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

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

Section 1

Executive Summary

The State of California Department of Healthcare 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, 2022 through December 31, 2022 (CY 2022). The capitation rates that are the subject of this certification report include those developed for the following models:

- Two-Plan
- Geographic Managed Care (GMC)
- Whole Child Model (WCM)
- Regional
- County Organized Health Systems (COHS)
- Coordinated Care Initiative (CCI) Medi-Cal Only and partial dual-eligible beneficiaries

Note the 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 2021–2022 Medicaid Managed Care Rate Development Guide dated June 2021, which is the applicable version of the guide for CY 2022. 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 2022 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 2021 certified capitation rates, can be found in the attached files, listed below:

- *FINAL CY 2022 Medi-Cal Detail CRCS Package LB Rate Smry 2021 12.xlsx*
- *FINAL CY 2022 CA CCI Medi-Cal Only & Partial Dual Rate Ranges 2021 12.xlsx*
- *FINAL CY 2022 Medi-Cal BHT Supp Rate Exhibits 2021 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 2022 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. Another significant change is the decision to carve retail pharmacy out of the managed care program effective January 1, 2022. Other changes are also effective during the CY 2022 rating period, all of which are described later in this report.

There are specific capitation rates at the MCO, county/rating region, and COA level, which had large positive or negative changes when compared to the prior capitation rates (CY 2021). Within the files listed above, there is a tab labeled "Large Changes" that describes the drivers of the change for particular capitation rates that had large changes. The drivers of the change are described for any capitation rate that had a change greater than 10% or less than -1% when compared to the CY 2021 capitation rates. The changes are described with the inclusion of the COVID-19 per member per month (PMPM) add-on within the CY 2021 rates but excluding the Pharmacy PMPM add-on, compared to the CY 2022 rates prior to any PMPM add-ons, as this provides for an apples to apples comparison. This comparison is done after the application of the blended risk-adjusted rate process and before the add-on PMPMs are applied. Beyond the changes described in this comparison, various other items contribute to the overall change in the certified capitation rates. These items include the pharmacy carve-out, the MCO tax, directed payments, pass-through payments, and elements of the CalAIM initiative including major organ transplants (MOTs) as a covered benefit in non-COHS counties and enhanced care management (ECM) rate add-ons. Overall, the aggregate capitation rate change from the CY 2021 to CY 2022 capitation rates was -7.2% for the Two-Plan, GMC, Regional, and COHS models, and -4.3% for the CCI Non-Dual Institutional population. The decreases in the capitation rates are mainly driven by the pharmacy carve-out, with pharmacy services applicable for the CY 2021 capitation rates but not the CY 2022 capitation rates.

There will be two different sets of capitation rates applicable for CY 2022, since Proposition 56 (Prop 56) budget appropriations end for the value based purchasing (VBP) program effective June 30, 2022. As a result, the VBP PMPM add-on is applicable for the first six months of CY 2022 and not effective for the second six months of CY 2022. The certified rates differ for the two time periods due to this, with all other rating elements unchanged.

Throughout the full 12-month rating period, the base plan-specific, county average capitation rates, and risk-adjustment calculations (before the application of add-ons) are the same for the entire 12-month period.

It should also be noted there will be a future amendment to this certification that will be submitted to CMS. Certain assumptions material to the rates in this certification depend on the status of the public health emergency (PHE). This rate certification assumes the PHE will conclude on December 31, 2021. A future amendment may be submitted to CMS if there are material impacts to the program due to the length of the PHE.

In addition, California provides full-scope coverage to beneficiaries 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). These UIS members are federally eligible to receive pregnancy and emergency related services. Within the rates calculated within this certification, capitation rates are set at the COA level, and the UIS and SIS members are embedded together within all COA groups. Through communication with CMS, it has come to DHCS and Mercer's attention that these UIS members should be separated from the SIS population for capitation rate development purposes. In a future rate certification amendment, the UIS and SIS members will be separated, and capitation rates will be calculated separately for both populations. Further for the UIS population, the future rate certification amendment will only certify to the federally eligible services for this population.

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.

Since 2014, DHCS currently administers a 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 are responsible to cover all long-term care (LTC) services for their members age 21 or older. For the CCI program, the capitation rate development process is done separately for members with full Medicare and Medicaid

coverage (Full-Dual eligible members), and is not part of this certification report. Capitation rate development for non-dual and partial-dual eligible members is covered within this certification. Unless otherwise noted, references to CCI within this certification refer to non-dual and partial-dual eligible beneficiaries only.

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 *FINAL CY 2022 Medi-Cal Detail CRCS Package LB Rate Smry 2021 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.
- Kaiser Foundation Health Plan (Kaiser) only 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 Health Plan 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 in CY 2022 in paying one single capitation rate by COA for each of these health plans spanning multiple counties. To develop the region rate in each of these instances, the county rates by COA and MCO were blended together using a weighted average of each county rate by COA and MCO using projected CY 2022 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 2022, there are 24 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 *FINAL CY 2022*

Medi-Cal Detail CRCS Package LB Rate Smry 2021 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, certain mental health (MH) services for members with mild to moderate MH needs and conditions are covered.

There are differences in covered services that do exist between the COHS and non-COHS managed care models as well as the CCI program. These differences are noted below:

In all COHS counties and for CCI beneficiaries within Two-Plan and GMC counties, LTC services are covered for the entire period in which a member resides in a LTC facility. For all other recipients (members under age 21 or classified as ACA Expansion members in Two-Plan and GMC CCI counties, all members in non-CCI, Two-Plan, and GMC counties and all members in Regional model counties), LTC services are covered for members who reside in a facility for the month of admission plus one additional full month.

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).
- 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 under their new dental pilot program.
- Administration of 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, there are three major benefit/service changes effective January 1, 2022. These include the following:

- MOTs in Two-Plan, GMC, and Regional counties (these are already covered in COHS counties and currently, only kidney and corneal transplants are covered in non-COHS counties.)
- ECM services
- 14 Community Supports services are now allowable in the managed care contracts as “in lieu of” services [ILOS] in accordance with 42 CFR §438.3(e)

Additional benefit changes effective during the CY 2022 rating period are the following:

- Doula services
- Dyadic Health Care (DHC) services
- Rapid Whole Genome Sequencing (rWGS)
- Community Health Worker (CHW)

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. Notable exceptions to mandatory managed care enrollment are beneficiaries dually eligible for Medicare in non-CCI and non-COHS counties, as well as members residing in San Benito County (regardless of dual eligibility status). Managed care enrollment is voluntary in these instances.

As part of the CalAIM initiative, various additional populations will become enrolled in managed care effective January 1, 2022, who were previously enrolled in fee-for-service (FFS). These populations are listed below.

- 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

Also through the CalAIM initiative, beneficiaries in the COHS model and CCI counties with share of cost (excluding LTC aid code members) and Omnibus Budget Reconciliation Act (OBRA) beneficiaries in Napa, Solano, and Yolo counties will be disenrolled from managed care. These beneficiaries will receive coverage through the FFS delivery system.

Additionally, the State will enroll members age 50 and above without SIS into managed care. Additional details on the transitioning populations can be found in the "Program Changes" section of this report.

Within the CCI counties, Medi-Cal recipients aged 21 and older eligible for full Medicare benefits (defined as having Part A and Part B Medicare coverage) are covered within the Medi-Cal program, but are enrolled in the CCI program. Rates developed for the Full-Dual CCI members are included in a separate capitation rate package with a separate certification. An exception to this is Full-Dual members with an ACA Expansion aid code. These members are not eligible for the CCI program and are included within the SPD/Full-Dual COA group for capitation rate payment purposes.

