Mercer

Government Human Services Consulting

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

Capitation Rate Development and Certification Amendment

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

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Section 1

Executive Summary

The 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 calendar year (CY) 2022 rating period. The original capitation rates were developed by Mercer and certified in a report dated December 2021, (please see the attached document: *CA CY 2022 (01 01 2022 - 12 31 2022) Rate Cert Report 2021 12.pdf*). An addendum to this certification was also dated December 27, 2021 providing more details on risk sharing mechanisms within the CY 2022 capitation rates. Subsequent to the submission of those reports, revisions to the capitation rates were needed for the following items:

- Revisions related to the COVID-19 Public Health Emergency (PHE)
  - Implementation of a 10% unit cost increase for long-term care (LTC) services (including Hospice) due to the fee schedule increase during the PHE.
  - Adjustments due to the extension of the PHE halting disenrollments:
    - Managed Care Organization (MCO) Tax
    - Pass-through Payments
    - Risk adjusted county/region averages
- Revisions not related to the COVID-19 PHE
  - Delayed implementation date of the Dyadic Health Care Services and Doula programmatic changes until January 1, 2023. As such, these program changes are not applied in this amended version of the rates.
  - Implementation of the AB97 and Partial Duals transition population programmatic changes since they were not known before the time of the original certification.
  - An update to the Major Organ Transplant (MOT) add-on to reflect finalized case rates.

Please see the attached documents detailing the revised rates for the CY 2022 rating period:

- CA CY 2022 (01 01 2022 - 12 31 2022) Rate Revised Cert Report 2023 04.pdf
- CA CY 2022 (01 01 2022 - 12 31 2022) Rate Revised Cert Report 2023 04.docx
- FINAL CY 2022 Medi-Cal Detail CRCS Package LB Rate Smry 2023 04.xlsx
- FINAL CY 2022 Medi-Cal Detail CRCS Package UB 2023 04.xlsx

- FINAL CY 2022 CA CCI Medi-Cal Only & Partial Dual Rate Ranges 2023 04.xlsx
- FINAL CY 2022 CA CCI Medi-Cal Only & Partial Dual Upper Bound CRCS Sheets 2023 04.xlsx
- FINAL CY 2022 CA CCI Medi-Cal Only & Partial Dual Program Change Chart 2023 04.xlsx
- CY 2022 Private Hospital DMPH IP HQAF Pass-through 2023 04.pdf
- CY 2022 Private Hospital OP ER HQAF Pass-through 2023 04.pdf
- CY 2022 MLK IP Pass-through 2023 04.pdf
- CY 2022 BCHO Pass-through 2023 04.pdf

All other rating-elements not addressed in this revision remain unchanged from the CY 2022 capitation rates delivered previously.

This revision describes the updates that were made and provides the certification of actuarial soundness required by 42 CFR §438.4. This revision was developed to provide the requisite rate documentation to DHCS and to support the Centers for Medicare & Medicaid Services (CMS) rate review process.

Across all counties, MCOs, and populations (excluding the Two-Plan/GMC CCI Non-Dual Institutional capitation rates), the revised CY 2022 capitation rates represent a 1.0% decrease when compared to the original certified CY 2022 mainstream capitation rates that included all rate add-ons. For the Two-Plan/GMC CCI Non-Dual Institutional capitation rates, the revised CY 2022 capitation rates represent a 6.2% increase when compared to the original certified CY 2022 capitation rates.

Please note, an additional amendment to the CY 2022 rates is still forthcoming. The additional amendment will separate the capitation rates for members with Unsatisfactory Immigration Status (UIS) and Satisfactory Immigration Status (SIS). Further, the amendment will split the UIS capitation rates into federally eligible and State only components.

Overview

The revised capitation rates for the DHCS Two-Plan, GMC, Regional and COHS models managed care programs, as well as the Coordinated Care Initiative Medi-Cal Only and partial dual-eligible beneficiaries, were developed in accordance with rate-setting guidelines established by CMS and include the changes described in this revision letter. Highlights of the changes are described for the various rate components in the remainder of this revision letter.

