIS beneficiaries is only applicable to the state only UIS capitation rates and therefore not part of this certification.

Enhanced Care Management

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

The impact of the program to the CY 2023 capitation rates was developed at a statewide level, with county-specific adjustments, to derive health plan and county specific PMPM add-ons to the capitation rates. Without any prior claims experience, the development of this adjustment focuses on the needs of the ECM-eligible population — specifically who meets the criteria and the assumed amount of care management utilized.

Additionally, with the sun setting of the CCI program effective December 31, 2022, the following populations transitioned from the CY 2022 CCI Duals ECM rates to their appropriate COA groups for CY 2023 ECM rate setting:

- Institutional/Full-Dual maps to LTC/Full-Dual
- Community/Full-Dual maps to SPD/Full-Dual

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

The following flow charts detail the caseload and provider hour breakdown for varying severity levels of ECM members. These charts, built at a statewide level, detail the hours spent by Care Managers (CM) and CHW at varying severity levels, the distribution of these severity levels over the course of the rating period, as well as the distinction between the ECM rate development groups:

- WPC/HHP “grandfathered” ECM enrollees — individuals who transitioned from WPC and HHP in early CY 2022
- LTC ECM members — institutionalized individuals looking to transition back into the community
- Regular ECM — all other ECM enrollees (this group was referred to as “ECM New” for CY 2022 rate development)

For CY 2023 ECM rates, in order to account for the multiple start dates for various ECM groups and counties, caseload assumptions were modified to be based on the length of time an individual is enrolled in ECM (1–6 months, 7–12 months, and >1 year). This new methodology allowed for more flexibility with population changes and provided the ability to more appropriately reflect caseload assumptions as the ECM program ramps up.

Medi-Cal Enhanced Care Management CY 2023 ECM Statewide Base Data Development

Severity Level ¹	Percent Distribution	Members Enrolled 1–6 Months			Members Enrolled 7–12 Months			Members Enrolled > 1 Year				
		CM	Month		CM	Month		CM	Month			
			CHW	Combined		CHW	Combined		CHW	Combined		
Level 1 — High Touch	20%	3.0	7.4	10.5	25%	3.0	7.4	10.5	25%	3.0	7.4	10.5
Level 2 — Medium Touch	25%	2.3	4.6	6.9	25%	2.3	4.6	6.9	25%	2.3	4.6	6.9
Level 3 — Low Touch	25%	1.2	2.2	3.5	30%	1.2	2.2	3.5	35%	1.2	2.2	3.5
Level 4 — Maintenance	30%	0.9	1.2	2.1	20%	0.9	1.2	2.1	15%	0.9	1.2	2.1
(A) Total Hours per ECM Enrollee per Month	100%	1.7	3.5	5.3	100%	1.9	3.9	5.8	100%	1.9	4.0	5.8

(B) ² Employee Cost	\$126,341	\$68,463	\$87,581	\$126,341	\$68,463	\$87,213	\$126,341	\$68,463	\$87,165
(C) ³ Overhead	20%	20%	20%	20%	20%	20%	20%	20%	20%
(D) = (B) / (1 - (C)) Total Cost	\$157,926	\$85,579	\$109,476	\$157,926	\$85,579	\$109,016	\$157,926	\$85,579	\$108,956
(E) = (D) / (130 * 12) ⁴ Cost/Hour	\$101.23	\$54.66	\$70.18	\$101.23	\$54.66	\$69.88	\$101.23	\$54.66	\$69.84
(F) = (A) * (E) PEPM	\$176.84	\$194.29	\$371.13	\$189.50	\$214.29	\$403.79	\$191.29	\$217.15	\$408.44

LTC ECM Members	Members Enrolled 1–6 Months				Members Enrolled 7–12 Months				Members Enrolled > 1 Year				
	Severity Level ¹	Percent Distribution	Month			Percent Distribution	Month			Percent Distribution	Month		
			CM	CHW	Combined		CM	CHW	Combined		CM	CHW	Combined
Level 1 — High Touch	25%	2.8	5.2	7.9	10%	2.8	5.2	7.9	0%	2.8	5.2	7.9	
Level 2 — Medium Touch	25%	2.1	3.5	5.5	20%	2.1	3.5	5.5	5%	2.1	3.5	5.5	
Level 3 — Low Touch	35%	1.4	2.1	3.5	35%	1.4	2.1	3.5	10%	1.4	2.1	3.5	
Level 4 — Maintenance	15%	1.0	1.3	2.3	35%	1.0	1.3	2.3	85%	1.0	1.3	2.3	
(A) Total Hours per ECM Enrollee per Month	100%	1.8	3.1	4.9	100%	1.5	2.4	3.9	100%	1.1	1.5	2.6	
(B) ² Employee Cost		\$128,341	\$88,483	\$90,193		\$128,341	\$88,483	\$91,189		\$128,341	\$88,483	\$93,656	
(C) ³ Overhead		20%	20%	20%		20%	20%	20%		20%	20%	20%	
(D) = (B) / (1 - (C)) Total Cost		\$157,928	\$88,579	\$112,741		\$157,928	\$88,579	\$113,986		\$157,928	\$88,579	\$117,069	
(E) = (D) / (130 * 12) ⁴ Cost/Hour		\$101.23	\$54.88	\$72.27		\$101.23	\$54.88	\$73.07		\$101.23	\$54.88	\$75.04	
(F) = (A) * (E) PEPM		\$188.85	\$188.44	\$355.30		\$158.42	\$130.27	\$283.70		\$113.51	\$79.81	\$193.31	

Regular ECM Members	Members Enrolled 1–6 Months				Members Enrolled 7–12 Months				Members Enrolled > 1 Year				
	Severity Level ¹	Percent Distribution	Month			Percent Distribution	Month			Percent Distribution	Month		
			CM	CHW	Combined		CM	CHW	Combined		CM	CHW	Combined
Level 1 — High Touch	35%	3.0	7.4	10.5	30%	3.0	7.4	10.5	30%	3.0	7.4	10.5	
Level 2 — Medium Touch	25%	2.3	4.6	6.9	25%	2.3	4.6	6.9	20%	2.3	4.6	6.9	
Level 3 — Low Touch	20%	1.2	2.2	3.5	20%	1.2	2.2	3.5	25%	1.2	2.2	3.5	
Level 4 — Maintenance	20%	0.9	1.2	2.1	25%	0.9	1.2	2.1	25%	0.9	1.2	2.1	
(A) Total Hours per ECM Enrollee per Month	100%	2.1	4.1	6.5	100%	1.9	4.1	6.1	100%	1.9	4.0	5.9	
(B) ² Employee Cost		\$128,341	\$88,483	\$86,788		\$128,341	\$88,483	\$87,033		\$128,341	\$88,483	\$87,046	
(C) ³ Overhead		20%	20%	20%		20%	20%	20%		20%	20%	20%	
(D) = (B) / (1 - (C)) Total Cost		\$157,928	\$88,579	\$108,485		\$157,928	\$88,579	\$108,791		\$157,928	\$88,579	\$108,807	
(E) = (D) / (130 * 12) ⁴ Cost/Hour		\$101.23	\$54.88	\$69.54		\$101.23	\$54.88	\$69.74		\$101.23	\$54.88	\$69.75	
(F) = (A) * (E) PEPM		\$207.64	\$242.88	\$450.50		\$198.78	\$225.72	\$422.49		\$191.40	\$219.32	\$410.72	

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

Since the base per enrollee per month (PEPM) was developed using SFY 2021 salary information, 30 months of 5.0% annual provider cost trend was applied to bring the base data to the CY 2023 contract period.

County-specific Adjustments for Per Enrollee Per Month and Outreach

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

1. **County Wage Adjustment (applied to unit cost)** — an adjustment was applied to factor in wage differences for ECM providers between counties in California.
2. **County Rural Adjustment (applied to utilization)** — similar to HHP, a 25% upward adjustment factor was applied to account for the additional service hours required to serve ECM enrollees residing in a rural setting.
3. **Overlapping CM Program Adjustments** — an important responsibility of ECM providers is to ensure there are not duplication of services with other CM programs. As such, the ECM rates contain offset adjustments for the portion of the projected population that is enrolled in multiple CM programs.
 - A. **Medicare Part B Dual Enrollees** — this adjustment accounts for Part B eligible ECM enrollees who are eligible for CMS' Chronic Care Management (CCM), Behavioral Health Integration (BHI), or Medicare Advantage CM programs. ECM providers are expected to collaborate with the member's physician in order to pursue the appropriate CCM and BHI payments from CMS for their ECM enrollees with Part B coverage. Additionally, National Committee for Quality Assurance (NCQA)-accredited Medicare Advantage Plans have CM requirements that are similar to some ECM services. As CMS will be covering ECM-like services through the CCM, BHI, and Medicare Advantage Plans programs, a portion of the CMs service hours (utilization) were reduced. The result is a downward rate adjustment to the SPD, SPD/Full-Dual, LTC, and LTC/Full-Dual COAs to account for the overlap in services rendered.
 - B. **County-run Targeted Case Management (TCM) Services Adjustment (applied to utilization)** — this adjustment accounts for the overlap between TCM and ECM services for ECM enrollees enrolled in both programs.
 - C. **Short Doyle TCM Services Adjustment (applied to utilization)** — this adjustment accounts for the overlap between the county-run Short Doyle MH TCM program and ECM services for ECM enrollees enrolled in both programs.
 - D. **CCS** — similar to TCM, it is appropriate to apply a carve-out adjustment to the ECM rates for CM services children receive through CCS that overlap with ECM services.
 - E. **Existing Care Coordination Adjustments** — the WCM program includes some CM services comparable to those provided through ECM. The WCM CM services are accounted for in rate development through a Care Navigation rate add-on. Through our clinical review of the CM requirements of both programs, Mercer determined WCM ECM enrollees have 25% of their ECM services are accounted for through the WCM capitation rate. As such, 25% of the WCM ECM medical component PMPM is carved out of the WCM capitation rate.

Converting from a Per Enrollee Per Month to Per Member Per Month Add-on

The entirety of the ECM rate development is done at a PEPM-level. To convert this to a PMPM, projected targeted individuals and ECM enrollees are used to convert the PEPM and monthly outreach costs to a PMPM⁸.

⁸ *Identifying ECM "Eligible" Members for Outreach and Enrollment*

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

For members that transitioned from other sun setting care management programs (i.e., WPC and HHP), the State and Mercer leveraged actual ECM enrollment through June 2022 along with appropriate disenrollment assumptions through CY 2023.

As for the “non-transitioning” ECM enrollees (counts and member months), ECM-eligible individual counts (excluding HHP/WPC transitioned individuals) by health plan and COA were projected based on guidance provided by the ECM policies from DHCS regarding identifying ECM-eligible “populations of focus”. In the development of these projections, Mercer also leveraged actual ECM enrollment through June 2022 to help inform growth assumptions through CY 2023.

Ultimately, accounting for ramp-up assumptions, the rate development assumes that by the fourth quarter of CY 2023, 1.0% of managed care members will be enrolled in ECM. After a full ramp up of the ECM program, it is expected that 1.5%–2.5% of managed care members will be enrolled in ECM.

Half of the lower bound administrative load and the full underwriting gain (2.0%) load were used for the ECM add-on.

Enhanced Case Management Rates for UIS and SIS Populations

The rate methodology and assumptions for UIS and SIS populations remain the same in the development of the monthly PEPM cost based on their length of time enrolled in ECM (i.e., 1–6 months, 7–12 months, and 13+ months). At this time, there is insufficient data to support variation in PEPM-related assumptions between the UIS and SIS populations. However, there is sufficient data to support variations in projected ECM enrollment for the UIS and SIS populations. As such, the CY 2023 rates reflect a variation in PMPMs between the UIS and SIS populations. Two separate data points drive these variations in projected ECM enrollment:

- ECM actual enrollment reporting for the WPC/HHP transitioned population — these transitioned member counts make up a significant portion of the enrollment forecast for CY 2023.
- Identifying ECM “Eligible” Members for Outreach and Enrollment — Mercer observed generally consistent results in terms of the UIS/SIS split. Since the ramp up of ECM continues to occur throughout CY 2023 and the rate development is still largely assumption driven, it was appropriate to apply a statewide adjustment factor to each health plan/county’s combined UIS/SIS eligible percentages in order to calculate their UIS and SIS percentages. This statewide adjustment was applied at the COA level to all COA groups except for LTC and LTC/Full-Dual. Given the small size and volatility of the LTC rate cells, Mercer assumes no variation between SIS and UIS eligibility percentages.

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

Health Plan of San Mateo Dental

Effective January 1, 2022, dental services are covered in San Mateo County. This add-on is applicable only to the SIS population, and the add-on for the UIS population is considered state only. Given this was a new managed care benefit after the base period, the data utilized was CY 2021 Medi-Cal Dental FFS data in San Mateo County. The data was then adjusted for the following items:

1. Removal of California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Prop 56) supplemental payments.
2. Services provided at FQHCs were adjusted to an “arms-length” amount not inclusive of the full PPS rate.
3. Annualized trend factors were applied for 24 months to the midpoint of the CY 2023 rating period.
4. Various managed care adjustments were made to price the benefit consistent with expectations within managed care.
5. Items as part of the CalAIM initiative were addressed
 - A. DHCS implemented a State directed payment under 42 CFR § 438.6(c) imposing a minimum fee schedule for certain dental services under the contract using State plan approved rates. An additional adjustment was applied to applicable preventive services to increase the unit cost from base expected managed care levels to 75% of the Schedule of Maximum Allowance, consistent with the State directed payment.
 - B. An adjustment to reflect the Caries Risk Assessment new benefit.
 - C. An adjustment to reflect the Silver Diamine Fluoride new benefit.
 - D. An adjustment to reflect the Lab Processed Crowns new benefit.
6. Lower bound administration and underwriting gain loads consistent with the broader rate development were utilized in the development of the PMPM add-on.

The Prop 56 Dental State directed payment under 42 CFR § 438.6(c) is applicable to services covered under this pilot program. The impact of this State directed payment is displayed as an additional PMPM add-on. The Prop 56 supplemental payments, removed from the CY 2021 FFS base data, were adjusted similarly to project forward to CY 2023:

- Annualized utilization trend factors were applied for 24 months to the midpoint of the CY 2023 rating period.
- Various managed care adjustments were made consistent with utilization expectations within managed care.
- An adjustment to reflect the Lab Processed Crowns new benefit, which is subject to Prop 56 supplemental payments.
- Lower bound administration and underwriting gain loads consistent with the broader rate development were utilized in the development of the PMPM add-on.