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.

Share of cost members (recipients who establish eligibility for Medicaid by deducting incurred medical expenses) are not part of the non-CCI Two-Plan, GMC, and Regional managed care population; therefore, none of these costs are included in the development of the Two-Plan, GMC, and Regional rate ranges. Share of cost members are part of the COHS managed care population and the Institutional populations (only) in CCI counties. As noted previously, these share of cost members (excluding LTC aid code members) will be transitioned to FFS effective January 1, 2022.

Rate Structure

The base data sets used to develop the Two-Plan, GMC, Regional, and COHS CY 2022 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
- SPD/Full-Dual

  - In non-CCI counties, this COA consists of SPD/Full-Dual members (all ages) and dual eligible members with an ACA Expansion aid code.
  - In CCI counties, this COA consists of SPD/Full-Dual members under age 21 and dual eligible members with an ACA Expansion aid code.
- LTC (COHS counties only)
- LTC/Full-Dual (COHS counties only)
  - In non-CCI COHS counties, this COA consists of all Full-Dual eligible beneficiaries with an LTC aid code, for all ages
  - In CCI COHS counties, this COA consists of all Full-Dual eligible beneficiaries with an LTC aid code, only for beneficiaries under the age of 21
- Institutional (applicable in Two-Plan and GMC CCI counties only)
- WCM (COHS counties only, not included in Ventura County)

Supplemental Payment Groupings

- Behavioral Health Treatment (BHT)
- Maternity

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 (BHT and maternity). Services specific to the supplemental payments 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 the supplemental payments is provided later in this certification report.

Note the Hepatitis C and HCBS High supplemental payments from prior years are no longer applicable for CY 2022. Hepatitis C supplemental payments are no longer applicable due to the pharmacy carve-out. The HCBS High supplemental payments (CCI counties only) are no longer applicable as Multipurpose Senior Support Program (MSSP) services will be carved out of managed care effective January 1, 2022, and a decision was made to move CBAS costs into the capitation rates starting then. Additional details for the HCBS High supplemental payment discontinuation are discussed 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 the regular California 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 Breast and Cervical Cancer Treatment Program (BCCTP) population (now a subset of the SPD population) who meet federal standards, the CHIP population, and the ACA Expansion population. For CY 2022, the BCCTP and CHIP populations receive 65% FMAP. For CY 2022, the ACA Expansion population receives 90%.

DHCS uses aid codes in its capitation payment system to identify qualifying recipients for higher FMAP. With certain exceptions, such as individuals who do not have SIS for whom federal financial participation is available for emergency and pregnancy related services only, the full capitation rate for these recipients receives the higher FMAP.

The COA groups for which capitation rates are paid are tied to the aid codes and since FMAP is also tied to these aid codes, there is an apparent but non-substantive relationship between FMAP and the COA groups. The most expensive COA groups are the Institutional, 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 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 point increased FMAP percentage applies to the standard 50% FMAP, and smaller increases apply to the BCCTP and CHIP population FMAPs.

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

In addition to the populations that receive enhanced FMAP, there are services for which the State receives a different FMAP than the regular FMAP, which applies on a population basis. 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.

Rate Methodology Overview

Capitation rates for the Two-Plan, GMC, Regional, COHS, and CCI 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, COHS, and CCI models. However, the actuaries are certifying to a rate within the developed rate range.

For rate range development for the Two-Plan, GMC, Regional, COHS, and CCI model MCO populations, Mercer used CY 2019 MCO-reported encounter data, the CY 2019 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, COHS, and CCI 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 calendar year (CY 2019 for the CY 2022 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 2022. 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 a BHT 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 2022 Two-Plan, GMC, Regional, COHS, and CCI 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 2022 internal rate ranges utilize a full rebase incorporating the most complete and current data period (CY 2019). 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% — 13.85% (upper bound non-medical load) = **86.15%.**
  - Assumed lower bound MLR: 100% — 10.05% (lower bound non-medical load) = **89.95%.**
- COHS models:
  - Assumed upper bound MLR: 100% — 13.50% (highest upper bound non-medical load across COHS plans) = **86.50%.**
  - Assumed lower bound MLR: 100% — 10.50% (highest lower bound non-medical load across COHS plans) = **89.50%.**
- CCI Institutional in Two-Plan and GMC models: 100% — 4.60% (highest upper bound non-medical load) = **95.40%.**

The State has chosen to not impose remittance provisions related to this MLR for CY 2022.

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 “best 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), ad hoc claims data, and DMHC-required Medi-Cal specific financial reporting. CY 2019 served as the base data period. The CY 2019 encounter and CY 2019 RDT claims data included utilization and unit cost detail by COA group, by county/region, by MCO, and by 19 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
- Pharmacy
- Laboratory and Radiology
- Transportation
- CBAS
- Hospice
- MSSP
- In-Home Supportive Services (IHSS)
- 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. 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 abortion. Mercer has relied on data and other information provided by the MCOs and DHCS in the development of these rate ranges. Mercer has reviewed the data and information for reasonableness and Mercer believes the data and information utilized in the rate development to be free of material error and suitable for rate range development purposes for the populations and services covered under the Two-Plan, GMC, Regional, and COHS model contracts. Mercer did not audit the data or information, and if the data or information is materially incomplete or inaccurate, Mercer's conclusions may require revision. However, Mercer did perform alternative procedures and analyses, which provide a reasonable assurance as to the data's appropriateness for use in capitation rate development under the State Plan.

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 may be missing from providers who are paid via a capitation arrangement), and not reflective of all liabilities still outstanding for the CY. These factors were developed uniformly for all MCOs (they are not plan-specific factors) by COS. 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 a few exceptions (WCM, Kaiser, Aetna Better Health [Aetna], and United Healthcare [United] in all counties/rating regions, detailed below), which are consistent with the base data development process described for these unique instances previously.

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 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 as follows:

- Hospital Adjustments
- MH Services for Members Diagnosed with Severe Mental Illness Carve-Out
- Pharmacy Carve-Out
- BHT Carve-Out and Comprehensive Diagnostic Exam (CDE) Reallocation
- MSSP Carve-Out
- Global Non-Medical Expense Adjustment
- MH — OP
- Provider Incentive Adjustments
- SPD/Full-Dual Non-Covered Services Adjustment
- “Value Added” Services Adjustment
- Molina Transportation
- CalOptima Base Data Adjustment
- LA County Cost-Based Reimbursement Clinics (CBRC)
- Hemlibra®
- Blue Shield of California Systems Conversion
- Santa Clara Family Health Plan (SCFHP) Non-LTC Payments in LTC
- Removal of Globally Capitated Services Paid by Direct Plan
- CalOptima WCM Base Data Adjustment
- Kaiser, United, and Aetna Base Data Development

Hospital Adjustments

Adjustments to MCO reported hospital costs were necessary in some select cases. These adjustments occurred for four MCOs: HPSJ, San Francisco Health Plan (SFHP), CalOptima, and PHC. 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 throughout CY 2018 and 2019 dates of service. 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.