All Rate-Setting Elements Not Addressed Herein

There have been no changes made to any rate-setting components not addressed in this revision. For more detail related to these unchanged elements of the certification, please refer to the original December 2021 certification report and its corresponding supporting documents.

Revision — Long-Term Care Rate Changes

Rate increases for LTC services are largely handled through a program change adjustment and are based on legislatively mandated fee-for-service rate increases, including annual rate increases. In addition, DHCS implemented a 10% fee increase for LTC facilities effective for the duration of the PHE declared by the Secretary of Health and Human Services for Coronavirus Disease 2019, beginning March 1, 2020, which is anticipated to produce corresponding pricing pressures in the managed care delivery system. The underlying assumption in the original certified rates was that this increase would not be applicable for the CY 2022 rating period. For all revised capitation rates contained herein, the underlying assumption is that this increase will be applicable for the entirety of the CY 2022 rating period.

Revision — Hospice Rate Changes

Similar to the LTC category of service (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 fee-for-service (FFS) rate increases for Hospice room and board. In addition, DHCS implemented a 10% fee increase for LTC facility room and board rates (including for Hospice facilities) effective for the duration of the PHE declared by the Secretary of Health and Human Services for Coronavirus Disease 2019, beginning March 1, 2020, which is anticipated to produce corresponding pricing pressures in the managed care delivery system. Like the LTC rate changes mentioned above, the underlying assumption in the original certified rates was this increase would not be applicable for the CY 2022 rating period. For all revised capitation rates contained herein, the underlying assumption is this increase will be applicable for the entirety of the CY 2022 rating period.

Revision — Population Acuity Adjustment

The population acuity adjustment is intended to account for the change in the underlying acuity level of the Medi-Cal managed care population due to the halt in disenrollments during the PHE. At the time of the original development of the CY 2022 capitation rates, the PHE end date was assumed to be December 2021, with the disenrollments occurring throughout the rating period. Subsequent to the original certification, the PHE was extended beyond the CY 2022 rating period. Mercer updated the analyses (described in detail in the original certification) with the understanding the halt in disenrollments occurred for the entirety of the rating period. The updated analyses resulted in the following adjustments (statewide averages):

- Child COA: -0.4% (original adjustment -0.2%)
- Adult COA: -2.3% (original adjustment -1.1%)
- ACA Expansion COA: -2.1% (original adjustment -1.2%)

Revision — Programmatic Changes

Delayed Benefits

Dyadic Health Care Services

In the original development of the CY 2022 capitation rates, dyadic health care services were originally assumed to be effective July 1, 2022. After the development of the original version of these rates, the implementation of this benefit was delayed to January 1, 2023. Therefore, the impact of this benefit was removed in this amended version of CY 2022 capitation rates.

Doula

In the original development of the CY 2022 capitation rates, doula health care services were originally assumed to be effective July 1, 2022. After the development of the original version of these rates, the implementation of this benefit was delayed to January 1, 2023. Therefore, the impact of this benefit was removed in this amended version of CY 2022 capitation rates.

New Benefits

AB 97

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, which include 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

Adjustments were developed using encounter data, by COA, for the provider types listed above during the period of January 1, 2019 to December 31, 2019. This adjustment accounts for pricing pressures based on FFS payment increases which managed care plans are anticipated to pay.

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 CY 2019 FFS data was primarily impactful to the SPD COA.

The membership volume impact, in aggregate, for Two-Plan, GMC, and Regional counties was 3.7% to the existing Managed Care population. For this population, the associated FFS data was used to derive the assumed per member per months (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.

Revision — Major Organ Transplants

DHCS implemented a 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.