Specialty Mental Health Services for Kaiser Members (Sacramento and Solano)

Specialty MH services in Sacramento and Solano counties for Kaiser members are a managed care covered benefit in these instances. Kaiser is a direct contracting health plan in Sacramento County and global sub-contractor to PHC in Solano County. As these two items are applied as capitation rate add-ons, they are included with other capitation rate add-ons noted previously in this subsection. This benefit will be carved out completely to FFS effective July 1, 2023, as noted previously.

To develop the Kaiser SMI PMPM add-ons in Sacramento and Solano counties, Mercer utilized supplemental SFY 2020–2021 data that Kaiser submitted which isolated to MH services for members diagnosed as having a SMI. This data was reviewed and adjusted as appropriate for rate setting purposes. Specifically, the unit cost levels were reviewed and adjusted similar to the process used for the SFY 2020–2021 RDT data used for rate setting. Additionally, this data was trended forward to the CY 2023 rating period and administration and underwriting gain loads were applied consistent with the broader rate development process (using lower bound trends, administration, and underwriting gain load assumptions). The PMPM add-ons are applied to both the Kaiser Sacramento capitation rates and PHC rates outside of the risk-adjustment process. Please note that these PMPMs are only effective for the first six months of the rating period (January 1, 2023–June 30, 2023) due to the aforementioned carve-out.

As a result, the final certified capitation rates for Kaiser in Sacramento County and PHC are different for the first six months and the second six months of the CY 2023 contract period. The only difference between the two sets of rates is the application of this PMPM add-on for the first six months but not the second six months.

Program Changes Considered, but Not Adjusted For

In addition to the program changes mentioned in the sections above, Mercer analyzed several program and policy changes for inclusion in CY 2023 capitation rates, but ultimately found these to have no rate impact.

Populations Transitioning from Managed Care to Fee-for-Service

Certain Medi-Cal populations designated by CalAIM within managed care will transition to FFS effective January 1, 2022. These populations are:

- OBRA
- Share of Cost in COHS and CCI

Structurally, the OBRA population has been set at its own rate. As this population will be transitioning to FFS effective January 1, 2022, a rate was simply not set for this COA.

For the Share of Cost population, the estimated membership volumes were ultimately an immaterial proportion of the total population, and was therefore found to have a minimal impact on the capitation rates.

Asset Thresholds

Asset limit qualifications will be raised for non-Modified Adjusted Gross Income, LTC, and Medicare Shared Savings Program Medi-Cal applicants effective July 1, 2022.

From discussions with DHCS surrounding the incoming population, the projected incoming membership is minimal, and there is no reasonable indication these incoming members would have a different cost profile than the members currently in managed care. Therefore, no explicit adjustment was made for this program change.

Populations Transitioning into Managed Care or Extending Managed Care Coverage

The following populations have been analyzed and ultimately found to have low membership volume and/or similar cost profiles to the total population. Therefore, no explicit adjustment was made for the following populations:

1. Post-partum Expansion — identified beneficiaries who receive pregnancy-related services would be eligible for Medi-Cal postpartum care for up to 12 months after the last day of the pregnancy effective January 1, 2022.
2. Health Insurance Premium Payout Transition — the Health Insurance Premium Payout program will be discontinued effective January 1, 2022, and these members will be transitioned to managed care.
3. Rady Program Discontinuation — effective December 31, 2020, members in the Rady Children's program will transition into the managed care or FFS delivery systems. CCS services will be covered by the FFS delivery system in this county.

Telehealth — Post Public Health Emergency

Pursuant to the Welfare and Institutional Code, WIC 14124.12(f), telehealth modality flexibilities present during the PHE will be extended through December 31, 2022 regardless of the PHE end date. These flexibilities anticipate payment levels made for telehealth services to be in line with similar services provided at an in-person setting. Therefore, no explicit adjustment was made in the CY 2023 rates.

Substance Use Disorder in the Emergency Department

Starting January 1, 2021, the initiation of medication for substance use disorders in the ER system (billed under health care common procedure coding system [HCPCS] code G2213) was added as a reimbursable service in the Medi-Cal fee schedule with a reimbursement rate of \$58.05. Mercer identified the potential utilization of this benefit using SFY 2020–2021 managed care encounter data and ultimately found this benefit would have no rate impact due to low utilization in conjunction with relatively low reimbursement costs. Therefore, no explicit rate adjustment was applied.

Asthma Remediation Services

Effective July 1, 2022, the in home remediation assessment benefit will be expanded to include CHWs as an allowable provider. As this benefit is not changing in scope, but adding a new type of provider, this benefit was ultimately deemed to have no rate impact.

Population Health Management

On January 1, 2023, all managed care plans will be required to meet population health management (PHM) standards by either having full NCQA Health Plan Accreditation or by demonstrating to DHCS that they meet the PHM standards for NCQA Health Plan

Accreditation. By January 1, 2026, all managed care plans must obtain NCQA Health Plan Accreditation and NCQA Health Equity Accreditation. As many plans are already NCQA accredited, and all others should be meeting these basic NCQA management standards, this was determined to have no material impact to managed care capitated rates.

Annual Cognitive Health Assessment for Eligible Members Age 65 or Older

Effective July 1, 2022, California SB 48 expanded the Medi-Cal schedule of benefits to include an annual cognitive assessment for Medi-Cal members who are 65 years of age and older if they are otherwise ineligible for a similar assessment as part of an annual wellness visit through the Medicare program. Given that this change only impacts non-dual and partial dual members without Medicare Part B coverage, in conjunction with relatively low reimbursement levels, this was determined to be immaterial and no explicit rate adjustment was applied.

Biomarker Testing

Effective July 1, 2022, California SB 535 prohibited managed care plans that already cover biomarker testing from requiring prior authorization for biomarker testing for plan members with advanced or metastatic stage III or stage IV cancer. This bill also prohibited managed care plans from requiring prior authorization for biomarker testing for cancer progression or recurrence in members with advanced or metastatic stage III or stage IV cancer. Initial plan surveys found that the vast majority of plans would not need to change their current policy to comply with SB 535.

COVID-19 Masks

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

COVID-19 and Pediatric Vaccine Counseling

COVID-19 and pediatric vaccine counseling-only visits for children under 21 years of age, and COVID-19 vaccine counseling-only visits for adults when covered within the scope of practice of the provider, were added as a benefit with an effective date of December 2, 2021, the date that CMS issued the press release announcing this requirement. Potential utilization and reimbursement levels under managed care were assessed and this was determined to be immaterial with no explicit rate adjustment applied.

Routine Cost of Clinical Trials

Effective July 1, 2022, SB 583 would expand an existing benefit mandate to require coverage of health care services related to participation in clinical trials connected to any life-threatening disease. Prior to July 1, 2022, routine costs were only covered for Stage IV Cancer trials. Potential utilization and ramp up assumptions were assessed for this new benefit, and it was determined to be immaterial to managed care capitated rates.

Violence Prevention Services

Effective January 1, 2023, Violence Prevention Services will be added as a new covered benefit under Medi-Cal. Reimbursement rates per unit will be set between \$16.90 and \$28.50 and Violence Prevention Services workers will need either a Violence Prevention Professional Certification issued by the Health Alliance for Violence Intervention or a certificate of completion in gang intervention training from the Urban Peace Institute. Potential utilization and ramp up assumptions were assessed for this new benefit, and it was determined to be immaterial to managed care capitated rates.

Genetic Disease Screening Program Prenatal Screening Fee Changes

Effective September 19, 2022 the California Department of Public Health prenatal screening program will be the only authorized entity that can bill Medi-Cal managed care plans for screening for fetal trisomies and/or neural tube defects. Fees charged under this program were found to be marginally lower than what managed care plans currently pay for prenatal screenings, resulting in minimal savings for the health plans. Therefore, an adjustment was not applied to managed care capitated rates for CY 2023.

Acupuncture

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

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

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

Population Adjustments

For CY 2022, two additional adjustments were applied to the managed care data. Both of these adjustments are applied within columns (K) and (L) of the CRCS in the Excel file titled *CY 2023 Medi-Cal Detail CRCS Package LB Rate Smry 2022 12.xlsx*. More detail on each adjustment is described in the next two subsections.

Long-Term Care Category of Aids Utilization Management/Quality Assurance/Care Coordination Adjustment

An increase was applied to the All Other COS for both the LTC and LTC/Full-Dual COAs in non-CCI Two-Plan, GMC, and Regional “transitioning” counties to recognize the MCO’s obligation to provide UM/QA/CC services for members under managed care. The base data

for these COAs in these counties was FFS data, and therefore did not reflect expenses for UM/QA/CC services. An adjustment was applied within column (L) of the CRCS.

Population Acuity Adjustment

Since the beginning of the PHE (beginning March 1, 2020), Medi-Cal ceased disenrolling members with certain exceptions such as members who moved out of state, passed away, or voluntarily requested to be disenrolled. As a result, the Medi-Cal managed care enrollment numbers began increasing significantly; a reversal of the trend observed prior to March 1, 2020. Mercer analyzed how the changing enrollment counts affected the underlying risk of the remaining population, using two distinct methods.

The first method used was a durational analysis that segmented members into fixed cohorts based on their Medi-Cal enrollment month. The time period of the analysis was January 2018 to December 2021. However, more weight was given to the pre-PHE time period (prior to March 2020) since most disenrollments halted after this time, and observed costs during the PHE were also affected by a myriad of systemic issues as a result of the COVID-19 pandemic. Within each fixed cohort the costs were evaluated over time, measuring how costs changed as members disenrolled. There was a challenge in determining how much of the change in costs were attributable to members disenrolling versus how much was due to natural trends. To attempt to control for this Mercer also evaluated the total population (across all cohorts) over the same time period to tease out the trend effect. The result of the analysis showed that as members disenrolled from a fixed cohort, the resulting costs of the remaining population increased, suggesting that members who disenrolled were lower acuity. Therefore, beginning in March 2020, as disenrollments significantly slowed down, it had a downward effect on the overall acuity of the total population.

Another method leveraged was the leaver/joiner analysis that was used for the population acuity adjustment applied in the CY 2022 rating period, updated with CY 2023 enrollment projections. This method involved a risk study which segmented the managed care population into three groups; leavers, joiners, and constant members. Using Medicaid Rx, risk scores were developed for each population segment; leavers and joiners exhibited a materially lower risk score compared to constant members. Then Mercer analyzed the distribution of leavers, joiners, and constant members in the enrollment counts, comparing the distribution in the SFY 2020–2021 base period to projected enrollment through CY 2023. Mercer projected how the distribution may change into the CY 2023 rating period, with the assumption the PHE would end in January 2023. In the development of the adjustment, the mix of leavers (i.e., members who would have otherwise left the program if not for the PHE) as a proportion of total enrollment was assumed to increase. Due to the increase in leavers, the joiner and constant proportion necessarily decreased. This analysis suggests the same directional adjustment (downward) as the durational analysis.

The COA groups that experienced the most significant enrollment changes from the start of the PHE were Adult and ACA Expansion. The Child and SPD COA groups were also included in the analysis, however the enrollment impact was much lower for these groups and the analysis showed the acuity impact to be minimal. Historically, the volume of monthly new enrollments and disenrollments (i.e., “churn”) for Child and SPD has been much lower than Adult and ACA Expansion. Therefore the population acuity adjustment was only deemed appropriate for the Adult and ACA Expansion COA groups.

The adjustment varied by county based on county-specific enrollment trends, as the effect the PHE had on enrollment varied by county. The statewide average adjustment for CY 2023 was materially lower than what was applied in CY 2022. This was due to the base period (SFY 2020–2021) being impacted by the halt in disenrollments, whereas the base period for the CY 2022 was not. This adjustment is applied to all COS' within column (K) of the CRCS in the Excel file titled *CY 2023 Medi-Cal Detail CRCS Package LB Rate Smry 2022 12.xlsx*. In aggregate, the impact of this adjustment was as follows:

- Adult: 0.54% decrease
- ACA Expansion: 0.28% decrease.

Cost-Based Reimbursement Clinics in Los Angeles County

As discussed in Section 3, additional amounts for CBRCs were added to the FQHC base data for the SPD COA in LA County. These additional amounts were projected into CY 2023 using the FQHC trend factors. As a result, these CBRC amounts are fully reflected in column (O) of the CRCS for both LA Care and Health Net for the SPD COA (in addition to the original FQHC and CBRC costs already reflected in the base data and projected to CY 2023). As noted previously, due to the higher costs associated with CBRCs, the CBRC costs were split into two components. One component subject to risk adjustment that reflects unit cost levels in line with typical professional services, and a “not subject to risk adjustment” carve-out amount containing the cost levels above and beyond typical professional services cost levels. Within column (P) of the CRCS, the carve-out amounts not subject to risk adjustment are removed from the plan-specific rate calculation (both medical and administrative and underwriting gain loads are included in this removal). The rates subject to risk adjustment can be found in column (Q) of the CRCS. These plan-specific rates then flow into the blended plan-specific and risk-adjusted county average rate calculation process, which is described later in this certification report. Once the blended plan-specific and risk-adjusted county average rates are calculated, the lower bound medical component of the “not subject to risk adjustment” carve-out amount is added back into the SIS capitation rates for both LA Care and Health Net. The lower bound medical component carve-out amounts that are added back into the capitation rates are \$61.07 and \$33.57 for LA Care and Health Net, respectively. Similarly, \$2.46 PMPM and \$1.13 PMPM was added to the federal component of the UIS data on the FQHC line for SPD members in LA Care and Health Net, respectively.

Maternity Supplemental Payment Development

In the development of the maternity supplemental payment, the base data (as described in Section 3) was projected into CY 2023. The steps below describe the process utilized in the development of the CY 2023 maternity supplemental payment rates applicable to the Child, Adult, ACA Expansion, and WCM COA groups.

- Trend base costs forward to the midpoint of the rating period.
 - The trend development process is described in a previous subsection.
- Adjust for applicable program changes:
 - No program changes were applied to the maternity supplemental payment rate.