To appropriately account for this in the base data, DHCS/Mercer worked with HPSJ to identify the anticipated savings to develop an appropriate adjustment to apply to the base data. Data provided by HPSJ indicating anticipated future spend for the high cost drugs, compared to what was reported in the CY 2019 RDT, informed the adjustment applied. The following amounts were removed from the CY 2019 base data:

County	Dollars Removed
San Joaquin	~$1.5 million
Stanislaus	~$9.1 million

San Francisco Health Plan

SFHP communicated to DHCS/Mercer of an upcoming contract change 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 contract. SFHP reviewed CY 2019 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 increased the CY 2019 base data costs by approximately $20.0 million.

CalOptima

In prior rate setting periods, DHCS/Mercer adjusted the reported hospital capitation expenditures for the 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 CY 2019 were still not reflective of reasonable contracting levels, CalOptima provided the hospital capitation PMPM amounts through the end of CY 2020. This reporting showed, for the ACA Expansion COA, a continued decrease through to the second half of CY 2020 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 2020 to December 2020 period were de-trended, using the trend factors discussed later in the trend section, to the CY 2019 period. The differences between the reported CY 2019 levels and the de-trended go-forward amounts were removed in the following amounts for the ACA Expansion COA: approximately $42 million for IP,

approximately $10 million for OP, and approximately $4.5 million for ER. The same analysis showed no adjustment was necessary for other COA groups.

Partnership Health Plan of California

In prior rate setting cycles, PHC indicated they were in the midst of making significant changes to their hospital contracting arrangements. Overall, PHC indicated they were able to hold payment levels relatively flat because of these contract negotiations, with general decreases to the ACA Expansion COA and increases to other COAs. In review of the CY 2019 base data, hospital costs per day appeared to be more in line for the ACA Expansion COA compared to the other COA groups within the Northern PHC counties, while noticeable differences were still observed within the Southern PHC counties. A reduction of approximately $11.8 million was made to the CY 2019 base data for the IP COS for the Southern region only (no adjustment for the Northern region). This approximate $11.8 million reduction was derived by assuming PHC was able to hold contracted rates flat for 12 months and making a base data adjustment that reflected this, consistent with the feedback received from PHC regarding their ability to hold contracted rates flat. It should also be noted that while approximately $11.8 million was removed in total, approximately $25.3 million was removed from the ACA Expansion COA, and approximately $4.4 million was removed from the Child COA, while approximately $17.9 million was redistributed to the Adult and SPD COAs. This was done to be consistent with the contracting process done by PHC, in addition to bringing IP hospital costs per day in line across the COAs.

Across the Two-Plan and COHS models (there were no hospital adjustments within the GMC or Regional models); these hospital pricing adjustments resulted in a net removal of approximately $58.9 million from the CY 2019 base data.

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

For members covered by Kaiser in Solano County, MH services to treat beneficiaries with a serious mental illness (SMI) services have historically been included in the subcapitation rate paid by Partnership South Health Plan to Kaiser. This adjustment removed $1.7 million paid by Partnership to Kaiser for SMI services from the Solano County base data leveraged for CY 2022 rate setting. Costs associated with these services will now be included as a capitation rate add-on outside of the base capitation rates. This process was done since there has been discussion of potentially excluding these services from the benefit package for Kaiser in Solano County in the future, but this exclusion has been delayed until after the CY 2022 rating period.

Pharmacy Carve-Out

Effective January 1, 2022, retail pharmacy services will be carved out of managed care and covered by the State through the FFS delivery system. Specifically, the following pharmacy benefits when billed by a pharmacy 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, based on MCO RDT reporting. The RDT data source was reviewed and validated against encounter data for reasonableness.

For the CY 2019 period, approximately $5.4 billion in pharmacy costs were removed from the base data across the Two-Plan, GMC, Regional, and COHS models.

BHT Carve-Out and Comprehensive Diagnostic Exam Reallocation

Since DHCS utilizes a supplemental payment to reimburse the MCOs for costs associated with BHT services, it is necessary to remove BHT costs from the capitation rates. The MCO-reported CY 2019 base costs for BHT services also included amounts for CDEs. However, beginning July 1, 2019, CDEs were no longer covered under the BHT supplemental payment, and instead are covered under the capitation rate. Within the CY 2019 RDT, MCOs reported all costs for both BHT services for direct members as well as the BHT supplemental payments made to global subcontractors. Separately in the RDT, the MCOs are required to report monthly cost and utilization information separately for BHT services performed for their beneficiaries. Using this separately reported data, the BHT costs as reported by the MCOs were removed from the BHT COS line. Further, the BHT supplemental payments made to global subcontractors included costs specific to CDEs; those costs related to CDEs were moved from the BHT COS line to the NPP COS line. For validation purposes, the MCO-reported BHT data was reviewed against historical BHT utilization and therapy costs per hour over time by MCO in addition to being compared to regional and statewide figures. This data was reviewed and discussed with each MCO as part of the rate development process. No adjustments were made to the RDT-reported information.

For the CY 2019 period, approximately $490 million of BHT cost was removed from the base data across the Two-Plan, GMC, Regional, and COHS models. No CDE costs were removed from the base data, but approximately $1.3 million in CDE cost was reallocated (in a budget neutral fashion) to the NPP COS line.

MSSP Carve-Out

Within CCI counties in prior rating periods, DHCS utilized a supplemental payment to reimburse the MCOs for costs associated with HCBS (i.e., IHSS, CBAS, and MSSP services). Effective January 1, 2018, IHSS were carved out of the managed care contracts and were therefore not included in the RDT reported data for the CY 2018 period. Effective January 1, 2022, MSSP services will also no longer be a managed care covered benefit, and as a result it is necessary to remove MSSP costs reported in the CY 2019 base experience in CCI counties, since none of these costs will be paid for within the capitation rates. To remove the costs associated with these services, the RDT-reported amounts for each of these COS lines were removed. CBAS is the only remaining service for the CY 2022 contract period associated with the historical HCBS High supplemental payment. As such, that supplemental payment no longer applies for CY 2022 rates, and MCO reimbursement for CBAS is now included within the capitation rates for all COA groups.

For the CY 2019 period, approximately $2.1 million of MSSP costs were removed from the base data across the CCI counties.

Global Non-Medical Expense Adjustment

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 health plan) to administer managed care coverage for some of their Medi-Cal population. The member

months (MMs) capitated and the capitation amounts paid in these arrangements are reported within the RDT by rate cell 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. 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 CY 2019 base data, these non-medical data elements are considered when developing the broader non-medical capitation rate loads.

For CY 2019, the following factors were used to remove non-medical loads from reported global subcapitation payments in the RDT data: 5% for instances where the global subcontractor is Kaiser, 7% otherwise. Further, 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 and direct contractor experience, including 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 $217 million from the CY 2019 base data.

Mental Health–Outpatient

The coverage of MH services for recipients with mild to moderate MH conditions became a new managed care benefit on January 1, 2014. For the CY 2022 capitation rates, Mercer reviewed five years (January 2015 through December 2019) of Medi-Cal managed care MH services experience. Based on this data, it was clear the mild-to-moderate MH experience was not completely ramped up during the CY 2019 base data period. Data from Medicaid programs within other states, which cover similar MH services, were also used to help inform the expectation of utilization for the MH carve-in. The MH–OP PMPMs were developed by MCO, county/region, and COA group for all Medi-Cal managed care recipients.

The RDT-reported MH–OP COS line was adjusted using the analysis described in the preceding paragraph. This adjustment added approximately $81.8 million to the CY 2019 base data across all models.

