Mercer

Government Human Services Consulting

Two-Plan, Geographic, Managed Care, 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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Contents

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) 2023 rating period. The original capitation rates were developed by Mercer and certified in a report dated December 21, 2022, and updated in an amendment dated July 14, 2023. Please see the attached documents: *CA CY 2023 (01 01 2023 - 12 31 2023) Rate Cert Report 2022 12.pdf* and *CA CY 2023 (01 01 2023 - 12 31 2023) Rate Cert Amendment Report 2023 07.pdf*. Subsequent to the submissions of the report and amendment, further revisions to the capitation rates were needed for the following items:

- Revision of the Unsatisfactory Immigration Status (UIS) federally eligible percentages.
- Addition of certain hospice costs in CalOptima's base data.
- Revision of the population acuity adjustment.
- Policy changes impacted by updates in enrollment and the updated UIS federal percentages:
  - Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) and Sub-Acute (SA) long-term care (LTC) member transition.
  - LTC utilizers in non-LTC categories of aid (COAs) and full-dual member transitions.
  - Assembly Bill (AB) 97 buybacks.
  - LTC directed payment.
- Addition of a new policy change for continuous glucose monitoring (CGM) for beneficiaries aged 21 years and over.
- Addition of the Distinct Part Nursing Facilities (DP-NFs) pass-through payment pursuant to 42 CFR § 438.6(c).
- Addition of the Managed Care Organization (MCO) tax add-on.
- Revision of the Major Organ Transplant (MOT) State directed payment, pursuant to 42 CFR § 438.6(c), to reflect the finalized University of California (UC) case rates.
- Revision of the Specialty Mental Health Services add-on for Kaiser Members in Sacramento and Solano counties.

- Revision of the Designated Public Hospital (DPH) Quality Incentive Pool (QIP) and District and Municipal Public Hospital (DMPH) QIP State directed payment program pool amounts pursuant to 42 CFR § 438.6(c).
- Addition of a new State directed payment for the Skilled Nursing Facility (SNF) and Workforce and Quality Incentive Program (WQIP) pursuant to 42 CFR § 438.6(c).
- Please see the attached documents detailing the revised rates for the CY 2023 rating period:
  - CA CY 2023 (01 01 2023 - 12 31 2023) Rate Cert Amendment Report 2024 05.pdf
  - CA CY 2023 (01 01 2023 - 12 31 2023) Rate Cert Amendment Report 2024 05.docx
  - CY 2023 Medi-Cal Detail CRCS Package LB Rate Smry 2024 05.xlsx
  - CY 2023 Medi-Cal Detail CRCS Package UB 2024 05.xlsx
  - CY 2023 Directed Payments DPH QIP 2024 05.pdf
  - CY 2023 Directed Payments DMPH QIP 2024 05.pdf
  - CY 2023 DP-NF Pass-Through 2024 05.pdf
  - CY 2023 Medi-Cal DPH QIP and DMPH QIP Directed Payment Summary 2024 05.xlsx

All other rating elements not addressed in this revision remain unchanged from the CY 2023 capitation rates delivered previously.

This revision describes the updates 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.

Overview

The revised capitation rates for the DHCS Two-Plan, Geographic Managed Care (GMC), Regional, and County Organized Health Systems (COHS) models managed care programs 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 21, 2022 certification report, the July 14, 2023 amendment, and any corresponding supporting documents.

Section 2
Revision Details

Base Data

UIS Federal Percentage Development

As described in the original rate certification report, the UIS base data was collected in total across both federal and State-only services, and federal percentages separately developed by COA and category of service (COS) were used to limit the UIS base data to be specific to federally eligible services only. Subsequent to the release of the original capitation rates, it was determined that updates to the logic to identify federally eligible services was needed. Specifically, the logic used to identify emergency services was updated to include a more robust identification of dialysis services and exclude non-emergent transportation services inadvertently identified as emergency. As a result of these updates, the base data for the UIS population was updated to include more dialysis services and fewer transportation services. Consistent with the original capitation rates and base data time period, State fiscal year (SFY) 2020–2021 encounter data was utilized in making these updates. The methodology used is consistent with what was used in the development of the original CY 2023 rates, with the revisions to the logic applied. Please refer to the original certification report, *CA CY 2023 (01 01 2023 – 12 31 2023) Rate Cert Report 2022 12.pdf*, dated December 21, 2022, for additional detail regarding development of UIS federal percentages.