- Add load for administration and underwriting gain:
 - Note, the development of non-benefit load assumptions is described in Section 5 of this certification report. For the maternity supplemental payment, the assumed administrative expense load leveraged the process described in Section 5 for the standard CY 2023 capitation rates, with a focus on the variable component that typically represents approximately half of the total administrative loading. This is a supplemental payment and is consistent with the historical approach in that only the variable portion of the administrative load is applied since the fixed portion is included in the member's monthly capitation payment. Section 5 provides a summary of the detailed administrative loading percentages specific to supplemental payments including maternity. The underwriting gain load for this payment rate is consistent with those applied for the standard CY 2023 capitation rates (2% at the lower bound, 3% at the midpoint, and 4% at the upper bound).
- SIS and UIS Payment Rates
 - As noted in Section 3, base acuity factors of 1.0 were applied to derive the UIS base data, and as a result the base data is the same for the UIS and SIS populations. Since no differences are assumed in trend and program change factors by COS, the resulting supplemental payment rates are the same for the UIS and SIS populations by county. The maternity payment specific for the UIS population is considered 100% federal.

Other Items

Health Care-Acquired Conditions

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

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

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

Graduate Medical Education

With regard to Graduate Medical Education (GMED) costs and along with item AA.3.9 of “Documentation Requirements for Actuarially Sound Capitation Rates, Effective Date: November 15, 2014”, DHCS staff has confirmed there are no provisions in the Two Plan, GMC, Regional, and COHS model managed care contracts regarding GMED. The Two Plan, GMC, Regional, and COHS model MCOs do not pay specific rates that contain GMED or other GMED-related provisions. As MCO data serves as the base data for the rate ranges, GMED expenses are not part of the capitation rate development process.

Third-Party Liability

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

Member Cost Sharing

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

Retrospective Eligibility Periods

MCOs in the Two-Plan, GMC, Regional, and COHS model managed care programs are not required to cover retrospective eligibility periods for their enrollees. These periods are covered in the Medi-Cal FFS program. Since MCO data serves as the base data for the rate ranges, retrospective eligibility periods are not part of the capitation rate development process. No adjustments are necessary.

Mental Health Parity and Addiction Equity Act

With regard to the MH Parity and Addiction Equity Act, DHCS staff has confirmed there are no provisions in the Two-Plan, GMC, Regional, and COHS model managed care contracts in violation of MH Parity and Addiction Equity Act.

Institution for Mental Disease

Covered benefits associated with these capitation rates do not include services associated with an Institution for Mental Disease (IMD). In addition, if a managed care member is in an IMD in a given month, the state does not pursue federal match for that individual for that month. Therefore, the only potential rate impact from a federal perspective for members utilizing an IMD for more than 15 days in a given month would be associated with the potential impact of those members experiencing significantly higher costs than other non-IMD utilizing members. The consideration of this potential limited impact was viewed as immaterial and no adjustments were made to the base data. This element of the rate setting process will continue to be monitored in future rate setting periods.

Provider Overpayments

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

Section 5

Projected Non-Benefit Costs

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

- Administration
- Underwriting gain
- MCO tax (expired December 31, 2022)

Capitation rates appropriately include provision 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

Below is a table detailing the aggregate mid-point administrative percentages assumed within the rate development for all model types for CY 2023. The range for the regular administrative loading is +/- 0.9% at the upper/lower bound from the mid-point value for the Two-Plan, GMC, and Regional models and +/- 0.5% for the COHS model.

Model or COHS Plan	CY 2022 Administrative Load	CY 2023 Administrative Load	CY 2023 Administrative Load For Supplemental Payments and Add-On Rates
Two-Plan/GMC/Regional	8.95%	8.25%	4.125%
CenCal Health	7.75%	7.50%	3.750%
HP of San Mateo	8.35%	8.00%	4.000%
Central California Alliance	8.90%	8.15%	4.075%
CalOptima	5.50%	5.40%	2.700%
Gold Coast HP	9.00%	8.50%	4.250%
PHC	5.55%	5.50%	2.750%
COHS Total	6.72%	6.44%	3.398%
All Two-Plan/GMC/Regional/COHS	8.35%	7.89%	5.036%

For CY 2023, the administrative load for the Two-Plan, GMC, Regional, and COHS model MCOs is developed in aggregate across all COA groups. For COHS counties, this is developed using MCO/county-specific experience, consistent with prior rating periods. With the mandatory LTC population transition from FFS to managed care in the Two-Plan, GMC, and Regional models, the covered populations between counties in all model types during the rating period will be more in alignment compared to prior years. This incoming LTC population will account for a material portion of the covered population's costs. Further this population inherently has a lower administrative load percentage as a percentage of total costs compared to the existing general acute care population in these model types, which suggests a lower administrative loading percentage for the Two-Plan, GMC, and Regional model counties across all members. This, along with the increased enrollment projected for the CY 2023 rating period, still heightened due to the time necessary to process PHE disenrollment as well as the transition of various FFS populations into managed care (as detailed in the Program Changes section of this certification), justifies the reduction of the administrative loading percentages across all model types. Ultimately, part of the goal to use the same targeted administration percentage for all plans (other than COHS plans) is to increase program MCO administrative efficiency while providing appropriate funding for contractual requirements. Mercer believes DHCS continues to make long-term progress on that goal. The administration load factor is expressed as a percentage of the capitation rate (that is, percent of premium).

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

The mid-point percentage was developed in large part from a review of the MCOs' historical-reported administrative expenses. The administrative costs are reviewed to ensure they are appropriate for the approved State Plan services and Medicaid eligible members. Mercer also utilized its experience and actuarial judgment in determining the mid-point and lower/upper bound percentages to be reasonable. Based on the review of the most recent Medi-Cal specific administrative cost data and information, which indicates an overall decrease of administration percentage from multiple data sources including the most recent quarterly financial data through the last quarter of CY 2021, Mercer decreased the assumed administration percentage level accordingly for CY 2023 rates for Two-Plan, GMC, Regional, and COHS plans.

It should also be noted, the aggregate percentages developed are across the entire program, which includes the SIS population in total as well as both the federal and state only components for the UIS population. While the percentages are the overall targeted aggregate administrative percentages, the administrative expense associated with each COA group and UIS/SIS distinction varies from the overall percentage. The administrative component can be viewed in two pieces; a fixed cost component and a variable cost component. The fixed cost component represents items such as accounting, salaries, rent, and information systems, while the variable cost component represents items such as claims processing and medical management per eligible. Allocating the administrative costs as a

uniform percentage of capitation rate for each of the COAs and UIS/SIS distinction is an appropriate method; however, it does not take into account the differences in fixed versus variable administrative costs for each.

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

If the fixed cost component of administrative costs is broken down and viewed on a PMPM basis, then this fixed dollar amount is a larger percentage of the capitation rate of the less expensive COA groups, and a smaller percentage of the capitation rate for the more expensive COA groups. This concept has been applied in a budget-neutral fashion (no administrative dollars have been gained or lost) to the capitation rates, whereby the administrative percentage will be greater for less expensive COA groups than the aggregate administrative percentage over the entire population. Similarly, the administrative percentage for the more expensive COA groups will be less than the aggregate administrative percentage over the entire population.

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

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

Underwriting Gain

The mid-point underwriting gain remained consistent with the prior rating period at 3% for the CY 2023 rating period across all Two-Plan, GMC, Regional, and COHS model MCOs. The range for the underwriting gain component is +/- 1.0% at the upper/lower bounds from the mid-point value for all models. Mercer has implicitly and broadly considered the cost of capital within our rating assumptions.

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

Managed Care Organization Tax

Effective July 1, 2016, DHCS implemented a CMS-approved⁹ MCO tax for applicable full service health care plans and their various lines of business. This tax expired on June 30,

⁹ <http://www.dhcs.ca.gov/services/medi-cal/Documents/CAMCOTaxlett51716.pdf>

2019. DHCS then submitted another MCO tax proposal for July 1, 2019 through December 31, 2022. In response to this request, CMS only approved the tax for January 1, 2020 through December 31, 2022¹⁰. This tax approval expired on December 31, 2022 and as such, MCOs are not responsible for any MCO tax liabilities for the CY 2023 rating period. Therefore, an MCO tax PMPM add-on was not added to the CY 2023 capitation rates.

¹⁰ <https://www.dhcs.ca.gov/services/Documents/WaiverMCOtaxApproval-4-15-20.pdf>

Section 6

Risk Adjustment

SIS capitation rates for DHCS' Two-Plan, GMC, and Regional models are risk-adjusted using the Chronic Illness and Disability Payment System and Medicaid Rx (CDPS+Rx) health-based payment model, Version 6.5, developed by University of California, San Diego (with a phase-in for GMC counties described later in this section). Risk adjustment applies to the SIS population, specifically, the Child, Adult, ACA Expansion, and SPD COA groups only. In addition, since a separate maternity payment rate has been developed, maternity costs were excluded from the risk-adjustment process for the Child, Adult, and ACA Expansion COA groups.

Since risk adjustment is applied to distribute funds to MCOs within a county/region and COHS models only have one MCO per county/region, capitation rates for DHCS' COHS models are not risk-adjusted. Risk adjustment is also not applied to the LTC and LTC/Full-Dual COA groups, as well as LTC utilizers residing within the four risk-adjusted COA groups. This is because no readily available model exists for the institutionalized population and associated Medi-Cal data elements. Further, for the LTC and LTC/Full-Dual COA groups, the corresponding capitation rate is specific to members residing in a LTC facility, which in itself appropriately matches payment to risk. Similarly, the WCM rates are not risk-adjusted since no readily available model exists for this very specific population and there is only one MCO per county/region.

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

Additionally, CY 2023 capitation rates for the UIS population are not subject to risk adjustment. One issue is that the UIS population increased by a substantial amount beginning in May 2022, due to the inclusion of the age 50 and older population that is detailed in the program changes section. This population coming into managed care either has no Medi-Cal experience at all or only has Medi-Cal experience for pregnancy-related and emergency services. Due to this, Mercer does not believe the data is sufficient to use to perform a diagnosis-based risk adjustment process. Second, the UIS populations can be relatively small when compared to the SIS populations. Due to credibility concerns in many

instances, this contributed to the reasons to not risk adjust the UIS population. This decision will be re-visited in future rate setting years.

The individual acuity factors and final plan factors in effect for CY 2023 were based on claims and encounter data with dates of service October 1, 2020 through September 30, 2021 (referred to as the study period), using encounter data submitted by the MCOs to DHCS by April 29, 2022. After individual acuity factors were calculated using the above study period, these acuity factors were aggregated by MCO and COA groups using each plan's enrollment snapshot as of June 2022 to calculate the unadjusted risk factors for each Two-Plan, GMC, and Regional model MCO subject to risk adjustment. For GMC counties only, a phase-in of the CDPS+Rx model was applied. Specifically, the results of the CDPS+Rx risk-adjustment process for MCOs in GMC counties was used with 50% credibility and the remaining credibility was given to the CY 2022 risk-adjustment results, limited to SIS members only to be consistent with the CY 2023 risk-adjustment process.

To ensure the risk-adjustment process does not increase or decrease the total amount of capitation payments, the MCOs' risk factors are adjusted for budget neutrality. The intent of this adjustment is to recalibrate all the MCO risk-adjustment factors to yield a county/region average of 1.0000. Each MCO's own risk-adjustment factors are then applied to the county/region average base capitation rates to arrive at each MCO's risk-adjusted rate. For CY 2023 rates, specific to Two-Plan and Regional model counties, a quality component is used to determine the percentage that blends the risk-adjusted county/region average rates with the "plan-specific" rates. Within these counties, the risk-adjusted county/region average rates can move up from 75% to 100% or down to a minimum of 50% depending on the direction that benefits the higher quality plan. For the GMC counties, similar to prior years, the risk-adjusted county average rates for each MCO are blended at 75%, with the "plan-specific" rate approach blended at 25%. Mercer believes this blending approach is appropriate and consistent with the risk-adjustment process utilized in previous rate development processes.

The risk-adjustment process only includes experience data for individuals who have at least six months of total Medi-Cal eligibility within the 12-month study period. Individuals who do not meet the six-month eligibility criterion are assigned the respective MCO's average risk factor associated with that individual's COA group, with an exception in LA County. Members in LA County who did not receive a score were assigned an assumed score based on the county average risk score for scored recipients by the CDPS+Rx age and gender demographic groups.

The CDPS+Rx risk adjustment model, Version 6.5, updated by University of California, San Diego, has been further adjusted to more closely align with the risk associated with the Two-Plan, GMC, and Regional model covered benefits. For example, the cost weights reflected in the national model were developed assuming standard benefit packages (including options of including or excluding pharmacy and BH service), utilizing over 30 states' data. Since the model is applied to the Two-Plan, GMC, and Regional programs, Mercer modified the cost weights to reflect California Medi-Cal-specific data and services covered under the Two-Plan, GMC, and Regional managed care programs. For additional details of the risk adjustment methodology, please see the separate document *CY 2023 CA RAR Methodology Letter FINAL 2022 12.pdf*.

Application of Risk Adjustment in the Rate Calculation

In an effort to encourage and reward quality, cost efficiencies, and effectiveness, DHCS is using a blended plan-specific and risk-adjusted county average rates approach for CY 2023, similar to the approach used for prior rate development periods. As mentioned in the prior subsection, the CY 2023 blend makes use of a quality component to determine the percentage that blends the risk-adjusted county/region average rates with the “plan-specific” rates in Two-Plan and Regional counties and a 75% of the risk-adjusted county average with a 25% of the “plan-specific” rate approach in GMC counties. Each of these approaches produces actuarially sound rates or rate ranges; blending the approaches does not impact actuarial soundness but enhances DHCS program goals.

Plan-Specific Rates

The same general methodology employed for the “plan-specific” portion of the blend in the CY 2022 rate development has been utilized for CY 2023. While a large number of rate setting factors, components, and loads are not MCO-specific (items such as utilization trend, unit cost trend, administration, and underwriting gain are the same for all risk-adjusted MCOs), at the mid-point, the medical expense base data has a strong relationship to recent MCO claims experience. For this reason, this approach has often been referred to as “plan-specific” rate setting. In spite of the stated caveats, Mercer retains that terminology.

Risk-Adjusted County/Region Average Rates

County-specific rates are developed on a weighted average basis using CY 2023 projected enrollment. All MCO data/experience in a county considered in the plan-specific approach are considered here. In Mercer’s opinion, with two or more MCOs in a county, a best practice is to also incorporate the use of risk adjustment, where an MCO’s plan-specific budget-neutral risk scores are applied to the applicable county specific rates.

For CY 2023, this blending applies to the Child, Adult, ACA Expansion, and SPD COA groups. The maternity supplemental payment was developed on a county-specific basis. All other COA/supplemental groups, other than the above five, are plan-specific.