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 2022. As a result, base data adjustments were made for multiple MCOs. The adjustments specific to each affected MCO are described below.

San Francisco Health Plan

Within the CY 2019 RDT, SFHP reported provider incentive dollars within their submission for a Strategic Use of Reserves (SUR) program which runs through June 30, 2019. 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 CY 2019 base data. SFHP also noted this program ended on June 30, 2019, prior to the start of CY 2022. Additionally, 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.

Santa Clara Family Health Plan

With moving their Provider Performance Incentive Program from a fiscal year to a calendar year basis, SCFHP reported incentive payments made to providers for overlapping time periods in the CY 2019 RDT (payments made for January 2019 through June 2019 were paid under the incentive program in effect for both July 2018 through June 2019 and January 2019 through December 2019). Through the discussion guide process, the MCO confirmed these payments, due to the overlapping time periods, allowed providers to earn more than they would in future years. Hence, the fiscal year payments (for July 2018 through June 2019) were removed from the CY 2019 base data to better reflect incentive payment levels in CY 2022.

CalOptima

CalOptima has a shared risk pool incentive arrangement with their professional providers, which pays professional providers an incentive if their delegated members stay under a specified budgeted amount for hospital costs. This arrangement exists for all COA groups. When reviewing PMPM costs specific to this incentive arrangement, it was noted the PMPM costs were disproportionately high for the ACA Expansion COA group compared to other COAs. Additionally, CalOptima also has a pay for value professional incentive program that rewards providers for meeting certain quality performance standards.

A majority of the ACA Expansion professional incentive payments were from the shared risk pool incentive, while the pay for value program made up the majority in the other COAs. An adjustment was applied to the incentive payment amount for the ACA Expansion population to reduce the total professional incentive payment to be 10% of total professional expenditures in the base data. The 10% assumption was derived using actuarial judgement, but also from reviewing incentive payment data across all MCOs for the ACA Expansion COA. When all MCOs' professional incentive dollars, as a percentage of total professional expenditures were lined up for the ACA Expansion COA, the following statistics show the distribution of the percentages across all plans (excluding CalOptima):

- Minimum Percentage: 0.3%
- Maximum Percentage: 20.0%
- Median Percentage: 2.5%
- Straight Average Percentage: 3.8%
- Eightieth Percentile Percentage: 5.0%

A broad 10% assumption was utilized as it was viewed as an appropriate amount in line with other MCO reporting, and took into consideration CalOptima reporting for other COA groups.

Additionally, this percentage is consistent with similar adjustments that have been applied to the ACA Expansion COA group in prior rate years.

California Health & Wellness

In 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 2022 rate development.

Across the Two-Plan, GMC, Regional, and COHS models, approximately $32.4 million was removed from the CY 2019 base data due to this adjustment.

SPD/Full-Dual Non-Covered Services Adjustment

Consistent with how DHCS makes capitation payments for this population, MCOs were instructed to report Medi-Cal beneficiaries with an ACA Expansion aid code and Full-Dual coverage (Medicare Part A and Part B) within the SPD/Full-Dual reporting bucket of the RDT. Historically, these members were grouped in the ACA Expansion COA group, but should not have been, since no dual-eligible beneficiaries should be included in this COA. In many instances, MCO contracting for these members was performed at the rate cell level, which did not include appropriate considerations for Medicare coverage. In the CY 2019 base data; this was especially an issue in situations where the MCO had capitation arrangements with providers. As such, an adjustment was needed for the SPD/Full-Dual rate cell to remove MCO payments for services that should be covered by Medicare, leaving only cost profiles that reflect Medicaid as a payer of last resort within the base data.

The adjustment was calculated in the following manner. For COS lines where a significant portion of costs are generally covered by Medicare (such as IP and professional services), the RDT data for these services were first compared to the prior year base data for the SPD/Full-Dual COA group (CY 2018) after the application of the Non-Covered Services Adjustment. The data was also compared to the CY 2017 base data after the application of the Medicare Part B/D efficiency analyses. If, in aggregate, PMPM costs for these Medicare-covered services exceeded 10% of the base PMPM costs seen in CY 2018, the PMPMs were adjusted to be 10% higher than the CY 2018 amounts. The adjusted CY 2019 data is more representative of a true Full-Dual population where Medicaid acts as the payer of last resort. For COS lines generally not covered by Medicare (namely, LTC, Transportation, and CBAS), no adjustments to the RDT-reported amounts were made (since the plan should have paid these costs as the primary payer and should continue to pay these costs as the primary payer going forward). After these adjustments were made to the reported RDT data, the SPD/Full-Dual data for each plan was run through a smoothing and credibility adjustment process to arrive at the final base data.

Additionally, Full-Dual beneficiaries with an ACA Expansion aid code in CCI counties are not eligible for the CCI program. As a result, if one of these members resides in a nursing facility (NF) for the month of admission, plus one additional month, the member should be moved into the FFS delivery system based on the MCO contracts specific to non-CCI populations. Through review of the RDT submissions, it was noted LTC PMPM costs for the

SPD/Full-Dual COA in Two-Plan and GMC CCI counties were much higher than anticipated. Through this review, it was determined some MCOs were not moving these ACA Expansion Full-Dual members into the FFS delivery system when they resided in a NF for the required period. Since months beyond the month of admission, plus an additional month, are much more costly than the average month for an SPD/Full-Dual member, an adjustment to the LTC COS line was made to account for this. To make this adjustment, the LTC PMPMs were reduced to a level more in line with other LTC PMPM levels for the SPD/Full-Dual COA in non-CCI counties, based on a smoothing and credibility adjustment process.

Across the Two-Plan, GMC, Regional, and COHS models, approximately $59.2 million was removed from the SPD/Full-Dual rate cell for the CY 2019 period.

Value-Added Services Adjustment

As part of the CY 2019 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 year (CY 2019), but were provided as value-added service. For the Two-Plan, GMC, Regional, COHS, and CCI model plans, 23 MCOs reported costs for value-added services within this section of the RDT, totaling approximately 0.2% of total medical expenditures across those health plans. Since the use of these value-added services was not defined in the MCO contracts, the costs reported by these health plans 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 ILOS. 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 get added back in as a program change adjustment, described later in this report.

Across all Two-Plan, GMC, Regional, COHS, and CCI models, approximately $30.5 million was removed from the CY 2019 base data as a result of this adjustment.

Molina Transportation

Contrary to appropriate practice where transportation to and from a CBAS facility should be billed to the CBAS facility by the transportation provider, and incorporated into the CBAS facility daily rate paid by MCOs to the CBAS facility, Molina was directly paying transportation providers for trips to and from CBAS facilities. This is in addition to paying a daily rate to the CBAS facilities, which already included a transportation component. These trips were therefore double-counted in the CY 2019 RDT. Effective October 2019, CBAS trips are no longer paid for by Molina separately. As such, while these CBAS trips were reported in the CY 2019 RDT, they have been removed from the base data as they would reflect transportation costs that would not be incurred in CY 2022. This adjustment resulted in an approximate $8.4 million decrease to the CY 2019 base data across all Molina counties.