CalOptima Hospice Base Data

Similar to LTC facilities, Hospice room and board services were subject to a 10% payment level increase during the public health emergency (PHE). DHCS made a policy decision to extend the 10% increase to specific facilities regardless of the end date of the PHE. This payment level increase was not explicitly accounted for in the Hospice program change, but was assumed to already be in effect during the base period. As part of the Coronavirus Disease 2019 temporary unit cost increase carve out adjustment described in the original certification report, these costs were inadvertently carved out for CalOptima. This carve out amount (approximately $93 thousand) has been added back to CalOptima's base experience.

Program Changes

Populations Transitioning from Fee-for-Service to Managed Care

Full-Duals and LTC Utilizers in Non-LTC Aid Codes Transitioning from Fee-For-Service to Managed Care (CalAIM — Phase II)

This portion of the amendment was necessary to address uncertainty in rate-setting related to health plan selection/assignment for LTC utilizers in non-LTC COAs and Full-Dual beneficiaries transitioning from fee-for-service (FFS) to managed care. Mercer's initial assumed distribution of these members to transition to each health plan in a given county for CY 2023 rate development was based on existing member distributions by COA group. The Seniors and People with Disabilities (SPD) and SPD/Full-Dual COA groups are most at risk for large impacts if the proportion by plan of members transitioning greatly differed from what was assumed in the original rates. Since LTC utilizers cost significantly more than non-LTC utilizers on average and are embedded in capitation rates based on aid code, it is necessary to recognize differences in how these members transitioned to the health plans from FFS (e.g., if Plan A has 2% of their population for a specific COA residing in an LTC facility and Plan B has 1% residing in an LTC, Plan A's per member per month [PMPM] costs can be expected to be significantly higher than Plan B, where original assumptions assumed equal mix for each plan). Given the lower volume of LTC utilizer members and associated impact for the Child, Adult, and Affordable Care Act (ACA) Expansion COA groups, Mercer did not make any amendments to the rates related to this risk for these COA groups.

Mercer reviewed the volume of SPD and SPD/Full-Dual transitioning members for CY 2023 using the following methodology:

1. Created a roster of SPD and SPD/Full-Dual FFS members in 4Q2022 that were deemed eligible to transition to managed care beginning January 1, 2023.
2. Members for this roster were identified consistent with the transitioning population program change process in the original rates, and were classified as either a Full-Dual Beneficiary or an LTC utilizer in a non-LTC COA.
3. Health plan assignment was reviewed for these members within January 2023 through May 2023 eligibility information to determine revised health plan distributions.
4. Using the difference in rates/revenue when comparing resulting rates using the actual distribution of enrollment compared to the assumed distribution of enrollment in the original rates, Mercer determined a rate adjustment was necessary if the impact to total Medi-Cal revenue for a given plan by county/region was greater than 1.0% (positive or negative). There were multiple counties where this occurred and only rates in these counties were updated for this.

5. Rate amendments are applied to all health plans in a county, and to both SPD and SPD/Full-Dual, when at least one health plan in that county triggers the revenue impact threshold.
6. For each adjusted county/region, LTC utilizer transitioning distributions were updated for the SPD COA, while both LTC utilizer and Full-Dual transitioning distributions were updated for the SPD/Full-Dual COA.
7. The volume of transitioning members by county/region and COA were not adjusted from the original rating assumptions (i.e., health plan redistribution only)
8. The UIS population was not adjusted from the original rating assumptions due to low member volume for LTC utilizers.

These adjusted transitioning distributions were then used to re-calculate the plan-specific program change adjustments for the Full-Duals transitioning from FFS to managed care and LTC utilizers in non-LTC aid codes program changes, based on a more accurate distribution to each health plan.

ICF-DD and SA LTC Populations (CalAIM — Phase II)

In the original development of the CY 2023 capitation rates, the ICF-DD population was originally assumed to transition from FFS to managed care in all Two-Plan, GMC, and Regional model counties on July 1, 2023. Additionally, the SA population was originally assumed to transition in all Two-Plan, GMC, and Regional model non-Coordinated Care Initiative (CCI) counties on July 1, 2023. After the development of the original version of these rates, the implementation of this transition was delayed to January 1, 2024. Therefore, the adjustment originally applied for this program change was removed in this amended version of CY 2023 capitation rates.

The resulting relativity factors for all transitioning populations were ultimately aggregated across all transitioning population adjustments, including those from the prior original development of capitation rates that were not updated, to arrive at the final adjustment applied for all transitioning populations. This was done by MCO, COA, and COS for both the Satisfactory Immigration Status and UIS populations separately.