Application of Risk-Adjustment Factors

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

- Amounts included within the CRCS sheets — note, these rating components are included in the CRCS sheets but are carved out of the rate subject to risk adjustment. The amounts carved out can be found in column {P} of the CRCS sheets.
 - SPD CBAS PMPMs — note that the gross medical expense PMPM was carved out.
 - Child and SPD BHT PMPMs — note that the gross medical expense PMPM was carved out.
 - Long-term LTC utilizers PMPM impact in the Adult, ACA Expansion, and SPD COA groups — to derive the PMPM to carve out, the impact of including these members into the capitation rates (via base adjustment for CCI counties and as a program

change for transitioning counties) was backed out to carve out the amount not subject to risk adjustment.

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

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

Quality Component

The final blend of the “plan-specific” and risk-adjusted rates will be determined by a quality component, which measures relative performance across a number of quality metrics. The default risk-adjusted rate blend of 75% will adjust up or down, in a budget neutral fashion, in the direction that rewards the higher performing MCO. The details of the Quality Component are described in the accompanying methodology letter titled *CY 2023 CA Quality Component Methodology Letter 2022 12.pdf*.

Managed Care Organizations Excluded From Risk Adjustment

The risk-adjustment process described in this section is applicable to all Two-Plan, GMC, and Regional model MCOs, with the following exceptions:

- Anthem Blue Cross in San Benito County — there is only one plan in the county. Therefore, risk adjustment does not apply.
- Kaiser in the Three Kaiser Regional Counties (Amador, El Dorado, and Placer) — Kaiser is the only MCO that exclusively operates in these three regional counties alone and has a comparatively smaller population size than the two MCOs that operate in the broader 18 regional counties. As a result, risk adjustment does not apply to Kaiser in these three counties.
- Aetna in Sacramento and San Diego counties — this MCO continues to exhibit considerable ramp up, which is expected to follow into CY 2023. As a result, a decision was made to not apply risk adjustment to this MCO in both counties.

Regional Capitation Rates

As noted in a previous section, certain capitation rates set at the MCO and county level will be consolidated into one set of regional capitation rates that will be paid to these MCOs (consistent with the CY 2022 capitation rates). This consolidation will take place in the following instances:

- Fresno, Kings, and Madera — CalViva Health and Anthem Blue Cross
- San Joaquin and Stanislaus — Health Net of California and HPSJ
- Riverside and San Bernardino — Inland Empire Health Plan and Molina Healthcare
- Santa Barbara and San Luis Obispo — CenCal Health
- Monterey, Santa Cruz, and Merced — Central California Alliance for Health

Once the blended “plan-specific” and risk-adjusted county average rates are calculated for the MCO and county combinations noted above, the MCO and county specific capitation rates are blended together using projected CY 2023 enrollment to arrive at the final CY 2023 capitation rates, prior to the application of PMPM add-ons. Additionally, for any PMPM add-ons to the capitation rates, as discussed in the “Program Changes” section as well as the next section within this report, each PMPM add-on will be blended using similar CY 2023 projected enrollment, and the region average capitation rates will include the rate subject to risk adjustment and also the PMPM add-ons at the regional level.

Section 7

Special Contract Provisions Related to Payment

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

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

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

Incentive Arrangements

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

Student Behavioral Health Incentive Program

The state implemented the Student Behavioral Health Incentive Program (SBHIP) starting CY 2022, which provides incentive payments to MCOs for achievement of specified milestones and measures. The total maximum incentive funding that may be earned across all participating MCOs over the full duration of the program is \$389 million. The SBHIP has no effect on the development of capitation rates.

The purpose of SBHIP is to incentivize MCOs to improve coordination with county BH departments and schools, to build infrastructure, partnerships, and capacity statewide to increase the number of students receiving preventive and early intervention BH services.

The SBHIP will be for a fixed period of three Program Years (PYs):

- PY 1 will be January 1, 2022 through December 31, 2022, which aligns with California's CY 2022 rating period.
- PY 2 will be January 1, 2023 through December 31, 2023, which will align with California's CY 2023 rating period.
- PY 3 will be January 1, 2024 through December 31, 2024, which will align with California's CY 2024 rating period.

MCOs will receive incentives for achievements in targeted intervention areas such as:

- BH wellness programs
- Telehealth infrastructure to enable services and/or access to technological equipment
- BH screenings and referrals
- Suicide prevention strategies
- Substance use disorder
- Building stronger partnerships to increase medically necessary Medi-Cal reimbursable services
- Culturally appropriate and targeted populations
- BH public dashboards and reporting
- Technical assistance support for contracts and/or agreements
- BH workforce
- Care teams
- IT enhancements for BH services
- Prenatal and postpartum access for pregnant students and teen parents
- Parenting and family services.

The enrollees covered by the SBHIP include Medi-Cal populations that are enrolled in grades TK-12 public schools. The providers covered by SBHIP are county BH departments, local schools districts, and school-linked community based providers.

Additional detail regarding the SBHIP is available through the managed care contract, APL “Student Behavioral Health Incentive Program”, and similar instructions issued to MCOs.¹¹

CalAIM Incentive Payment Program

CalAIM is a multi-year DHCS initiative to improve the quality of life and health outcomes of the Medi-Cal managed care population through the implementation of broad delivery system, program and payment reform across the Medi-Cal program. CalAIM’s ECM and Community Supports programs launched January 1, 2022, requiring significant investments in care management capabilities, ECM and Community Supports infrastructure, information technology and data exchange, and workforce capacity across MCOs, city and county agencies, providers and other community-based organizations.

The state will continue the CalAIM Incentive Payment Program (IPP) during CY 2023 which provides incentive payments to MCOs for the achievement of specified metrics and milestones. The total maximum incentive funding that may be earned across all participating MCOs over the full duration of the program is \$1.5 billion. The IPP has no effect on the development of capitation rates.

¹¹ <https://www.dhcs.ca.gov/services/Pages/studentbehavioralhealthincentiveprogram.aspx>

The purpose of IPP is to build appropriate and sustainable capacity, drive MCO investment in delivery system infrastructure, bridge current silos across physical and BH care service delivery, reduce health disparities and promote equity, achieve improvements in quality performance and incentivize MCO take up of Community Supports.

The IPP will be for a fixed period of three PYs:

- PY 1 will be January 1, 2022 through December 31, 2022, which aligns with California's CY 2022 rating period.
- PY 2 will be January 1, 2023 through December 31, 2023, which will align with California's CY 2023 rating period.
- PY 3 will be January 1, 2024 through June 30, 2024, which will align with the first half of California's CY 2024 rating period.

MCOs will receive incentive payments for achievement of pre-determined milestones and metrics in domains such as:

- Delivery System Infrastructure
- ECM Capacity Building
- Community Supports Capacity Building and Take-Up
- Quality and Emerging CalAIM Priorities

The enrollees covered by the IPP are Medi-Cal populations that may benefit from enhancements in care management capacity and infrastructure, alternative care delivery, and improvements in quality. The providers covered by the IPP include, but are not limited to, counties, hospitals, professional providers, community-based organizations, and ECM and Community Supports providers.

Additional detail regarding the IPP is available through the managed care contract, APL 21-016 and any subsequent revisions, and similar instructions issued to MCOs.¹²

Housing and Homelessness Incentive Program

As part of the state's overarching HCBS spending plan, the state implemented the Housing and Homelessness Incentive Program (HHIP) during CY 2022 which provides incentive payments to MCOs for the achievement of specified metrics and milestones. The total maximum incentive funding that may be earned across all participating MCOs over the full duration of the program is \$1.3 billion. The HHIP has no effect on the development of capitation rates.

The purpose of HHIP is to address homelessness. MCOs would be able to earn incentive payments for making investments and progress in addressing homelessness and keeping people housed. MCOs would have to meet specified metrics in order to receive available incentive payments. As a condition of participations, MCOs would be expected to develop, in partnership with local public health jurisdictions, county BH, public hospitals, county social

¹² APL 21-016 is available at <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-016.pdf>.

services, and local housing departments, and submit a Local Homelessness Plan to DHCS. The Local Homelessness Plan must include, among other elements:

- A housing and services gaps/needs assessment.
- Mapping the continuum of services with focus on homelessness prevention, interim housing (particularly for the aging and/or disabled population), rapid re-housing (families and youth), and permanent supportive housing.
- Available services, how referrals will be made, how other local, state, and federal funding streams will be leveraged, and how progress will be tracked towards goals.
- How CalAIM services are integrated into homeless system of care.

The HHIP will be for a fixed period of two PYs:

- PY 1 will be January 1, 2022 through December 31, 2022, which aligns with California's CY 2022 rating period.
- PY 2 will be January 1, 2023 through December 31, 2023, which will align with California's CY 2023 rating period.

The enrollees covered by the HHIP include, but are not limited, to; aging adults; individuals with disabilities; individuals with SMI and/or substance use disorder needs at risk for, or transitioning from incarceration, hospitalization, or institutionalization, families, individuals reentering from incarceration, homeless adults, chronically homeless individuals, persons who have/had been deemed (felony) incompetent to stand trial, Lanterman-Petris Short Act designated individuals, and veterans.

The providers covered by HHIP include but are not limited to public health departments, county BH, public hospitals, and others.

Additional detail regarding the HHIP is available through the managed care contract, APL 22-007 and any subsequent revisions, and similar instructions issued to MCOs.¹³

Health Equity and Practice Transformation Payments

Health Equity and Practice Transformation Payments is a multi-year DHCS initiative to improve the quality of life and health outcomes of the Medi-Cal managed care population through the implementation of multiple programs to advance equity, reduce disparities in care, and support smaller independent practices to undertake quality-related practice transformations.

The state will implement the Health Equity and Practice Transformation Payments in CY 2023 in the form of incentive payments to MCOs for the achievement of specified metrics and milestones. The total maximum incentive funding that may be earned across all participating MCOs over the one-year duration of the program is \$25 million. The Health Equity and Practice Transformation Payments has no effect on the development of capitation rates.

¹³ All Plan Letter 22-007 is available at <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-007.pdf>.

The purpose of the Health Equity and Practice Transformation Payments is to incentivize MCOs to build partnerships with small independent practices to develop practice transformation plans, needs assessments, and gap analyses in order to address the goals of the Comprehensive Quality Strategy. This initial program will act as a catalyst for MCOs and small practices to enact processes to reduce health disparities and promote equity.

The Health Equity and Practice Transformation Payments will be for a fixed period of one year:

- PY 1 will be January 1, 2023 through December 31, 2023, which will align with California’s CY 2023 rating period.

MCOs will receive incentive payments for achievement of planning and partnership milestones and metrics that will support future efforts in domains such as:

- Maternity and early childhood health transformation
- Childhood and adolescent health transformation
- Whole person primary care transformation
- Early childhood health

The enrollees covered by the Health Equity and Practice Transformation Payments are all Medi-Cal populations, particularly those who may access services through small and/or independent practices that have struggled to update their practices. The providers covered by the Health Equity and Practice Transformation Initiative include, but are not limited to, Pediatric, Primary Care, OB/GYN, and Behavioral Health providers.

Additional details regarding the Health Equity and Practice Transformation Payments will be available through the managed care contract, associated APLs, and similar instructions issued to MCOs.

Withhold Arrangements

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

Risk Sharing Mechanisms

Proposition 56/General Fund

The state is continuing two-sided, risk corridors associated with the four of the five Prop 56/General Fund directed payment initiatives which had such mechanisms in the prior rating period (CY 2022). These are financial monitoring mechanisms to ensure the State directed payments are distributed in accordance with the state’s contractual terms and terms of the CMS-approved preprints, and are not subject to 42 CFR § 438.6(b)(1). These arrangements are further discussed in the Delivery System and Provider Payment Initiative subsection of this report. No risk-sharing mechanism will be in place for the Prop 56 Dental directed payment.

Rationale for the Use of the Risk-Sharing Arrangement

Risk corridors are necessary for these programs for several reasons. First, for some of the Prop 56 arrangements, there was limited credible and complete claims experience data available in the base period with which to develop capitation rates. Second, for most of these programs, DHCS has not completed an initial year of risk corridor calculations. DHCS is in the process of completing the second year of the Prop 56 Physician Services risk corridor (Bridge Period [July 1, 2019–December 31, 2020]). When more risk corridor results are available, DHCS will be in a better position to assess the prior rate setting assumptions and continuing need for such terms of payment. Lastly, the risk corridors support DHCS' policy interest in mitigating potential perverse financial incentives for MCOs to avoid appropriate utilization of services subject to these Prop 56 directed payments by limiting gains and losses associated with these initiatives to a reasonable threshold.

Description of How the Risk-Sharing Arrangement is Implemented

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

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

The risk corridor will consist of the following bands:

- If the aggregate MEP is less than or equal to 98 percent, the MCO will remit to DHCS within 90 days of notice the difference between 98 percent of the medical portion of the MCO's Prop 56 Directed Payments capitation payment revenues and the aggregate amount of the MCO's MEP numerator, plus a proportional amount for the non-medical portion of the capitation payments aligned with the Prop 56 Directed Payments.
- If the aggregate MEP is greater than 98 percent but less than 102 percent, the MCO will retain all gains or losses, with no reconciliation payments from DHCS to the MCO, or vice versa.
- If the aggregate MEP is greater than or equal to 102 percent, DHCS will remit to the MCO the difference between 102 percent of the medical portion of the MCO's Prop 56 Directed Payments capitation payment revenues and the aggregate amount of the

MCO's MEP numerator, plus a proportional amount for the non-medical portion of the capitation payments aligned with the Prop 56 Directed Payments.

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

There is no impact on the CY 2023 capitation rates for the provision of a risk corridor. The CY 2023 capitation rates, outlined in the rate certification, reflect Mercer's best estimate of the anticipated costs associated with the Prop 56 Directed Payments.

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

Mercer confirms the CY 2023 Prop 56 Directed Payment add-on risk sharing mechanism was developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medi-Cal covered populations and services under the managed care contract.

Enhanced Care Management

DHCS will continue to use a symmetrical, two-sided risk corridor which was originally implemented during CY 2022 as part of the CY 2023 ECM program. This risk mitigation mechanism will be applicable to all MCOs receiving the ECM add-on.

Rationale for the Use of the Risk-Sharing Arrangement

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

Description of How the Risk-Sharing Arrangement is Implemented

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

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

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

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

The risk corridor will consist of the following bands:

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

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

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

- Non-medical expenses (e.g., non-service investments for infrastructure and capacity).
- Incurred but not reported expenses that cannot be adequately supported.
- Medical expenses for non-ECM services and populations (e.g., expenses for Community Supports services), expenses for members who do not meet ECM population or phase-in criteria.
- Unreasonable outlier medical expense levels for which the MCO does not provide satisfactory justification based on member mix, utilizer acuity, unique network considerations, and/or other factors. As experience may be inherently more volatile in the first year of the ECM benefit, DHCS will ensure the review process includes discussion with MCOs in advance of any adjustments to provide an opportunity to support outlier cost levels.
- Related party expense levels in excess of unrelated party expense levels.