CalOptima Base Data Adjustment

In addition to the hospital pricing and incentive adjustments mentioned above, a further base data adjustment was required for CalOptima. The CY 2019 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. As a result,

DHCS/Mercer adjusted the CalOptima reported ACA Expansion professional data downward to a targeted level equivalent of an 80/20 blend of the professional PMPMs for the Adult and SPD COA groups. This 80/20 blend was informed by the historical and on-going acuity reviews of the ACA Expansion COA group relative to Adult and SPD. This blend was further reviewed with comparable COHS model cost levels and deemed appropriate. The result of targeting this professional cost PMPM was the removal of approximately $42.5 million.

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 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 208 program change adjustments. For CY 2022, these costs are reflected within the base data. As a result of this adjustment, a PMPM amount of $58.22 was added to the base data for LA Care and $28.74 for Health Net in the FQHC COS line for the SPD COA only.

The data for this adjustment utilized CY 2019 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 CY 2019 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 that 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.

Hemlibra®

Hemlibra® is a "blood factor like" drug that is carved out of managed care and paid through FFS, consistent with blood factor. Because the decision to carve-out Hemlibra® was made during CY 2019, it was necessary to remove any managed care Hemlibra® spend that occurred in CY 2019 from the base. In total, approximately $1.6 million were removed statewide across all MCOs.

Blue Shield of California Systems Conversion

Through RDT discussions with Blue Shield of California it was identified that a system conversion in CY 2019 caused additional and/or incorrect payments to be made to providers.

The cost impact of this was quantified for each COA on a COS basis and an adjustment was applied to remove these costs from the RDT experience. To inform the adjustment, Blue Shield provided supplemental data and information related to the incorrect payments made to providers. In total, approximately $11.7 million was removed from the base data across all COA groups for Blue Shield of California.

Non-LTC Capitation Payments in LTC

Through RDT discussions with SCFHP, it was identified that during the CY 2019 base period, some capitation payments were made to providers that delegated LTC risk to the provider. Originally, these members for which the capitation was paid were not residing in a LTC facility, but eventually some members hit the required days in a LTC facility to qualify for the Institutional capitation rate. While the plan received the full Institutional capitation rate for these members, there was no mechanism in the contract with the providers to reimburse the providers at a rate commensurate with the LTC experience. As a result, the RDT data reported by the plan did not contain the full costs for these Institutional members. Going forward, these capitation payments will primarily be replaced with full-scope liability for the health plan (including LTC services) during the CY 2022 contract period. In total, approximately $2.2 million was added to the Institutional COA base data for SCFHP.

Removal of Globally Capitated Services that were Paid by Direct Plan

During development of the CY 2019 base data, it was discovered that CalOptima and Gold Coast Health Plan reported costs for services that should have been covered under global subcapitation arrangements. Dollars reported in these instances were removed to avoid duplication of costs that should have been covered through the global subcapitation payment made by the direct plans to the global plan. The impact of this adjustment removed approximately $6,000 across all COAs and service categories for CalOptima and $376,000 for Gold Coast Health Plan.

CalOptima WCM Base Data Adjustment

Since the WCM program was not effective for CalOptima until July 1, 2019, the CY 2019 RDT reported experience was not fully reflective of CalOptima's expected PMPM costs within the WCM program. For the WCM population within CalOptima's RDT submission, the first six months (January 2019 through June 2019) is only reflective of non-CCS managed care covered services for WCM individuals, while the second six months (July 2019 through December 2019) contains both non-CCS and CCS services. As a result, an adjustment was made to complete the CY 2019 RDT reported experience. To make this adjustment to the RDT experience, encounter data for CalOptima was reviewed for the second half of CY 2019 only. This was reviewed as it is a more complete picture of CalOptima's expected PMPM costs once the WCM program became effective. Utilizing this data source, CalOptima's reported RDT data was adjusted upwards to be more in line with expected WCM experience. This adjustment added approximately $152.7 million across all categories of service to CalOptima's WCM base data.

Kaiser, United, and Aetna Base Data Development

Special adjustments to MCO-reported data were necessary in some select cases. These adjustments occurred for three MCOs: Kaiser, Aetna, and United. 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 all COAs excluding SPD/Full-Dual, to develop Kaiser base data for CY 2022, a 50% weight was given to a risk adjusted county/region average (this was the approach taken in prior rating periods) and a 50% weight was given to a repriced version of Kaiser's CY 2019 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 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. The final step for this base data component is the inclusion of Kaiser specific maternity prevalence in the base data. The remaining 50% of the base data is comprised of Kaiser's CY 2019 RDT data with some adjustments. The adjustments were required as the reported unit cost levels for some service categories are clear outliers and not representative of the expected costs of servicing the Medi-Cal population. For the professional COS (PCP, SP, FQHC, and NPP) and Laboratory and Radiology service categories, Kaiser's reported utilization was used, but unit cost levels were repriced by the county/region average unit costs in the counties in which Kaiser operates. The PMPM for each service category was then calculated from reported utilization and repriced unit costs. These two data sources were blended together at 50% credibility each to arrive at Kaiser's base data for each county and COA.

For the SPD/Full-Dual COA, the process described above in the "SPD/Full-Dual Non-Covered Services Adjustment" subsection was utilized in the base data development process for each county.

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 base data for CY 2022, a 50% weight was given to a risk adjusted county average, and the remaining 50% weight was given to a pure county average, which was the approach taken in prior rating periods. The risk adjusted county/region average data is established for all other MCOs within Sacramento and San Diego separately. Then, Medicaid 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 final step for this base data component is to include the Aetna specific maternity prevalence in the base data. The remaining 50% of the base data is comprised of a pure county average within each respective county. The process described above was done for the Child, Adult, ACA

Expansion, and SPD COAs. For the SPD/Full-Dual and Institutional COAs, the base data is based on a county average within each respective county.

United Healthcare

Consistent with prior rating periods, United's RDT-reported information alone was not deemed fully credible for use in the development of base data. To develop United base data for CY 2022, a 25% weight was given to a risk adjusted county average rate adjustment process (similar to the process applied for Aetna in San Diego and Sacramento counties), another 25% weight was given to United's CY 2019 RDT reported data, and the remaining 50% weight was given to a pure county average (similar to Aetna's process noted above). This blend was applied to the Child, Adult, ACA Expansion, and SPD COAs for all service categories except pharmacy. For the SPD/Full-Dual and Institutional COAs, the base data is based on a county average within San Diego County.

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 applied 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 MMs for the base data year (CY 2019) 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.

Larger MM 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 MMs 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 MMs, 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. 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 given zero credibility and the base factors are renormalized to add to 100%. For example, if the plan-specific encounter data was not deemed reasonable, but the RDT was reasonable, these amounts would be 87.5% plan-specific RDT data, 0% plan-specific encounter data, 9.375% smoothed RDT data, and 3.125% smoothed encounter data for a fully credible COA. Based on this, it is possible for both plan-specific RDT and encounter data to be deemed unreasonable and all credibility would be given to the smoothed values in this instance. It is also possible for RDT data to be deemed reasonable with encounters unreasonable or vice versa. All credibility factors are renormalized based on which plan-specific data elements 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. It should also be noted there are instances where a plan-specific data element may be perfectly reasonable for that plan (this is often the case for a plan that has a higher than normal volume of FQHC activity), but not reasonable for the smoothed averages. In these cases, these data elements are excluded from the smoothed averages, but that plan-specific data element is given credibility only for that MCO, COA, and COS combination.