CGM

Effective January 1, 2022, CGM became a covered benefit for members aged 21 years and older with Type 1 Diabetes. In addition, after the development of the original version of these rates, CGM was established as a partially carved out service under Medi-Cal Rx, meaning that CGMs are covered by the health plans (and not FFS) if billed on a non-pharmacy claim.

In the original version of these rates, all CGM costs were identified within the SFY 2020–2021 base period and fully carved out of rate development through the Medi-Cal Pharmacy and Durable Medical Equipment Carve-Out base data adjustment. Mercer utilized CY 2022 encounters (January 1, 2022 to

December 31, 2022) to project costs pertaining to the expansion of this benefit, as well as to address the benefit becoming a partially carved out service. The adjustment excluded any CGM costs billed on pharmacy claims, as these costs will be reimbursed through FFS via Medi-Cal Rx.

AB 97 Buybacks

This adjustment in the original CY 2023 rates used the original logic to identify State and federal services. Due to the updates in the logic for dialysis and transportation services, this adjustment was updated accordingly to more appropriately classify services subject to the AB 97 buybacks as State or federal. This update only affected the UIS federal capitation rates. Specifically, a bigger portion of this adjustment was classified in the federal component of the UIS capitation rates, since the original logic was not completely identifying dialysis services as federally eligible.

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 Capitation Rate Calculation Sheets (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 in the original certification report.

MOTs

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 2023 case rates for the UC hospital system. The CY 2023 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 was 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 2023.

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

In the original development of the CY 2023 capitation rates, specialty mental health services in Sacramento and Solano counties for Kaiser members were originally assumed to transition from Managed Care to FFS on July 1, 2023. As a result, the initial capitation rates for Kaiser in Sacramento County and Partnership HealthPlan of California (PHC) in Solano County were different for the first six months and the

second six months of the CY 2023 contract period, with the only difference between the two sets of rates being the application of this PMPM add-on for the first six months but not the second six months. After the development of the original version of these rates, the implementation of this transition was delayed to January 1, 2024. Consistent with this delay in transition to FFS, the original six-month add-on PMPMs are now applicable for the entire CY 2023 contract period. Hence, there is no longer a difference in PMPM between the first six months and second six months for Kaiser in Sacramento County and PHC in Solano County in this amended version of CY 2023 capitation rates.

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 Maintenance of Eligibility (MoE). At the time of the original development of the CY 2023 capitated rates, the MoE end date was assumed to be January 2023, with enrollment beginning to drop in March 2023 (see column A in the exhibit below). Subsequently, the MoE end date was determined to be March 2023, with enrollment beginning to drop in July 2023. Mercer updated the initial analysis (described in detail in the original certification) with the actual 2023 enrollment which reflected the halt in disenrollments occurring later into the rating period. Part of the update to the initial analysis was to remove the 50% dampening element that was included in the prior calculations prior to the output of the final factors (see column B in the exhibit below).

This update, along with the updated enrollment within the initial assumptions was then blended with more current acuity factors developed utilizing the identification of actual members disenrolling during July 2023, August 2023, and September 2023. Leveraging this member information, encounter data was reviewed for the SFY 2021–2022 base period, as well as more recent encounter data through June 2023. Mercer analyzed and compared PMPM costs along with the portion of each group that were non-utilizers. Additionally, using the CDPS+Rx risk model, the risk scores were also compared for leavers versus non-leavers. In each of the comparisons noted, Mercer varied the classification of leavers to measure the sensitivity of the results. Some examples of different iterations of leaver classification are: those who left in July 2023 only, those who left in July 2023 and remained disenrolled through September 2023, and all those who were disenrolled as of September 2023. Currently, there are no data yet to suggest early leavers will have significantly different acuity than those who will disenroll later in the unwinding. Mercer also varied the time periods used for the comparisons, looking at different date ranges across July 2021 through June 2023. The results were very consistent across the various methods used in the current analyses, all demonstrating leavers are lower cost PMPMs, higher percent non-utilizer, and lower risk scores (see column C in the exhibit below for these results).

To reflect an equal balance of both approaches, Mercer used a 50/50 blend of the newer assumptions with the updated prior assumptions used in the original version of

the rates (see column D in the exhibit below for the final adjustment factors). Considering the volatility of the approaches, this even distribution of impacts is appropriate to balance the original components of rate development with the emergence (though limited to three months) of newer information.