- Separate and distinct payments that are exclusively for administrative costs as defined in Title 28, California Code of Regulations, § 1300.78, such as but not limited to network development and claims processing.
- An assumed non-medical component of global subcapitation payments made by MCOs to global subcontractors that aligns with assumptions used in the CY 2023 rate development (see Base Data Adjustments related to Global Non-Medical Expense Adjustment). Reductions will be applied in a manner that ensures alignment between allowable medical expenses and medical costs considered in the rate development process.

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

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

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

There is no impact on the CY 2023 capitation rates for the provision of a risk corridor. The CY 2023 capitation rates, outlined in this rate certification, reflects Mercer's best estimate of the anticipated costs associated with ECM.

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

Mercer confirms the CY 2023 ECM add-on risk sharing mechanism was developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medi-Cal covered populations and services under the managed care contract.

Major Organ Transplant

DHCS will continue the use of a risk corridor that was originally implemented in CY 2022 for the portion of the CY 2023 MOT PMPM add-on associated with the directed payment that directs MCOs to pay for the transplant event itself at Medi-Cal FFS-equivalent rates. This is a financial monitoring mechanism to ensure the State directed payments are distributed in accordance with the state's contractual terms and terms of the CMS-approved preprints, and is not subject to 42 CFR § 438.6(b)(1). The risk corridor will not apply to plans in COHS counties.

Rationale for the Use of the Risk-Sharing Arrangement

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

Description of How the Risk-Sharing Arrangement is Implemented

The risk-sharing arrangement will be a two-sided risk corridor that utilizes actual MOT expenditures experienced by the MCOs relative to MOT services subject to the directed payment requirements funded within the capitation rates. The risk corridor shall be based on a calculated MEP achieved by each MCO. The MEP shall be calculated in aggregate across all applicable COAs and rating regions where the MCO operates for dates of service within the rating period. The risk corridor calculations shall be performed no sooner than 12 months after the end of the rating period.

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

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

The risk corridor will consist of the following bands:

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

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

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

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

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

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

There is no impact on the CY 2023 capitation rates for the provision of this risk corridor. The CY 2023 capitation rates, outlined in this rate certification, reflects Mercer’s best estimate of the anticipated costs associated with MOT.

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

Mercer confirms the CY 2023 MOT directed payment risk sharing mechanism was developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medi-Cal covered populations and services under the managed care contract.

State Directed Payments

There are several State directed payments applicable to the Two-Plan, GMC, Regional, and COHS model CY 2023 capitation rates. All applicable directed payments are summarized in the table below. The following subsections provide more detail around each initiative.

Control Name of the State Directed Payment	Type of Payment	Brief Description	Is the Payment Included as a Rate Adjustment or Separate Payment Term?
Control Name TBD — Prop 56 Physician Services	Uniform dollar increase	Uniform dollar increases for specific Physician and other professional services	Rate adjustment
Control Name TBD — Prop 56 Family Planning	Uniform dollar increase	Uniform dollar increases for specific Family Planning services	Rate adjustment
Control Name TBD — Prop 56 Dental	Uniform dollar and percentage increases	Uniform percentage and dollar increases for specific dental services	Rate adjustment
ACEs Screening	Minimum fee schedule using State Plan approved rates	Minimum fee schedule for specific ACEs Screening services	Rate adjustment
Control Name TBD —	Uniform dollar increase	Uniform dollar increase for specific	Rate adjustment

Control Name of the State Directed Payment	Type of Payment	Brief Description	Is the Payment Included as a Rate Adjustment or Separate Payment Term?
Developmental Screenings		Developmental Screening services	
Dental Preventive Services	Minimum fee schedule using State Plan approved rates	Minimum fee schedule for specific Dental Preventive services.	Rate adjustment
CA_VBP_IPH.Oth_New_20220101-20241231 — MOT	Delivery system reform	FFS-equivalent payment requirement for network and non-network providers for newly transitioning organ and bone marrow transplant surgeries	Rate adjustment
Control Name TBD — Private Hospital Directed Payment (PHDP)	Uniform dollar increase	Uniform dollar increases for services limited to predetermined pool amounts for IP and OP/ER	Separate payment term
Control Name TBD — Enhanced Payment Program (EPP)	Uniform dollar or percentage increases	Uniform percentage increases to capitation payments and uniform dollar increases for FFS services limited to predetermined pool amounts by DPH class and IP/non-IP service sub-pools	Separate payment term
Control Name TBD — District and Municipal Public Hospital Directed Payment (DHDP)	Uniform dollar increase	Uniform dollar increases for services limited to predetermined pool amounts for IP/non-IP service sub-pools	Separate payment term
CA 438.6(c) Proposal J–2021–Designated Public Hospital (DPH)	Quality/performance payments	Payments based on performance on designated measures with specified maximum allowable	Separate payment term

Control Name of the State Directed Payment	Type of Payment	Brief Description	Is the Payment Included as a Rate Adjustment or Separate Payment Term?
Quality Incentive Program (QIP)		payments for each DPH	
CA 438.6(c) Proposal I–2021–District and Municipal Public Hospital (DMPH) QIP	Quality/performance payments	Payments based on performance on designated measures with specified maximum allowable payments for each DMPH	Separate payment term
Control Name TBD — Skilled Nursing Facility Workforce & Quality Incentive Program (WQIP)	Quality-adjusted uniform dollar increase	Uniform dollar increase for contracted services modified by quality based scores at the provider level	TBD
Control Name TBD–LTC FFS Equivalent	Delivery system reform	FFS-equivalent payment requirement for network providers for qualifying LTC services in transitioning counties; at-least FFS-equivalent requirement for qualifying LTC services in non-transitioning counties	Rate adjustment

There are no additional directed payments in the program for CY 2023 that are not addressed in this rate certification. There are no requirements regarding the reimbursement rates the health plans must pay to any providers unless specified in the certification as a directed payment or pass-through payment or authorized under applicable law, regulation, or waiver.

The WQIP state directed payment will require MCOs to reimburse eligible network SNFs a uniform per-diem increase for qualifying SNF services that occur during the CY 2023 rating period. The per-diem increase will be adjusted based on facility-specific performance on designated quality metrics following a uniform quality adjustment methodology across all eligible network SNFs. The WQIP state directed payment is pending finalization of the program parameters and is not included in this rate certification. The State will finalize and submit the preprint to CMS prior to the start of the rating period, after which the State directed payment will be incorporated through a rate amendment.

Proposition 56/General Fund Directed Payments

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

- Prop 56 Physician Services
- Prop 56 Family Planning
- Prop 56 Dental
- ACEs Screening
- Developmental Screening

Prop 56 add-ons are contingent on appropriations of funds being approved by the California Legislature. Currently, all components are effective for the entire CY 2023 period (January 1, 2023 through December 31, 2023). To the extent the California Legislatures does not appropriate Prop 56 funds for the State share for one or more of these payment initiatives for any portion of the CY 2023 period, the state will either discontinue the program(s) as of that date (and submit a rate certification amendment) or continue the program(s) using State General Fund for the State share. The ACEs Screening and Developmental Screening initiatives, listed above with no reference of “Prop 56”, will be funded by State General Fund for the State share in CY 2023.

To facilitate CMS rate review for each of the Prop 56/General Fund payment initiatives, the table below summarizes the Prop 56/General Fund payments incorporated into the capitation rates as a rate adjustment. The rest of this section is structured to provide documentation individually for each directed payment. Also note that a Dental Preventive Services directed payment is also listed in the table below, and described at the end of this subsection.

Control Name of the Directed Payment	Rate Cells Affected	Impact	Description of the Adjustment	Confirmation the Rates are Consistent with the Preprint	For Maximum Fee Schedules, Provide the Information Requested
Control Name TBD — Prop 56 Physician Services	All except SPD/Full-Dual and LTC/Full-Dual	See “Sum – Add-On Details” tabs in file titled <i>FINAL CY 2023 Medi-Cal Detail CRCS Package LB</i>	Adjustment is applied as a PMPM add-on to the rates. A description of the data, assumptions and methodology	Confirmed. The preprint is anticipated to be submitted to CMS in December 2022.	Not applicable

		<i>Rate Smry 2022 12.xlsx</i>	is provided in the narrative below.		
Control Name TBD — Prop 56 Family Planning	All except SPD/Full- Dual and LTC/Full- Dual	See exhibit referenced above	See prior description	Confirmed. The preprint is anticipated to be submitted to CMS in December 2022.	Not applicable
Control Name TBD — Prop 56 Dental	HPSM only All COAs	See exhibit referenced above	See prior description	Confirmed. The preprint will be submitted to CMS in December 2022.	Not applicable
ACEs Screening	All except SPD/Full- Dual and LTC/Full- Dual	See exhibit referenced above	See prior description	No preprint required (minimum fee schedule).	Not applicable
Control Name TBD — Development al Screenings	Child, Adult, ACA Expansion, SPD, and WCM	See exhibit referenced above	See prior description	Confirmed. The preprint will be submitted to CMS in December 2022.	Not applicable
Dental Preventive Services	HPSM only – All COAs	Impacts by COA for HPSM Dental Add- on: Child: 10.33% Adult: 0.97% ACA Expansion: 0.97% SPD: 1.10% SPD/Full- Dual: 0.28% LTC: 0.00% LTC/Full- Dual: 0.00%	Adjustment is described in HPSM Dental program change section	No preprint required (minimum fee schedule).	Not applicable

Prop 56 Physician Services Add-On Per Member Per Month

The Prop 56 Physician Services add-on PMPM provides a uniform dollar adjustment across 12-specific E&M CPT codes and 10 specific preventive visit CPT codes utilized by providers (listed in the following table).

Preprints for this payment initiative have been approved for prior rating periods and the renewal version applicable to the current rating period will be submitted to CMS for approval no later than December 31, 2022, with no changes to major terms and conditions with the lone exception of the American Medical Association deactivating the 99201 E&M code (before the previous CY 2022 preprint submission). The anticipation is providers who previously billed to the 99201 CPT code will transition to using the 99202 CPT code. To account for this anticipated shift in utilization, the historical 99201 CPT code office visits were priced at the 99202 CPT code add-on amount for purposes of rate development.

The dollar adjustments vary by E&M and preventive visit CPT code as displayed in the following table.

Procedure Code	Description	Uniform Dollar Amount
99202	Office/OP Visit New	\$35.00
99203	Office/OP Visit New	\$43.00
99204	Office/OP Visit New	\$83.00
99205	Office/OP Visit New	\$107.00
99211	Office/OP Visit Est	\$10.00
99212	Office/OP Visit Est	\$23.00
99213	Office/OP Visit Est	\$44.00
99214	Office/OP Visit Est	\$62.00
99215	Office/OP Visit Est	\$76.00
90791	Psychiatric Diagnostic Evaluation	\$35.00
90792	Psychiatric Diagnostic Evaluation With Medical Services	\$35.00
99381	Preventive Visit New	\$77.00
99382	Preventive Visit New	\$80.00
99383	Preventive Visit New	\$77.00
99384	Preventive Visit New	\$83.00
99385	Preventive Visit New	\$30.00
99391	Preventive Visit Est	\$75.00
99392	Preventive Visit Est	\$79.00

Procedure Code	Description	Uniform Dollar Amount
99393	Preventive Visit Est	\$72.00
99394	Preventive Visit Est	\$72.00
99395	Preventive Visit Est	\$27.00

The application of these adjustments across all managed care models and all impacted COA groups is shown in the table below. The table highlights the components of the total amounts including the projected MMs (based upon the baseline enrollment projection that utilized actual experience through July 2022), projected impacted E&M and preventive visits, the resulting PMPMs and the total dollars. The payment adjustments for the given E&M and preventive codes are being made to all eligible contracted providers who perform these services for managed care enrollees. Services where Medicare would be the primary payer (Full-Dual and Part B partial dual members) are excluded from the add-on payments. Services provided within FQHC/RHC facilities are also excluded from the add-on payments due to the wrap-around payment structure associated with these types of facilities. Services provided by AIHS providers and CBRCs are also excluded.

Physician (January 2023–December 2023)					
Population	COA	Projected MMs	Prop 56 Add-on Projected Units	Total PMPM	Total Dollars
SIS	Child	55,042,606	8,123,949	\$8.67	\$477,217,137
SIS	Adult	21,635,378	4,226,565	\$9.98	\$215,984,330
SIS	ACA Expansion	46,656,994	8,678,321	\$9.57	\$446,279,097
SIS	SPD	8,845,172	2,651,441	\$16.35	\$144,617,279
SIS	LTC	32,475	3,158	\$5.25	\$170,368
SIS	WCM	368,277	157,802	\$24.32	\$8,955,074
SIS	All COAs	132,580,902	23,841,237	\$9.75	\$1,293,223,286
UIS Federal	Child	1,992,648	1,791	\$0.05	\$105,784
UIS Federal	Adult	2,820,817	34,884	\$0.63	\$1,785,169
UIS Federal	ACA Expansion	4,473,464	19,108	\$0.22	\$973,629
UIS Federal	SPD	980,696	311	\$0.02	\$17,747
UIS Federal	LTC	13,641	0	\$0.00	\$0
UIS Federal	WCM	9,809	39	\$0.23	\$2,222
UIS Federal	All COAs	10,291,075	56,134	\$0.28	\$2,884,551
Total	All COAs	142,871,977	23,897,370	\$9.07	\$1,296,107,837

The PMPM adjustments were developed based upon MCOs' encounter data. MCO information submitted through the RDTs was reviewed and used to validate the encounter data. The encounters were utilized in developing a distribution and projected utilization of the impacted codes. Similar in structure to the base data development that reviews the reasonableness of each data element, a final PMPM was developed based upon the projected utilization by code and the known additional unit cost (uniform dollar increase) associated with each code. As described previously, certain provider types (FQHC/RHCs, AIHS providers, and CBRCs) were excluded from the analysis, as well as the exclusion of services provided where Medicaid was not the primary payer. This benefit cost PMPM is developed on a combined basis for all SIS and UIS populations. Acuity factors and percentages of pregnancy-related and emergency services for the UIS population were developed using code level SFY 2020–2021 base period encounter data by COA on a statewide basis. UIS Federal, UIS State-Only, and SIS PMPM add-on rates were then calculated in a "budget-neutral" manner from the combined add-on rate PMPM and the projected CY 2023 SIS and UIS enrollment. Lastly, the PMPM amount of each add-on rate component was adjusted to include half of the plan specific administrative load, which provides for the variable component of the administrative costs of the program while the fixed administrative costs are covered in the base capitation rates, and an underwriting gain of 2.0%. These load factors are consistent with the values utilized for other add-on PMPMs and supplemental payments as described in above sections. Further detail of these components including MCO-specific amounts are provided in the accompanying rate development exhibits in Excel format.