This smoothing and credibility process was applicable for all COS listed above with the exception of the following: MH–OP, 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 zero CBAS facilities. Due to these differences, per member utilization and cost data for CBAS vary greatly across MCOs and counties. Therefore, the smoothing and credibility process described previously does not work well for this particular COS. For this service, both RDT and encounter utilization and cost data were reviewed separately for each MCO and county and an appropriate PMPM amount was developed using these data sources. These services are reimbursed within the capitation rates for all COA groups.
- MH–OP: The process described in the “Base Data Adjustments” subsection above produces the final MH–OP base data figures. As a result of the separate process for this COS, no smoothing and credibility process is applied, since all base data considerations are incorporated in the separate process.
- BHT Services: As noted in the “Base Data Adjustments” subsection, all BHT services are removed from the base data due to the presence of a supplemental payment for these services. Additionally, cost for CDEs have been reallocated to the NPP COS. As a result, no smoothing and credibility adjustment process is applied, since base data values are zero for this COS. Additional detail regarding the development of the supplemental payment is described further in a separate methodology report.

Relational Modeling

The Two-Plan, GMC, Regional, COHS, and CCI 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.

Other Base Data Considerations

It should be noted the smoothing and credibility process alone was not used for unique situations for certain MCOs or populations. There are some situations where a modified approach was more appropriate to utilize. These instances are described in the next two subsections.

Two-Plan/GMC CCI Institutional Rate

Given the relatively small number of non-dual Institutional members throughout CCI counties, the managed care data for the Institutional rate cell in CCI counties is subject to large swings from year-to-year and is not fully reliable for rate setting purposes. As such, the base data for these populations is developed at a county level instead of MCO for an added measure of consistency. The RDT-reported data by CCI health plans was the starting point for the county base data. To arrive at the base data for this population, a credibility and smoothing process was implemented consistent with other Two-Plan and GMC COA groups.

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 that non-live birth expense data and non-live birth outcomes are excluded from the maternity supplemental payment analysis and the corresponding development of the CY 2022 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 2022.
- Same supplemental payment is utilized for the Child, Adult, and ACA Expansion COA groups as well as WCM members if a delivery event occurs.
- Carve-out maternity costs from the Child, Adult, and ACA Expansion COA groups, as well as WCM population rates.

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 is used as the main base data source for this base data development. The general process for the development of the maternity base data is described below:

- Calculate per delivery costs and utilization from CY 2019 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 that data quality might compromise the soundness of the rate, Mercer deems it necessary to

adjust the ratio to a more normalized level. Please note that maternity supplemental base data smoothing and adjustment process is cost neutral to the rate development process across the regular capitation rate and maternity supplemental payment rate as any adjustment only redistributes the costs between the regular capitation rate and maternity supplemental payment, and will not change the total costs used for rate development.

Behavioral Health Treatment Supplemental Payment

Effective September 15, 2014, MCOs became responsible for BHT Services to address autism spectrum disorder. Effective July 1, 2018, the MCOs' responsibility to cover these services expanded to include children not diagnosed with autism. These benefits are available for beneficiaries ages zero to 20 years old who are eligible for the early and periodic screening, diagnosis, and treatment (EPSDT) program and meet medical necessity criteria for the service. To further enhance the measured matching of payment to risk, DHCS utilizes a BHT supplemental payment for CY 2022. BHT services were removed from the CY 2019 base experience to allow the supplemental payments to cover the anticipated costs for these services. Effective July 1, 2019, CDEs are no longer covered under the BHT supplemental payment, and instead are covered under the capitation rate. Therefore, CDE base costs remained in the base data used for the capitation rates and were not used in the development of the BHT supplemental payment. Please see the following attachment (*CY 2022 BHT Supplemental Payment Methodology FINAL 2021 12.pdf*) for further details on the BHT supplemental payment methodology and subsequent rate development. Additionally, exhibits showing the final capitation rates and CRCS can be found in the Excel file titled *FINAL CY 2022 Medi-Cal BHT Supp Rate Exhibits 2021 12.xlsx*.

CBAS Rate Add-On

Historically, CBAS expense for members in the SPD COA group in non-CCI counties have been funded through the capitation rate and subject to risk-adjustment, while paid via the HCBS High supplemental payment in CCI counties. The large majority of CBAS spend is attributable to the SPD and SPD/Full-Dual populations and varies largely from county to county, and also between MCOs within the same county. Within the CY 2022 capitation rates, CBAS costs for SPD members are now treated as a capitation rate add-on and not subject to risk adjustment in all counties to better align CBAS within the rates to the appropriate MCO/county combinations. For all other COA groups subject to risk adjustment (namely, Child, Adult, and ACA Expansion), CBAS is reimbursed along with the other service categories in the capitation rates and subject to risk adjustment. In these COAs, CBAS PMPM costs are a very small portion of the total rates in these instances. Note the SPD/Full-Dual COA group is not risk-adjusted, and therefore based on plan-specific data, so the CBAS costs within the rates are inherently aligned to the appropriate MCO/county combinations.

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 CY 2019 to CY 2022
- Program Changes
- IP Efficiency Adjustment
- Emergency Department (ED) Efficiency Adjustment
- Physician-Administered Drugs
- 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 2022 rate range development for the Two Plan, GMC, Regional, COHS, and CCI model programs, Mercer developed trend rates at the COA level for each provider type or COS separately by utilization and unit cost components. For all COA group cohorts in the CY 2022 rating period, the CY 2019 base data was trended forward 36 months from the mid-point of CY 2019 to the mid-point of CY 2022.

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 report[1]. 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 are six 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 2021 to CY 2022. 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 CBAS provided following the tables. 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 2021**	**CY 2022**	**Change**
Laboratory and Radiology	3.26%	4.03%	0.78%
CBAS	0.85%	4.01%	3.16%
Hospice	0.25%	2.25%	2.00%
Other HCBS	2.00%	4.03%	2.03%
All Other	2.00%	4.03%	2.03%

Annual Trend Factors — SPD/Full-Dual and LTC/Full-Dual COAs			
COS	**CY 2021**	**CY 2022**	**Change**
IP Hospital	0.27%	2.98%	2.71%

The largest of the changes in trend assumptions year-over-year listed above is for the CBAS COS. Emerging experience displayed a large increase after the start of the PHE in the

[1] https://www.cms.gov/files/document/2018-report.pdf

utilization of CBAS on a services per utilizer basis. After further review, including discussions with MCOs, Mercer concluded that this increase in CBAS utilization was mostly tied 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 that utilized CBAS have been receiving these services more frequently than in the pre-pandemic base period. The most recent information from the California Department of Aging indicates the TAS flexibility continues to remain in effect, with an end date tied to a point in time beyond the ending of the PHE (timing to be determined). As a result, Mercer increased the utilization trend assumption for CBAS from the prior rating period for consideration of the impacts from the TAS flexibility.

Note that 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 trends through the program changes section of the methodology, with one exception. The one exception to this is within the Two Plan and GMC CCI Institutional rates, in which a small unit cost trend assumption was applied (0.5% at the mid-point) to account for increased pricing pressures communicated to Mercer through conversations with the CCI health plans.

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, across all MCOs, all COA groups, and all COS, average 0.5% for utilization and 2.6% for unit cost or 3.1% PMPM. This represents an increase of 0.5% over the aggregate trend figures at the lower bound from the CY 2021 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 November 17, 2021. 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 2022 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 files titled *FINAL CY 2022 Medi-Cal Detail CRCS Package LB Rate Smry 2021 12.xlsx* and *FINAL CY 2022 CA CCI Medi-Cal Only & Partial Dual Program*

Change Chart 2021 12.xlsx. Additionally, the program change adjustments identified below are applied in columns (F) and (G) of the CRCS, unless otherwise indicated.