The updated analyses resulted in the following adjustments (statewide averages, column D):

	[A]	[B]	[C]	[D] = Avg [B] & [C]
COA	Prior Method Original Enrollment	Prior Method Updated Enrollment	New Method	Final Adj.
Child	0.0%	0.0%	-1.4%	**-0.7%**
Adult	-0.5%	-1.7%	-5.9%	**-3.8%**
ACA OE	-0.3%	-0.8%	-5.5%	**-3.1%**

MCO Tax

Effective January 1, 2020, CMS approved an MCO tax for applicable full-service healthcare plans and their various lines of business. This tax approval expired on December 31, 2022. DHCS submitted another MCO tax proposal, which was approved retroactively by CMS to be effective April 1, 2023 through December 31, 2026. To calculate the total tax liability for each MCO, DHCS utilized enrollment from a prior year. Based on this enrollment period, each MCO's member months (MMs) were taxed at specific per member rates, categorized by tiers, which also varied depending on the member's type of coverage (Medicaid versus Non-Medicaid). Included below is a table summarizing the submitted tax structure for the applicable tax year, CY 2023.

CY 2023 MCO Tax Structure

Medicaid		Non-Medicaid	
Member Range	Tax Per Member	Member Range	Tax Per Member
0–1,250,000	$0.00	0–1,250,000	$0.00
1,250,001–4,000,000	$182.50	1,250,001–4,000,000	$1.75
4,000,001+	$0.00	4,000,001+	$0.00

For the CY 2023 calculations, Mercer used actual membership for April 2023 through December 2023 (informed by enrollment data through December 2023) to divide out each MCO's CY 2023 tax liability and develop the MCO tax PMPMs.

These PMPMs are added to the capitation rates after the blend of the plan-specific and risk-adjusted county average rates and, consistent with the MCO's tax liability, are only effective for nine months of the rating period (April 2023 through December 2023). Please also note that under the approved tax model, Aetna is not subject to any MCO tax for Medi-Cal members.

Risk Adjustment County/Region Average

With the update of enrollment to rely on actual CY 2023 MMs, updates were made to the county average rate calculation and the budget neutral risk score calculation within the risk-adjustment process. The original rates utilized projected MMs 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 MMs in both calculations. Specific to the risk-adjustment process, no changes were made in the calculation of the MCO-specific unadjusted risk scores; the only changes made were to the county average risk scores. As a result, the final budget neutral risk scores changed slightly.

Section 3

Special Contract Provisions Related to Payment — Revisions

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

- State directed payments
- Pass-through payments

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

State Directed Payments

There are several State directed payments applicable to the Two-Plan, GMC, Regional, and COHS model CY 2023 capitation rates. Directed payments, which are being revised in this amendment, are summarized in the table below. The following subsections provide more detail around each initiative. There have been no changes made to any other State directed payments not addressed in this revision.

Control Name of the State Directed Payment	Type of Payment	Brief Description	Is the Payment Included as a Rate Adjustment or Separate Payment Term?
CA_VBP_IPH.OPH2_Amend_20210101-20231231 — DPH QIP	Quality/performance payments	Payments based on performance on designated measures with specified maximum allowable payments for each DPH	Separate payment term
CA_VBP_IPH.OPH_Amend_20210101-20231231 — DMPH QIP	Quality/performance payments	Payments based on performance on designated measures with specified maximum allowable payments for each DMPH	Separate payment term

There are no additional directed payments in the program for CY 2023 that are not addressed in either this amendment or in the original rate certification. There are no requirements regarding the reimbursement rates the health plans must pay to any providers unless specified in the certification or this amendment as a directed

payment or pass-through payment, or authorized under applicable law, regulation, or waiver.

The following directed payments outlined below are paid as separate payment terms, and the actual payments associated with these directed payments will be paid in the future. A summary of the separate payment term directed payments, which are being revised in this amendment, 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	Magnitude on a PMPM Basis	Confirmation the Rate Development is Consistent with the Preprint	Confirmation that the State and Actuary will Submit Required Documentation at the End of the Rating Period (as applicable)
CA_VBP_IPH.OPH2_Amend_20210101-20231231 — DPH QIP	$2,040.32 million	The actuary certifies the incorporation of the separate payment term	See pink labeled columns in file titled *CY 2023 Medi-Cal DPH QIP and DMPH QIP Directed Payment Summary 2024 05.xlsx* for the PMPM estimates	Confirmed; the preprint is approved	Confirmed
CA_VBP_IPH.OPH_Amend_20210101-20231231 — DMPH QIP	$192.06 million	The actuary certifies the incorporation of the separate payment term	See exhibit referenced above	Confirmed; the preprint is approved	Confirmed