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

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

Prop 56 Family Planning

The Family Planning Prop 56 directed payment is a payment arrangement, which directs MCOs to pay a uniform and fixed dollar amount add-on payment for specific family planning services to eligible network and non-network providers based on the utilization and delivery of qualifying services for eligible enrollees covered under the contract. The preprints for this payment initiative have been approved for two prior rating periods and the renewal version applicable to the current rating period is anticipated to be submitted to CMS for approval no later than December 31, 2022, with no changes to major terms and conditions.

The following provides a brief description of this payment initiative:

- The type of this directed payment arrangement is a uniform dollar increase payment initiative.
- MCOs are required to pay the eligible providers for the applicable incurred period using the following uniform dollar increase schedule by procedure code for qualifying covered services provided to eligible managed care enrollees.

Procedure Code ¹⁴	Description	Uniform Dollar Amount
J7294	Contraceptive Vaginal Ring: Segesterone Acetate and Ethinyl Estradiol	\$301.00
J7295	Contraceptive Vaginal Ring: Ethinyl Estradio and Etonogestrel	\$301.00
J7296	Levonorgestrel — Releasing lu Coc Sys 19.5 Mg	\$2,727.00
J7297	Levonorgestrel — RIs Intrauterine Coc Sys 52 Mg	\$2,053.00
J7298	Levonorgestrel — RIs Intrauterine Coc Sys 52 Mg	\$2,727.00
J7300	Intrauterine Copper Contraceptive	\$2,426.00
J7301	Levonorgestrel — RIs Intrauterine Coc Sys 13.5 Mg	\$2,271.00
J7307	Etonogestrel Cntracpt Impl Sys Incl Impl & Spl	\$2,671.00
J3490U8	Depo — Provera	\$340.00
J7304U1	Contraceptive Patch: Norelgestromin And Ethinyl Estradiol	\$110.00
J7304U2	Contraceptive Patch: Levonorgestrel And Ethinyl Estradiol	\$110.00
J3490U5	Emerg Contraception: Ulipristal Acetate 30 Mg	\$72.00
J3490U6	Emerg Contraception: Levonorgestrel 0.75 Mg (2) & 1.5 Mg (1)	\$50.00
11976	Remove Contraceptive Capsule	\$399.00
11981	Insert Drug Implant Device	\$835.00
58300	Insert Intrauterine Device	\$673.00
58301	Remove Intrauterine Device	\$195.00
81025	Urine Pregnancy Test	\$6.00
55250	Removal Of Sperm Duct(S)	\$521.00
58340	Catheter For Hystero-graphy	\$371.00
58600	Division Of Fallopian Tube	\$1,515.00
58615	Occlude Fallopian Tube(S)	\$1,115.00
58661	Laparoscopy Remove Adnexa	\$978.00
58670	Laparoscopy Tubal Cautery	\$843.00
58671	Laparoscopy Tubal Block	\$892.00
58700	Removal Of Fallopian Tube	\$1,216.00

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

¹⁴ Services billed for the following CPT codes with modifiers UA or UB are excluded from these directed payments: 11976, 11981, 58300, 58301, 55250, 58340, 58555, 58565, 58600, 58615, 58661, 58670, 58671, and 58700.

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

There was relatively complete and credible claims experience data available in the base period, though it is subject to encounter under-reporting and other data issues. Similar to the rate development approach used for the prior period, Mercer leveraged the SFY 2020–2021 base period encounter data of the listed procedure codes to develop the base utilization by COA for each procedure code across all model types. Mercer adjusted the base utilization for estimated encounter under-reporting and anticipated ramp-up due to the enhanced payment under this payment initiative based on literature review of expected national utilization levels of family planning services by the following major service types among child bearing age females:

- Long-acting contraceptives
- Other contraceptives (other than oral contraceptives) when provided as a medical benefit
- Emergency contraceptives when provided as a medical benefit
- Pregnancy testing
- Sterilization procedures (for females and males)

Given the assumed utilizations for each code by COA and the known additional unit cost (uniform dollar increase schedule), Mercer then calculated the expected claims PMPM on a statewide basis as the benefit cost component of the add-on rate. Services provided within FQHC/RHC facilities are also excluded from the add-on payments due to the wrap-around payment structure associated with these types of facilities. Additional payments to AIHS providers and CBRCs are also excluded. In addition, because the network provider mix varies substantially across individual MCOs and individual rating regions, Mercer further adjusted the statewide claims PMPM using rating region specific and MCO-specific FQHC/RHC provider exclusion factors to develop the final claims PMPM, which vary by MCO and rating region. This benefit cost PMPM is developed on a combined basis for all SIS and UIS populations. Acuity factors as well as percentages of pregnancy-related and emergency services for the UIS population were developed using code level SFY 2020–2021 base period encounter data by COA on a statewide basis. UIS and SIS PMPM add-on rates were then calculated in a “budget-neutral” manner from the combined add-on rate PMPM and the projected CY 2023 SIS and UIS enrollment. Note, 0% of the Family Planning services was found to meet the criteria as a pregnancy-related or emergency service. As a result, no portion of the UIS rates specific to this directed payment are part of this certification. Lastly, the PMPM amount of each rate component was adjusted to include half of the plan-specific administrative load, which provides for the variable component of the administrative costs of the program while the fixed administrative costs are covered in the base capitation rates, and an underwriting gain of 2.0%. Further detail of these components, including MCO-specific amounts are provided in the accompanying rate development exhibits in Excel format.

See the table below for detailed impacts for the 12-month period.

Family Planning (January 2023–December 2023)					
Population	COA	Projected Member Months	Prop 56 Add-on Projected Units	Total PMPM	Total Dollars
SIS	Child	55,042,606	133,683	\$0.56	\$30,955,572
SIS	Adult	21,635,378	766,899	\$10.52	\$227,553,585
SIS	ACA Expansion	46,656,994	662,872	\$3.21	\$149,917,759
SIS	SPD	8,845,172	64,502	\$1.13	\$10,007,425
SIS	LTC	32,475	29	\$0.02	\$785
SIS	WCM	368,277	867	\$0.54	\$199,249
SIS	All COAs	132,580,902	1,628,852	\$3.16	\$418,634,376

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

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

Prop 56 Dental

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

Adverse Childhood Experiences Screening

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

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

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

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

The service was added in CY 2020, and there was no credible and complete claims experience data available in the SFY 2020–2021 base period. Similar to the rate development approach used for the prior period, Mercer identified eligible enrollees in the base period eligibility data based on their Medicare coverage status and specific age groups (age group 0–18 and age group 19–64) by COA across all model types to calculate the percentage of members eligible for this service within each COA. Note, enrollees above age 65 or with Medicare Part B coverage are not eligible for this service. Mercer worked together with the State to develop age group specific take-up- assumptions around the percentages of eligible members within each age group who will receive this service within the contract period. Note, this service is primarily intended for children, but adults under 65 are also eligible to receive this service if deemed medically necessary. Therefore, the assumed take-up assumptions are much lower for adults compared to children. Given the assumed utilizations for each group, the age group mix for each COA, and the known unit cost (minimum fee schedule), Mercer then calculated the expected claims PMPM as the benefit cost component of the add-on rate for the CY 2023 rating period. This benefit cost PMPM is developed on a combined basis for all SIS and UIS populations. Acuity factors, as well as percentages of pregnancy-related and emergency services for the UIS population, were developed using code level SFY 2020–2021 base period encounter data by COA on a statewide basis. UIS and SIS PMPM add-on rates were then calculated in a “budget-neutral” manner from the combined add-on rate PMPM and the projected CY 2023 SIS and UIS enrollment. Note that 0% of the ACEs Screening services was found to meet the criteria as a pregnancy-related or emergency service. As a result, no portion of the UIS rates specific to this directed payment is part of this certification. Lastly, the PMPM amount of each add-on rate component was adjusted to include half of the plan-specific administrative load, which provides for the variable component of the administrative costs of the program while the fixed administrative costs are covered in the base capitation rates, and an underwriting gain of 2.0%. Further detail of these components including MCO-specific amounts are provided in the accompanying rate development exhibits in Excel format.

See the table below for detailed impacts for the 12-month period.

ACEs Screening (January 2023–December 2023)					
Population	COA	Projected Member Months	Prop 56 Add-on Projected Units	Total PMPM	Total Dollars
SIS	Child	55,042,606	1,019,092	\$0.57	\$31,292,189
SIS	Adult	21,635,378	91,717	\$0.13	\$2,816,233

SIS	ACA Expansion	46,656,994	195,476	\$0.13	\$6,001,335
SIS	SPD	8,845,172	55,318	\$0.19	\$1,698,715
SIS	LTC	32,475	43	\$0.04	\$1,310
SIS	WCM	368,277	6,839	\$0.57	\$208,595
SIS	All COAs	132,580,902	1,368,485	\$0.32	\$42,018,377

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

Per the preprint and as described earlier in the certification, the add-on rate payment for this payment initiative will be subject to a two-sided risk corridor together with the Physician Prop 56 add-on rate payment and the Developmental Screening add-on rate payment.

Developmental Screening

The Developmental Screening directed payment is a payment arrangement, which directs MCOs to pay a uniform and fixed dollar amount add-on payment for specific developmental screening services to eligible network providers based on the utilization and delivery of qualifying services for eligible enrollees covered under the contract. The preprints for this payment initiative have been approved for two prior rating periods and the renewal version applicable to the current rating period will be submitted to CMS for approval no later than December 31, 2022, with no changes to major terms and conditions.

The following provides a brief description of this payment initiative:

- The type of this directed payment arrangement is a uniform dollar increase payment initiative.
- MCOs are required to pay the eligible providers for the applicable incurred period using the following uniform dollar increase schedule for qualifying covered services provided to eligible managed care enrollees up through age 20.

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

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

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

Though not a brand new service, there was no credible and complete claims experience data available in the SFY 2020–2021 base period. Similar to the rate development approach used for the prior period, Mercer identified eligible enrollees in the base period eligibility data based on their Medicare coverage status and specific age groups (age group 0–2 and age

group 3–20) by COA across all model types to calculate the percentage of members eligible for this service within each COA. Note, only children under age 20 and without Medicare Part B coverage are eligible for this service. Mercer developed age group specific take-up assumptions around the percentage of eligible members who will receive this service within the contract period. Note, this service is primarily intended for younger children under age three, though older children age three through 20 are also eligible to receive this service if deemed medically necessary. Given the assumed utilizations for each group, the age group mix for each COA, and the known additional unit cost (uniform dollar increase), Mercer then calculated the expected claims PMPM as the benefit cost component of the add-on rate. This benefit cost PMPM is developed on a combined basis for all SIS and UIS populations. Acuity factors as well as percentages of pregnancy-related and emergency services for the UIS population were developed using code level SFY 2020–2021 base period encounter data by COA on a statewide basis. UIS and SIS PMPM add-on rates were then calculated in a “budget-neutral” manner from the combined add-on rate PMPM and the projected CY 2023 SIS and UIS enrollment. Note, 0% of the Developmental Screening services was found to meet the criteria as a pregnancy-related or emergency service. As a result, no portion of the UIS rates specific to this directed payment is part of this certification. Lastly, the PMPM amount of each rate component was adjusted to include half of the plan-specific administrative load, which provides for the variable component of the administrative costs of the program while the fixed administrative costs are covered in the base capitation rates, and an underwriting gain of 2.0%. Further detail of these components, including MCO-specific amounts are provided in the accompanying rate development exhibits in Excel format.

See the table below for detailed impacts for the 12-month period.

Developmental Screening (January 2023–December 2023)					
Population	COA	Projected Member Months	Prop 56 Add-on Projected Units	Total PMPM	Total Dollars
SIS	Child	55,042,606	836,641	\$0.96	\$53,062,800
SIS	Adult	21,635,378	5,421	\$0.02	\$343,841
SIS	ACA Expansion	46,656,994	16,340	\$0.02	\$1,036,206
SIS	SPD	8,845,172	12,828	\$0.09	\$813,657
SIS	LTC	32,475	0	\$0.00	\$9
SIS	WCM	368,277	5,623	\$0.96	\$354,266
SIS	All COAs	132,580,902	876,854	\$0.42	\$55,610,779

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

Per the preprint and as described earlier in this certification, the add-on rate payment for this payment initiative will be subject to a two-sided risk corridor together with the Physician Prop 56 add-on rate payment and the ACEs Screening add-on rate payment.

Dental Preventive Services

Consistent with 42 CFR § 438.6(c)(1)(iii)(A), DHCS implemented a directed provider payment initiative that imposes a minimum fee schedule for network providers that provide certain dental services under the contract using State plan approved rates. The minimum fee schedule for these dental procedure codes applies to all eligible providers who perform these services for HPSM Dental pilot enrollees. These payments are included as a percentage increase to HPSM’s dental capitation rate add-on through a prospective program change. See the Program Changes subsection within Section 4 above regarding HPSM Dental for more details.

Hospital Directed Payments

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

Control Name of the State Directed Payment	Aggregate Amount Included in the Certification	Statement that the Actuary is Certifying the Separate Payment Term	The Magnitude on a PMPM Basis	Confirmation the Rate Development is Consistent with the Preprint	Confirmation that the State and Actuary will Submit Required Documentation at the End of the Rating Period (as applicable)
Control Name TBD — PHDP	\$4,891.43 million	The actuary certifies the incorporation of the separate payment term	See pink labeled columns in file titled <i>CY 2023 Medi-Cal Hospital Directed Payment Summary 2022 12.xlsx</i> for the PMPM estimates	Confirmed. The preprint will be submitted to CMS in December 2022.	Confirmed
Control Name TBD — EPP	\$1,982.56 million	The actuary certifies the incorporation of the separate payment term	See exhibit referenced above	Confirmed. The preprint will be submitted to CMS in December 2022.	Confirmed

Control Name TBD — DHDP	\$200.00 million	The actuary certifies the incorporation of the separate payment term	See exhibit referenced above	Confirmed. The preprint will be submitted to CMS in December 2022.	Confirmed.
CA 438.6(c) Proposal J—2021–DPH QIP	\$1,955.40 million	The actuary certifies the incorporation of the separate payment term	See exhibit referenced above	Confirmed. The preprint is approved.	Confirmed
CA 438.6(c) Proposal I—2021–DMPH QIP	\$166.34 million	The actuary certifies the incorporation of the separate payment term	See exhibit referenced above	Confirmed. The preprint is approved.	Confirmed

Information included in the attached spreadsheet (*CY 2023 Medi-Cal Hospital Directed Payment Summary 2022 12.xlsx*) includes the estimated PMPM impacts associated with each of these separate payment term directed payments by rate cell.