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. 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. Historically, 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.

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.

Non-Medical Transportation

Non-medical transportation (NMT) became a managed care covered benefit effective July 1, 2017. NMT refers to non-emergent transportation to and from medical appointments for beneficiaries where the mode of transportation has no medical component associated with it. This includes modes of transportation such as taxicabs and public transportation, and does not include modes of transportation such as non-emergent ambulance transportation or transportation via a wheelchair van, which are referred to as non-emergent medical modes of transportation. To develop a rate adjustment for this program change, supplemental transportation data was provided by the MCOs by three grouped modes of transportation (emergent, non-emergent medical, and non-medical), by COA, and by quarter for CY 2018 and CY 2019. Further, MCOs provided commentary on their expectations of NMT utilization into the future. Additionally, this data was supplemented with data from other state Medicaid programs to develop a benchmark NMT PMPM by COA. To develop the NMT adjustment PMPMs, the following process was applied.

Project Non-Medical Transportation Per Member Per Months for CY 2022

To project the total NMT PMPMs for the rating period, each plan's NMT PMPMs reported by quarter were reviewed over time. Based on the ramp up seen through the latest quarters of 2019, NMT PMPMs were trended from the latest quarter in CY 2019 to the CY 2022 period. A 5% ramp-up assumption was utilized in this trend application. This value was averaged with the projected NMT PMPM assumption used in the CY 2021 rate setting process, trended to CY 2022 using the same 5% assumption. This averaged value was used as the projected CY 2022 NMT for each MCO and COA.

Calculate Non-Medical Transportation Costs Assumed in the CY 2022 Rates

NMT data as reported by the MCOs in the CY 2019 base data period were used as the basis for the NMT amounts assumed in the rates. These amounts reported by the MCOs were trended to CY 2022 (using the trend factors developed for the Transportation COS line).

Calculate Non-Medical Transportation Per Member Per Month Adjustment

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

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. 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, two data sources were utilized (CY 2019 and CY 2020 dates of service were compiled for both data sources):

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

(emergent, non-emergent medical, and non-emergent non-medical), as well as trip counts for the affected GEMT codes (A0225, A0427, A0429, A0433, and A0434).

- Health plans-submitted encounter data limited to the GEMT codes affected by the fee increase (A0225, A0427, A0429, A0433, and A0434).

Based on review and analysis of these two data sources, utilization per 1,000 statistics were developed for the non-dual/Part A subpopulation (by health plan, COA, and county). 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 since 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, and COA group and applied in the transportation COS within the CRCS.

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

Adult Optional Benefits

Effective January 1, 2020, DHCS restored coverage for optional benefits for all adults age 21 or older in all settings. The optional benefits restored include vision (optometric and optician services, except certain lens fabrication not covered under managed care), audiology, speech therapy, podiatry, and incontinence creams and washes. DHCS already provides these services under the EPSDT benefit for individuals under 21 years of age and for pregnant women and beneficiaries receiving LTC in a NF. This benefit change is accounted for as a PMPM adjustment to the All Other COS for all applicable COAs.

To develop the PMPM adjustment for audiology, speech therapy, podiatry, and incontinence creams and washes, two data sources were utilized:

- Medi-Cal FFS data specific to each service for members age 21 or older from when the benefits were previously covered in Medi-Cal. The FFS data included dates of service from July 1, 2007 through June 30, 2009.
- Separately provided data from certain MCOs in the Medi-Cal program that already cover these benefits on their own. Note these services were not part of the State Plan benefit package and were not reported within the MCOs' RDT experience. This data included dates of service in CY 2017.

To derive the PMPM adjustments, both of these data sources were trended to CY 2022 (the period in which the benefits are effective) using trends in line with historical trend factors for the NPP and All Other COS lines. Then, a blend of each data source was utilized for each service and applied consistently for each COA. The blending factors utilized were based on actuarial judgment; no specific formulas were used to develop them. The PMPMs were developed at a statewide level, with no variation across counties, since recent data was not available to make reliable PMPM assumptions by county/region.

For vision services, the PMPM adjustment was developed by estimating the price for frames and lens dispensing fees, as well as developing an assumed utilization of the benefit. To estimate the price for frames and lens dispensing fees, encounter data from CY 2017 to CY 2019 was utilized, as this benefit is already covered in Medi-Cal for children under age 21, pregnant women, and beneficiaries residing in a NF. From this data, a price per eyeglasses was developed for CY 2022, which includes frames and lens dispensing fees only, as costs for lens fabrication provided by the Prison Industry Authority (PIA) are not covered in managed care. To develop the utilization assumption, historical figures budgeted by DHCS along with data estimates from the California Optometric Association estimate were reviewed. The California Optometric Association estimated approximately two million Medi-Cal beneficiaries aged 21–64 need eyeglasses.[2] Using this estimate as a benchmark, an assumption was then made about the number of those who need eyeglasses, to determine how many would actually obtain them in CY 2022 (the period in which the benefit is effective). The ramp up assumption used was 50% and was based on actuarial judgement.

Lens Fabrication

Generally, lens fabrication is not covered in managed care in the Medi-Cal program, except when it is not provided by the PIA. In San Mateo, Santa Barbara, and San Luis Obispo

[2] https://calmatters.org/health/2019/04/california-eyeglasses-medi-cal-restoring-benefitsr

counties, all lens fabrication had been a managed care covered benefit, as these benefits had not been provided by the PIA in these counties. Effective January 1, 2020, certain lens fabrication benefits typically covered by the PIA in most counties (non-specialty lenses) will no longer be covered under managed care in these three counties. As a result, a program change adjustment was applied to remove lens fabrication costs from the CY 2022 rates. To remove the costs associated with lens fabrication, CY 2019 encounter data specific to lens fabrication was reviewed for reasonableness and formed the basis of the adjustment. The final adjustment carved out only the appropriate portion of lens fabrication costs based on review of managed care encounter data.

Community-Based Adult Services AB 97 Buyback

Effective July 1, 2019, Medi-Cal restored CBAS facility payment rates in the FFS delivery system to levels in effect prior to the AB 97 10% rate reduction applied to certain CBAS facilities, which is expected to produce corresponding pricing pressures in managed care. As a result, a unit cost program change adjustment was applied to the CBAS COS line to account for this. This program change adjustment was developed by reviewing CY 2019 RDT and encounter data specific to CBAS. Based on the review of this data, if it was observed that a plan was paying a CBAS rate less than $76.27 (the state fee schedule CBAS daily rate without the AB 97 10% reduction applied [based on code S5102, which makes up the vast majority of CBAS]), an adjustment was made in these instances to raise the unit cost to $76.27. If a plan was paying CBAS daily rates in excess of this amount, no adjustment was made.

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 use conditions billed by the treating physician or other qualified health professional. No Medi-Cal claims experience specific to the Psych CoCM codes were available at the time when a PMPM adjustment was derived. Therefore, various assumptions were used to develop a PMPM adjustment by COA for adding coverage of these new codes, 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 2022, 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.