For the State directed payment, DHCS set CY 2022 case rates for the University of California (UC) hospital system. The CY 2022 MOT add-on rates were updated to reflect finalized UC case rates as the case rates included in the directed payment were finalized after the start of the rating period. As the UC cases rates are meant to cover only costs for the transplant event itself, which was defined as costs incurred during the inpatient stay of the transplant surgery, only the MOT event portion of the add-on rates were adjusted. Pre- and post-transplant period costs were not adjusted. Upon review of the FFS data used for the add-on rate development, it was determined adjustments were needed for Heart, Lung, Liver, and Intestine transplants to align payment rates with the finalized UC case rates for CY 2022. The statewide impact of this adjustment to the fully loaded rates was approximately $11 million for the CY 2022 rating period.

Revision — Pass-through Payments

As described in detail in the original certification letter, the following hospital pass-through payment PMPM add-on amounts were estimated as an uniform percentage increase to the estimated share of the capitation rate gross medical expenditure (GME) PMPMs for the applicable COS attributable to the applicable hospital class(es). These estimates resulted in total expenditures projected across applicable rate cells for the 12-month rating period matching a targeted amount for each pass-through payment. As mentioned above, the original CY 2022 projected enrollment was based on an assumed PHE end date of December 2021. As the PHE was extended beyond CY 2022, actual CY 2022 enrollment was significantly higher than projected. The Pass-through payment add-on PMPMs were re-calculated to use actual CY 2022 enrollment and reflect the revised GME PMPM components, adjusted as described earlier within this certification amendment. Mercer updated the uniform percentage increase for each of the hospital pass-through payment programs such that the total expenditures returned to the original targeted amounts. No other assumptions were revised. The following pass-through payment add-ons were revised, and the detailed build-up of the add-ons are provided in various attachments:

- Private hospital quality assurance fee (HQAF) and District and Municipal Public Hospitals (DMPHs) — detailed in Exhibit A CY 2022 Private Hospital DMPH IP HQAF Pass-through 2023.04.pdf and Exhibit B CY 2022 Private Hospital OP ER HQAF Pass-through 2023.04.pdf.
- Martin Luther King Jr. Community Hospital (MLK) IP component of the LA County SPD and ACA Expansion rate cells — detailed in Exhibit C MLK IP Pass-through 2023.04.pdf.
- Benioff Children’s Hospital Oakland (BCHO) in Alameda County for the Child and SPD rate cells — detailed in Exhibit D CY 2022 BCHO Pass-through 2023.04.pdf.

Revision — MCO Tax

As described in the original certification letter, the MCO Tax liability is set by DHCS (and approved by CMS) and is applicable to full-service health care plans. The MCO Tax PMPMs are created by dividing the total CY 2022 tax liability by the projected enrollment over that time-period. The original CY 2022 projected enrollment was based on an assumed PHE end date of December 2021. As mentioned above, subsequent to the original certification the PHE was extended beyond CY 2022. Mercer updated the MCO Tax PMPMs using the original, and unchanged, tax liability

divided by the updated CY 2022 enrollment counts, acknowledging the update to the PHE.

Revision — Risk Adjustment County/Region Average

With the update of enrollment to rely on actual CY 2022 member months, updates were made to the county average rate calculation and the budget neutral risk score calculation within the risk-adjustment process. The original certified capitation rates utilized original projected member months to calculate both the county average capitation rates and the county average unadjusted risk scores (weighted average across multiple plans within a county/rating region). The revised capitation rates now use actual member months in both calculations. Specific to the risk-adjustment process, no changes were made in the calculation of the MCO-specific unadjusted risk scores, only changes made were to the county average risk scores. As a result, the final budget neutral risk scores changed slightly.

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 revised Two Plan, GMC, Regional, and COHS (including WCM) models' capitation rates and CCI Non-Dual Institutional rates, for CY 2022, January 1, 2022 through December 31, 2022, 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. Collectively, 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, reinsurance, or incentive 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.

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,

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