The approach for developing the estimated PMPM impacts of each directed payment is similar to prior years. Mercer collected supplemental data from each health plan on historical utilization and expenditures by COS and provider class as well as the contracted share of those expenditures (payments associated with the MCO having a contract in place with the facilities). Based on a review of this supplemental data, for each directed payment provider class within each applicable COS, Mercer estimated the contracted share of revenue as well as the unit cost differential compared to the average unit cost across all providers, by rate cell. These metrics were utilized to estimate the PMPM impacts for each directed payment as described below.

Private Hospital Directed Payment Uniform Dollar Increase

The PHDP preprint will be submitted to CMS for approval no later than December 31, 2022. The PHDP is a uniform dollar add-on payment for services provided by the class of network private hospitals, limited to a pre-determined pool amount, with 70% designated to IP services, and 30% to OP/ER services. The PHDP is a separate payment term; the actual uniform dollar increase will be calculated after the end of each half of the CY 2023 period based on actual contracted IP and OP/ER services utilized within the class.

The approach for developing the estimated PHDP uniform dollar increases and PMPM impacts is similar to prior years. The estimated contracted share of revenue and unit cost differential for the private hospital class were applied to the gross medical expense (GME) PMPM component of the capitation rate by rate cell for each impacted COS (IP and OP/ER). These calculations produced estimated private contracted days (for IP) or visits (for non-IP),

by rate cell and in total, that formed the basis for creating estimated uniform dollar add-on payment for each COS that would total the intended directed payment target.

The directed payment target for PHDP was \$4,891.43 million for the entire 12-month rating period. The IP uniform dollar add-on payment estimate of \$1,253 and the OP/ER estimate of \$169 produced impacts of \$3,424.00 million and \$1,467.43 million for the respective COS. The attached exhibit (*Exhibit I CY 2023 Directed Payments PHDP 2022 12.pdf*) contains the full detail of these calculations for each COS. The resulting estimates on a PMPM basis by rate cell are provided in the attached spreadsheet (*CY 2023 Medi-Cal Hospital Directed Payment Summary 2022 12.xlsx*) as noted previously.

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

The directed payment target of \$4,891.43 million is a draft amount based on information provided by DHCS staff as of December 19 2022, after which Mercer was not able to incorporate further information as part of this certification. Mercer is aware that the final amount may be different as DHCS had not finalized the directed payment target at that time. The final amount will be incorporated through a rate amendment, if necessary.

Enhanced Payment Program

The EPP directed payment preprint will be submitted to CMS for approval no later than December 31, 2022. The EPP consists of two parts; first, uniform dollar add-on payment for services provided by the four classes of DPHs and second, uniform percentage increase to subcapitation (capitation) payments made to Class A and Class B DPHs. Payments are limited to predetermined pool amounts by DPH provider class. The pool amounts are split into capitation and FFS service sub-pools for applicable DPH classes, and non-capitation pool amounts are further split into IP and non-IP sub-pools. The EPP is a separate payment term; the actual uniform dollar add-on payments and uniform percentage increases will be calculated after the end of each half of the CY 2023 period based on actual contracted services utilized within the applicable provider classes and COS.

Classes A through D are outlined below:

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

Fee-For-Service Uniform Dollar Increase

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

dollar increases that would total the intended directed payment target for the given provider class and COS.

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

Capitation Uniform Percentage Increase

The approach for producing the estimated uniform percentage increase to capitation is similar to prior years. Mercer collected supplemental data from each health plan participating in Class A and Class B counties on historical capitation payments to DPHs and volume of DPH-assigned members. Based on a review of this supplemental data, Mercer estimated the capitation payments for DPH-assigned members anticipated during the rating period and the projected member months for the DPH assigned members by class and rate cell. These calculations produced estimated DPH capitation expenditures, by rate cell and in total, that formed the basis for creating estimated uniform percentage increases that would total the intended directed payment target for the given provider class. The methodology used to allocate actual payments associated with these directed payments will be consistent with the methods discussed in this certification and the 42 CFR § 438.6(c) preprint.

The total impact of the EPP directed payment across the classes is targeted to be approximately \$1,982.56 million. The attached exhibits (*Exhibit II CY 2023 Directed Payments EPP 2022 12.pdf*) contain the full detail of these calculations by Class, sub-pool, and impacted COS. The resulting estimates on a PMPM basis by rate cell are provided in the attached spreadsheet (*CY 2023 Medi-Cal Hospital Directed Payment Summary 2022 12.xlsx*).

District and Municipal Public Hospital Directed Payment Uniform Dollar Increase

The DHDP preprint will be submitted to CMS for approval no later than December 31, 2022. The DHDP is a uniform dollar add-on payment for services provided by the class of network DMPHs, limited to a predetermined pool amount, with 70% designated to IP (IP/LTC) services, and 30% to non-IP (OP/ER) services. The DHDP is a separate payment term; the actual uniform dollar increase will be calculated after the end of each half of the CY 2023 period based on actual contracted IP and non-IP services utilized within the class.

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

The directed payment target for DHDP was \$200.00 million for the entire 12-month rating period. The uniform dollar add-on payment estimates of \$859 for IP and \$274 for LTC produced the IP/LTC impact of \$140.00 million, while the OP/ER estimate of \$70 produced the OP/ER impact of \$60.00 million. The attached exhibit (*Exhibit III CY 2023 Directed Payments DHDP 2022 12.pdf*) contains the full detail of these calculations for each COS. The resulting estimates on a PMPM basis by rate cell are provided in the attached spreadsheet (*CY 2023 Medi-Cal Hospital Directed Payment Summary 2022 12.xlsx*) as noted previously.

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

Designated Public Hospital Quality Incentive Pool

The QIP DPH directed payment preprint encompassing the CY 2023 rating period was submitted to CMS on December 31, 2020 under control name CA 438.6(c) Proposal J – 2021. The DPH QIP directed payment provides value-based payments to DPHs for meeting specified performance measures linked to the utilization and delivery of services under the managed care contracts. Each county with an applicable non-UC DPH is designated a specified maximum allowable pool payment amount, and the UC facilities statewide are designated a maximum allowable pool payment amount.

The approach for producing the estimated impact is similar to prior years. The QIP DPH directed payment estimates are calculated as a uniform percentage increase to anticipated DPH expenditures in CY 2023 by rate cell; the uniform percentage estimate is modeled on a county-specific basis for the counties with non-UC DPHs and a statewide basis for the UC facilities. Each county/region and UC facilities are allocated a portion of the total respective QIPs. The estimated contracted share of revenue was applied to the capitation GME PMPM by rate cell for the non-UC DPHs and the UC DPHs. These calculations produced estimated DPH capitation expenditures, by rate cell and in total, which formed the basis for creating uniform percentage increases that would total the intended directed payment maximum allowable payment target for each non-UC county and for the UC facilities.

The total impact of the QIP DPH directed payment is targeted to be approximately \$1,955.40 million. The attached exhibits (*Exhibit IV CY 2023 Directed Payments DPH QIP 2022 12.pdf*) contain the full detail of these calculations. The resulting estimates on a PMPM basis by rate cell are provided in the attached spreadsheet (*CY 2023 Medi-Cal Hospital Directed Payment Summary 2022 12.xlsx*).

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

District and Municipal Public Hospital Quality Incentive Pool

The DMPH QIP directed payment preprint encompassing the CY 2023 rating period was submitted to CMS on December 31, 2020 under control name CA 438.6(c) Proposal I–2021. The DMPH QIP directed payment provides value-based payments to DMPHs for meeting specified performance measures linked to the utilization and delivery of services under the managed care contracts. Each county with an applicable DMPH is designated a specified maximum allowable pool payment amount.

The approach for producing the estimated impact is similar to prior years and similar to the calculation of the non-UC QIP DPH estimates. The QIP DMPH directed payment estimates are calculated as a uniform percentage increase to anticipated DMPH expenditures in CY 2023 by rate cell; the uniform percentage estimate is modeled on a county-specific basis for the counties with DMPHs. Each county/region is allocated a portion of the total respective QIP. The estimated DMPH contracted share of revenue was applied to the capitation GME PMPM by rate cell. These calculations produced estimated DMPH capitation expenditures, by rate cell and by county, which formed the basis for creating uniform percentage increases that would total the intended directed payment maximum allowable payment target for each DMPH county.

The total impact of the DMPH QIP directed payment is targeted to be approximately \$166.34 million. The attached exhibits (*Exhibit V CY 2023 Directed Payments DMPH QIP 2022 12.pdf*) contain the full detail of these calculations. The resulting estimates on a PMPM basis by rate cell are provided in the second tab of the attached spreadsheet (*CY 2023 Medi-Cal Hospital Directed Payment Summary 2022 12.xlsx*).

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

Major Organ Transplant Hospital Directed Payment

The MOT directed payment preprint encompassing the CY 2023 rating period is currently pending formal CMS approval. This directed payment is specific to hospital stays incorporating the MOT event and only applies to transplants transitioning from FFS to managed care. This directed payment directs MCOs to pay hospitals at levels that would be paid in the Medi-Cal FFS delivery system.

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

Control Name of the Directed Payment	Rate Cells Affected	Impact	Description of the Adjustment	Confirmation the Rates are Consistent with the Preprint	For Maximum Fee Schedules, Provide the Information Requested
CA_VBP_IPH. Oth_New_202 20101-20241231 — MOT	Child, Adult, ACA Expansion, SPD, SPD/Full-Dual	\$0	Adjustment is applied in the base and is a part of the MOT PMPM add-on.	Confirmed.	Not applicable

Long-Term Care Directed Payment

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

- Effective January 1, 2023 for SNF services and effective July 1, 2023 for ICF-DD and SA services, MCOs operating in Two-Plan/GMC/Regional non-CCI “transitioning” counties are required to reimburse network LTC providers at, and those providers are required to accept, the payment rate that would otherwise have been paid in the FFS delivery system (i.e., Medi-Cal FFS per diem rate). This requirement applies to all LTC services, both for services transitioning from FFS and all LTC services previously covered by MCOs in these counties.
- Effective January 1, 2023 for SNF services and effective July 1, 2023 for ICF-DD and SA services, MCOs operating in COHS and CCI “non-transitioning” counties are required to reimburse network LTC providers at no less than the payment rate that would otherwise have been paid in the FFS delivery system (i.e., Medi-Cal FFS per diem rate).

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

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

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

Pass-Through Payments

Pass-through payments, as described below, are applied in the Two-Plan, GMC, Regional, and COHS Model CY 2023 capitation rates.

The approach for developing the PMPM impacts of each pass-through payment is similar to prior years. Mercer collected supplemental data from each health plan on historical utilization and expenditures by COS and provider class. Based on a review of this supplemental data,

for each impacted provider class within each applicable COS, Mercer estimated the share of revenue by rate cell. These metrics were utilized to develop the PMPM impacts for each pass-through payment as described below.

A new pass-through payment for public distinct part nursing facility services transitioning from a FFS delivery system to a managed care delivery system under 42 CFR § 438.6(d)(6) is pending finalization of the program parameters and is not included in this rate certification. The pass-through payment transitions existing State Plan-approved supplemental payments for DP/NF services that will be covered for the first time under a managed care contract following the carve-in of LTC services. The pass-through payment program parameters will be incorporated through a rate amendment.

Private Hospital — Hospital Quality Assurance Fee and District and Municipal Public Hospitals

Historical adjustments associated with the private hospital quality assurance fee (HQAF) and DMPHs are continuing for CY 2023. The approach for making these adjustments within the capitation rates are being addressed through two paths; first, Pass-through Payments as defined by 42 CFR § 438.6(d), and 2) Directed Payments as defined by 42 CFR § 438.6(c). The directed payment approach is described earlier within this certification report and is paid through a separate payment term. The pass-through components of the HQAF/DMPH adjustments are paid as a PMPM add-on amount by rate cell, included within the certified rates. These have been developed in a fashion similar to historical approaches.

The estimated share of revenue for the private hospitals and DMPHs was applied to the capitation GME PMPM by rate cell for each impacted COS (IP and OP/ER for private hospitals, and only IP for DMPHs). These calculations produced estimated private and DMPH PMPMs, by rate cell and in total. It should be noted the GME amounts utilized to produce the baseline amounts are inclusive of projected maternity costs. This approach was taken so these adjustments did not impact the maternity supplemental payments (this is consistent with historical practice). The DMPH components of the capitation rates were increased by a uniform percentage increase to the IP component (19.59%). The private hospital components of the capitation rates were increased by a uniform percentage increase to the IP component (12.47%) and a uniform percentage increase to the OP/ER component (16.38%). The total target impact of \$1,797.4 million is projected across all of the California managed care models (Two-Plan, GMC, COHS, and Regional models) for the 12-month rating period. The development of these add-on amounts did not impact the underlying data or assumptions associated with the regular development of the capitation rates. Consistent with historical approaches, no additional administrative load or underwriting gain is included within these add-on amounts for HQAF/DMPH. The DMPH targeted expenditure is approximately \$97.4 million across the 12-month period and the DMPH targeted expenditure of \$97.4 million is part of the \$1,797.4 million total impact.

The aforementioned private/DMPH pass-through PMPM adjustments are added to the post risk-adjusted rates.

Included attachments labeled *Exhibit A CY 2023 DMPH IP Pass-Through 2022 12.pdf*, *Exhibit B CY 2023 Private Hospital IP HQAF Pass-Through 2022.12.pdf*, and *Exhibit C CY 2023 Private Hospital OP ER HQAF Pass-Through 2022 12.pdf* contain the detailed components behind these calculations. The resulting PMPM add-on rates by rate cell are

provided in the “Sum - Add-On Details” tabs within the attached spreadsheet *FINAL CY 2023 Medi-Cal Detail CRCS Package LB Rate Smry 2022 12.xlsx*.