DPH QIP — Revised

The DPH QIP directed payment preprint encompassing the CY 2023 rating period was approved by CMS on December 27, 2023, under control name CA_VBP_IPH.OPH2_Amend_20210101-20231231. The preprint revision adjusted the directed payment pool amount to $2,040.32 million for the 12-month CY 2023 rating period and made no other changes to the payment structure. 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 DPH QIP 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 gross medical expense (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 DPH QIP directed payment is targeted to be approximately $2,040.32 million. The attached exhibit (*CY 2023 Directed Payments DPH QIP 2024 05.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 DPH QIP and DMPH QIP Directed Payment Summary 2024 05.xlsx*), as noted previously. All other directed payments not mentioned in this amendment are unchanged from the prior certification.

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.

DMPH QIP — Revised

The DMPH QIP directed payment preprint encompassing the CY 2023 rating period was approved by CMS on December 27, 2023, under control name CA_VBP_IPH.OPH_Amend_20210101-20231231. The preprint revision adjusted the directed payment pool amount to $192.06 million for the 12-month CY 2023 rating period and made no other changes to the payment structure. 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 DPH QIP estimates. The DMPH QIP 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 $192.06 million. The attached exhibit (*CY 2023 Directed Payments DMPH QIP 2024 05.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 DPH QIP and DMPH QIP Directed Payment Summary 2024 05.xlsx*), as noted previously. All other directed payments not mentioned in this amendment are unchanged from the prior certification.

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.

Pass-Through Payments

DP-NF Pass-Through Payment

This new pass-through payment is for public DP-NF services transitioning from the FFS delivery system to the managed care delivery system under 42 CFR § 438.6(d)(6). The pass-through payment transitions existing State Plan-approved supplemental payments for DP-NF services that will be covered for the first time under a managed care contract following the carve-in of LTC services from the FFS delivery system. The transition of these services began on January 1, 2023.

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

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

and in total, which formed the basis for creating an estimated uniform dollar add-on payment that would total the intended pass-through payment target amount.

The total target impact of $100.6 million is projected across all counties in which DP-NF services are transitioning from FFS to managed care (non-COHS and non-CCI counties), where public DP-NF facilities exist, for the 12-month rating period, which is inclusive of only federally eligible days. The development of these add-on amounts did not impact the underlying data or assumptions associated with the regular development of the capitation rates. No additional administrative load or underwriting gain is included within these add-on amounts for DP-NF.

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

Included is an attachment labeled *CY 2023 DP-NF Pass-Through 2024 05.pdf* containing the detailed components behind these calculations. The resulting PMPM add-on rates by rate cell are provided in the "Sum — Add-On Details" tabs within the attached spreadsheet *FINAL CY 2023 Medi-Cal Detail CRCS Package LB Rate Smry 2024 05.xlsx*.

DP-NF Pass-Through Payment Base Amount Calculation

Consistent with 42 CFR § 438.6(d)(6)(iii), DHCS provided Mercer with the most recent known interim amount of FFS supplemental payments made two years prior to the first rating period of the transition period (CY 2021 payments) for the impacted transitioning counties. As defined in the State Plan-approved documentation for these supplemental payments, the finalized payments for CY 2021 will not be made available until late 2025. As such, these interim payment amounts serve as the starting point for the DP-NF pool amount development, totaling $113.1 million.

From there, and consistent with 42 CFR § 438.6(d)(6)(iii)(B), the volume of DP-NF days in FFS was reviewed for the CY 2021 and CY 2023 time periods to determine the share of public DP-NF days transitioning from FFS to managed care. This proportion of managed care DP-NF days to total DP-NF days resulted in a reduction factor of 79.4% to the aforementioned total DP-NF pool amount (i.e., 20.6% of days remained in FFS in CY 2023). This decreased the CY 2021 pool amount to $84.1 million for managed care.

Finally, and consistent with direction given by CMS, this CY 2021 pool amount was adjusted forward to represent CY 2023 dollars by applying LTC program change factors based on the FFS DP-NF rate increases that went into effect between CY 2021 and CY 2023. Applying these LTC program changes for a duration of two years to the impacted counties increased the total DP-NF pool amount to $100.6 million, which is the final amount utilized in the DP-NF estimated uniform dollar increase and PMPM impacts described above.

Section 4

Certification and Final Rates

This certification assumes items in the Medicaid State Plan or Waiver, as well as the managed care organization (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,

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