The development of these add-on amounts did not impact the underlying data or assumptions associated with the regular development of the capitation rates.

These pass-through payments are paid to private hospitals and DMPHs.

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

For the DMPH pass-through, the nonfederal share of this payment arrangement will consist of voluntary IGTs from eligible public entities. The entities transferring funds are DMPHs — public hospitals as defined by Welfare & Institutions Code §14105.98(a)(25) excluding DPHs as defined by Welfare & Institutions Code §14184.10(f)(1). The expected transferring entities will consist of cities, counties, and special health care districts; in general, the funding entities have general taxing authority, either directly or through receipt of property taxes from counties. The IGTs for the nonfederal share of the payments are voluntary, and the State solicits letters of intent from eligible transferring entities that will identify the approximate amount of IGTs they plan to provide. As the non-federal share of the final payments will be based upon actual member months realized by the MCOs, the total amount of IGTs that ultimately will be necessary for the payments will not be known until after the rating period has ended. To the best of our knowledge, the entities have not received State appropriations specific to this program at this time. As stated above, the nonfederal share of this payment will consist of voluntary IGTs for which the transferring entity will certify that the transferred funds qualify for federal financial participation. The State has yet to enter into any written agreements with the funding entities relating to the non-federal share of this payment arrangement. The State is not aware of any additional written agreements that currently exist between healthcare providers and/or related entities to finance the non-federal share specific to this payment arrangement. If approved, the State intends to enter into separate agreements with the transferring entities regarding the provision of IGTs for this purpose, including a mechanism whereby the transferring entities certify that the funds transferred are public funds and eligible for federal financial participation pursuant to applicable federal regulations.

Martin Luther King Jr. Community Hospital in Los Angeles County

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

The estimated share of IP revenue for MLK was applied to the capitation IP GME PMPM by rate cell. These calculations produced estimated MLK PMPMs by rate cell and in total. It should be noted that the GME amounts utilized to produce the baseline amounts are inclusive of projected maternity costs. This approach was taken so that these adjustments did not impact the maternity supplemental payments (this is consistent with historical practice). A uniform percentage increase for the MLK component of the IP COS was established to provide the needed adjustments to reflect the required costs. The development of these adjustments also include a 3.675% administrative load, which aligns with administrative costs assigned to the maternity supplemental payment as well as the administrative load included with the Prop 56 physician directed payment add-on payments. An underwriting gain of 2%, also consistent with the other payment mechanisms previously mentioned, is included as part of the add-on payment. The total adjustment including administrative load and underwriting gain is estimated to be \$35.94 million across CY 2023 based upon enrollment projections.

Included attachment labeled *Exhibit D CY 2023 MLK IP Pass-Through 2022 12.pdf* contains the detailed components behind these calculations. The resulting PMPM add-on rates by rate cell are provided in the “Sum - Add-On Details” tabs within the attached spreadsheet *FINAL CY 2023 Medi-Cal Detail CRCS Package LB Rate Smry 2022 12.xlsx*.

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

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

Benioff Children’s Hospital Oakland in Alameda County

Historical base data adjustments for Benioff Children’s Hospital Oakland (BCHO) in Alameda County for the Child and SPD rate cells are being presented as pass-through payments based upon the definition of a pass-through payment within 42 CFR § 438.6(d). As described in prior certifications, the payment levels incorporated within the base data utilized for rate development did not reflect the costs the hospital was incurring to serve the Medi-Cal population. Based upon a review of the cost information provided from the MCOs and the hospital, adjustments have been introduced to produce add-on PMPM amounts that reflect the difference between costs included in the base capitation rates and the actual costs.

The estimated share of revenue for BCHO was applied to the capitation GME PMPM by rate cell and applicable COS. These calculations produced estimated BCHO PMPMs by rate cell and in total. It should be noted the GME amounts utilized to produce the baseline amounts are inclusive of projected maternity costs. This approach was taken so these adjustments did not impact the maternity supplemental payments (this is consistent with historical practice). A uniform percentage increase across all applicable COS was established to reflect the needed adjustments to reflect total costs. The development of these adjustments also include a 3.675% administrative load that aligns with administrative costs assigned to the maternity supplemental payment as well as the administrative load included with the Prop 56 physicians directed payment add-on payments. An underwriting gain of 2%, also consistent with the other payment mechanisms previously mentioned, is included as part of the add-on

payment. The total adjustment including administrative load and underwriting gain is estimated to be \$22.59 million across CY 2023 based upon enrollment projections.

The detailed build-up of these adjustments are included in the attachment labeled *Exhibit E CY 2023 BCHO Pass-Through 2022 12.pdf*. The resulting PMPM add-on rates by rate cell are provided in the “Sum - Add-On Details” tabs within the attached spreadsheet *FINAL CY 2023 Medi-Cal Detail CRCS Package LB Rate Smry 2022 12.xlsx*.

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

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

Pass-Through Payments Base Amount Calculation

For the CY 2023 rating period, DHCS has confirmed the projected aggregate amount of pass-through payments to hospitals does not exceed either of:

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

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

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

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

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

General Methodology

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

1. Fifty (50) percent of the base amount defined at 42 CFR § 438.6(d)(2) applicable to the period of January 1, 2023 through June 30, 2023.
2. Forty (40) percent of the base amount defined at 42 CFR § 438.6(d)(2) applicable to the period of July 1, 2023 through December 31, 2023.

The aggregate amount resulting from this calculation is \$2,383,837,713 as displayed in the exhibit *CY 2023 Base Amount Calculation 2022 12.pdf*.

The 42 CFR § 438.6(d)(2)(i) component of the base amount is equal to the aggregate difference between the amounts calculated in accordance with 42 CFR § 438.6(d)(2)(i)(A) and (d)(2)(i)(B). This amount is the differential between the amount paid under Medicaid managed care and the amount Medicare FFS would have paid for inpatient and outpatient hospital services provided to eligible populations under the Medicaid managed care contracts for the 12-month period immediately two years prior to the CY 2023 rating period, which corresponds to CY 2021.

The 42 CFR § 438.6(d)(2)(i)(A) calculation includes three (3) elements; unit cost, utilization, and an adjustment to exclude state-only funded services provided to beneficiaries with UIS. Unit costs were based on Department of Health Care Access and Information, previously the Office of Statewide Health Planning and Development, statewide data for Medicare FFS beneficiaries. CY 2020 data was leveraged to arrive at estimated CY 2021 average unit costs for inpatient and outpatient hospital services. To maintain consistency with the approach used for the 42 CFR § 438.6(d)(2)(i)(B) component, unit cost trend was applied to the CY 2020 data in order to determine a reasonable estimate of CY 2021 unit costs. The trend applied was based on the average Consumer Price Index for All Urban Consumers for hospital related services over the previous four (4) state fiscal years (SFY 2017–2018 through SFY 2020–2021). The resulting estimated inpatient and outpatient unit costs are 3.69% higher year-over-year compared to the CY 2020 unit costs.

Utilization was calculated based on CY 2019 base data used in Medi-Cal managed care rate development that was trended forward to CY 2021. Distinct trends were applied for inpatient and outpatient hospital services based on the average base data utilization change over the previous four (4) calendar years (CY 2016 through CY 2019). For simplicity, the base period data was not trended to the rating period; however, the state may elect to apply trend adjustments, as appropriate, in the calculation of the base amount applicable to future rating periods.

Unit cost was multiplied by utilization for both inpatient and outpatient hospital services, respectively. The resulting amounts were then summed to determine the sub-total amount for the 42 CFR § 438.6(d)(2)(i)(A) component of the calculation. From this amount, a downward adjustment was applied to exclude the costs for non-federally claimable services associated with the UIS population to arrive at the total amount for 42 CFR § 438.6(d)(2)(i)(A).

The 42 CFR § 438.6(d)(2)(i)(B) calculation includes four (4) elements: unit cost, utilization, directed payments, and an adjustment to exclude state-only funded services associated with beneficiaries with UIS. CY 2019 data was trended to arrive at estimated CY 2021 average unit costs for inpatient and outpatient hospital services. The same trend used for the 42 CFR § 438.6(d)(2)(i)(A) component of the calculation was utilized here. Utilization is identical to that used for the 42 CFR § 438.6(d)(2)(i)(A) component of the calculation. Unit cost was multiplied by utilization for both inpatient and outpatient hospital services, respectively. The resulting amounts were then summed and further increased by the amount of applicable directed payments for inpatient and outpatient hospital services for the CY 2021 base period. The applicable directed payments were made as part of the DPH EPP and PDHP. These directed payments were first implemented beginning on July 1, 2017. From this amount, a downward adjustment was applied to exclude the costs for non-federally claimable services associated with the UIS population to arrive at the total amount for 42 CFR § 438.6(d)(2)(i)(B). This downward adjustment is less than the downward adjustment applied to 42 CFR § 438.6(d)(2)(i)(A) resulting in a net decrease to the Base Amount calculation after accounting for the state-only services provided to the UIS population.

Aggregate Difference

The aggregate difference between the total amounts of 42 CFR § 438.6(d)(2)(i)(A) and (d)(2)(i)(B) is \$5,297,417,039. This amount was multiplied by a factor of 0.45 to account for the 50% and 40% phase-down levels associated with the sixth and seventh fiscal years, respectively, occurring after July 1, 2017.

Trend Adjustments

At the time of this calculation, CY 2020 and partial CY 2021 cost and utilization data specific to Medi-Cal managed care was readily available for use in this calculation. However, this includes a large portion of data skewed due to COVID-19. DHCS, in consultation with CMS, opted to leverage Medi-Cal managed care from the CY 2019 period trended forward to determine the reasonable estimates in calculating the Base Amount for the CY 2023 rating period. Both unit cost and utilization trends were applied in the calculation of the amount specified by 42 CFR § 438.6(d)(2)(i). Trends were applied consistently for both 42 CFR § 438.6(d)(2)(i)(A) and (d)(2)(i)(B).

The unit cost trend adjustment is based on the Consumer Price Index for All Urban Consumers; Hospital and Related Services. The average year-over-year growth from July 1, 2017 through July 1, 2021 was used to determine an annual trend percentage of 3.69%. This source of growth is consistent with the annual growth rate historically approved by CMS in the preprint for the state's QIP. Based on CMS' approval of this data source for determining unit cost growth, DHCS believes this source is reasonable and appropriate. While alternative trends are possible and may be reasonable, that fact does not diminish the reasonableness of the state's approach in utilizing an established cost index to inform the trend assumption.

The utilization trend adjustment is based on the average year-over-year growth from CY 2016 through CY 2020 of the base data used for rate development. This data source remains consistent with the utilization driving the base amount calculation beginning with the SFY 2017–18 rating period.

Fiscal Impact

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

Phased-Down Base Amount with Trends = \$2,383,837,713

Unit Cost Trend Removed = \$2,474,373,678

Utilization Trend Removed = \$2,033,088,012

Unit Cost Trend and Utilization Trend Removed = \$2,124,723,988

DHCS believes both the unit cost and utilization trends applied in this calculation are reasonable and appropriate. However, the removal of either utilization or unit cost trend, or both, would not change the fact that the phased-down based amount exceeds the projected aggregate amount of pass-through payments for the CY 2023 rating period.

The 42 CFR § 438.6(d)(2)(ii) component of the base amount is assumed to be equal to \$0 at this time, consistent with the approach used for prior rating periods. The amount in accordance with 42 CFR § 438.6(d)(2)(ii) is the differential between the amount paid under Medicaid FFS and the amount Medicare FFS would have paid for inpatient and outpatient hospital services provided to eligible populations through the Medicaid FFS delivery system for the 12-month period immediately two years prior to the CY 2023 rating period that have subsequently shifted to the Medicaid managed care delivery system. There were material shifts of inpatient and outpatient hospital services, and of eligible populations, from Medicaid FFS to Medicaid managed care for the applicable time periods. However, given the 42 CFR § 438.6(d)(2)(i) component on its own exceeds the projected aggregate amount of pass-through payments for the CY 2023 rating period, DHCS has opted to keep this component of the calculation \$0 at the current time. The state reserves the right to utilize this component of the calculation in a future amendment of this certification, particularly in relation to the incorporation of pass-through payments for DP/NF services in accordance with 42 CFR § 438.6(d), or for future rating periods.

Section 8

Certification and Final Rates

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

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

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

Mercer certifies that the Two-Plan, GMC, Regional, and COHS models' capitation rates, for CY 2023, January 1, 2023 through December 31, 2023, were developed in accordance with generally accepted actuarial practices and principles, and are appropriate for the Medi-Cal covered populations and services under the managed care contract. Capitation rates are "actuarially sound" if, for the business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes. The undersigned actuaries are members of the American Academy of Actuaries and meet its qualification standards to certify to the actuarial soundness of these Medicaid managed care capitation rates.

Capitation rates developed by Mercer are actuarial projections of future contingent events. All estimates are based upon the information and data available at a point in time, and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely, and potentially wide, range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than

for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use. Actual MCO costs will differ from these projections. Mercer has developed these rates on behalf of DHCS to demonstrate compliance with the CMS requirements under 42 CFR § 438.4 and in accordance with applicable law and regulations. There are no stop loss or reinsurance arrangements in these rates. Use of these rates for any purpose beyond that stated may not be appropriate.

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

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

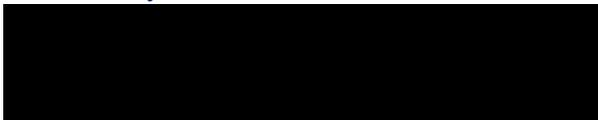
This certification report assumes the reader is familiar with the Medi-Cal program, Medi-Cal eligibility rules, and actuarial rating techniques. It has been prepared exclusively for DHCS and CMS, and should not be relied upon by third parties. Other readers should seek the advice of actuaries, or other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

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

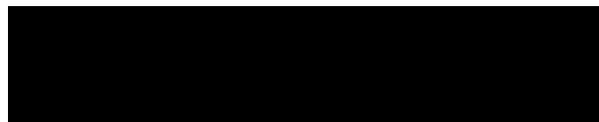
DHCS agrees to notify Mercer within 30 days of receipt of this report if it disagrees with anything contained in this report or is aware of any information or data that would affect the results of this report that has not been communicated or provided to Mercer or incorporated herein. The report will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

If you have any questions on the above or the certification report, please feel free to contact Robert O'Brien at robert.j.o'brien@mercer.com, or Jim Meulemans at james.meulemans@mercer.com.

Sincerely,



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



James J. Meulemans, ASA, MAAA, FCA
Partner



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