Coronavirus Disease Adjustment

Significant national uncertainty exists regarding the impact of COVID-19 during CY 2022 due to the ever-changing situation with regionalized infection rates, responses driven by local governments, and new treatment protocols, to name a few factors. Utilization and cost assumptions considered many elements, including infection rate and severity mix of cases, the impact of social distancing, the Federal Government’s involvement in COVID-19-related funding (e.g., HHS and FEMA), and the availability and take-up rate of a vaccine. Given the

limited experience resulting from the COVID-19 pandemic, Mercer used several data sources to develop the COVID-19 impacts to CY 2022 capitation rates, including Mercer and Oliver Wyman internal modeling, and national and state data sources.

Mercer separated assumptions into the following categories.

Testing

Testing costs were developed using a bottom-up approach. An assumed testing rate was developed through a combination of statewide-expected testing outcomes and rate cell demographic information. The analysis includes testing for current infection and antibody testing. Costs were included for the test, as well as associated administrative costs, and any corresponding services (e.g., ED or office setting).

Treatment

Treatment costs considered the estimated cost of treatment based on case severity. Scenarios were considered that ranged from in-home care for mild cases to hospitalization, including the intensive care unit, for more severe cases. Average treatment costs were developed based on projected treatment protocols, including average days in the hospital. The treatment costs were then weighted based on an assumed distribution of incidence rate and severity of cases, which varied by rate cell. For example, older members are assumed to be at higher risk for more severe infection, requiring more costly treatment than younger members. Results were calibrated based on rate cell demographic information, and adjusted to be county specific based on county specific IP hospital unit costs.

Deferred Care

No explicit adjustment for net deferred care is included in the CY 2022 capitation rates. This decision was driven by the arrival of available vaccines in CY 2021 as well as uncertainties around the timing of any potential deferred care. At the time this adjustment was considered within the rate development process, no conclusive evidence was available to indicate the level at which services would rebound in late CY 2021 or into CY 2022. As a result, no explicit adjustment was made.

Mental Health Outpatient Services Acuity

Acuity changes may occur as new needs develop and treatment becomes warranted. Based on national evidence that the pandemic is having a material impact on MH needs, Mercer is forecasting an uptick in BH-related services relative to the CY 2019 base data time period, including services to treat the mild to moderate MH conditions covered by managed care. CY 2022 capitation rates include additional costs for this increase, modeled as a 5% increase in the projected MH–OP services.

Considered but Not Adjusted

The following impacts were not explicitly adjusted in the COVID-19 program change:

- Coverage of Vaccines — the vaccine, including the cost to administer the vaccine, are not covered through managed care and any costs are paid for by the State via FFS. Consequently, no adjustment was made for these costs.

- Long-Term Impact of COVID-19 — given uncertainty around long-term implications of COVID-19, Mercer did not make an explicit assumption specific to this potential impact for CY 2022.

CalAIM Community Supports

Under the CalAIM initiative, a Community Supports program will be 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, will be available under managed care. The following 14 pre-approved Community Supports services will be available under Medi-Cal managed care through the CalAIM proposal:

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. 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

ILOS are medically appropriate and cost-effective alternatives to State Plan services or settings that will be authorized in the MCO contracts effective January 1, 2022. 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 CY 2019 base data period that were removed within the “Value-Added Services Adjustment” base data adjustment. If a value-added service reported in the CY 2019 RDT 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 2019.
- 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 2022 as the service began July 1, 2021, and it is likely the ramp up of the service will be gradual. A ramp up assumption of 24% was used for the CY 2022 capitation rates.

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

Doula Benefit

Doula services will become a Medi-Cal covered benefit effective July 1, 2022. Doula services include personal support to women and families throughout a woman's pregnancy, childbirth, and postpartum experience. Medi-Cal's standard doula benefit will include maternity and labor support visits, which can be at the member's home, or part of a member's office visit, and during delivery.

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, and ACA Expansion COAs, detailed below:

- Projected deliveries by COA for CY 2022 were calculated using the CY 2019 base period birth ratios and projected CY 2022 membership.
- The percentage of pregnancies and delivery events, as well the proportion of the eligible beneficiaries that would utilize the doula services during CY 2022, which were based on consultation with clinical resources and actuarial judgement.
- The reimbursement rate for doula services is based on information provided by DHCS. Additional cost adjustments were made based on review of other states' reimbursement rates for doula services.

Using the assumptions noted above, a projected PMPM for doula services was derived and the program change adjustment was calculated.

Continuous Glucose Monitoring Durable Medical Equipment Carve-Out

The continuous glucose monitoring benefit has been covered in managed care only in certain situations where the benefit was deemed medically necessary. Effective January 1, 2022, this benefit will be carved out of managed care as it is considered part of the pharmacy carve-out. As a result, this adjustment carves out all durable medical equipment expenses related to continuous glucose monitoring within the CY 2019 base period. This adjustment was calculated using encounter data specific to the codes applicable to the carve-out. This adjustment impacts the All Other COS.

Community Health Worker

Effective July 1, 2022, CHW will be seen as 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 this benefit is also available through ECM, this program change is separate from the ECM add-on detailed later in this certification letter.

Leveraging research on CHW staffing and using a build-up similar to the ECM model in identifying potential CHW utilizers, approximately 2.4% of the Medi-Cal managed care population were identified to be potential utilizers of CHW services. Assuming a 50% uptake (higher than the uptake assumption used for ECM given the lower acuity of these members

and an easier enrollment process), 1.2% of the managed care population would ultimately make use of this benefit.

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 of contacts, CHW enrollee program tenure, and level of need for members receiving CHW services. Program enrollees are then separated into three intensity levels — Low (0.72 average service hours/month), Medium (1.26 average service hours/month), and High (1.86 average service hours/month), with the distribution of members amongst the intensity levels varying by COA. This is 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. Given the emphasis on staffing the ECM program with CHWs for the CY 2022 rating period and the mid-year rollout of this benefit, a 5% ramp-up during the first six months of this program benefit is assumed.

Rapid Whole Genome Sequencing

rWGS will become a managed care covered benefit effective January 1, 2022. This benefit is available to infants ages 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 rWGS program. Further, this benefit will be 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 Health Care Services

Effective July 1, 2022, the DHC program change considers an integrated BH care model that provides health care for the child delivered in the context of the caregiver and family (i.e., “dyadic health care services”). Families are screened for various BH problems, including interpersonal safety, tobacco and substance misuse, and social determinants of health such as food insecurity and housing instability. Families who are given referrals receive follow-up to ensure they received the services. DHC services are available for Medi-Cal beneficiaries ages 0–20, and any services rendered during the DHC visit or child’s medical visit are billable to the child’s Medi-Cal ID. This program change offers the new benefits of DHC 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 DHC policy:

New Benefits from DHC Policy:

- DHC Visit
  - Note DHC 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 DHC 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 the DHC 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 CY 2019 eligibility; and furthermore, how many of those members would utilize DHC visits during their well-child visits. The assumed DHC visits vary by age groups that align with the suggested well-child visits from the Bright Futures Periodicity Schedule (*https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf*). Using this utilization of DHC visits, Mercer estimated the number of additional services provided (for both new and existing benefits) as a result of the DHC policy. This expected new utilization of the impacted benefits was analyzed based on the following three categories:

- During the DHC Visit
  - In addition to the new utilization of the DHC visit itself, Mercer analyzed the remaining impacted services for the likelihood of them also being provided during the DHC 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 DHC visits throughout the calendar year. Per DHCS' DHC policy, all services provided during the DHC visit are billable under the child's Medi-Cal ID. As such, this new utilization during the DHC 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 DHC Visit (Downstream Services)

  - Given that referrals for certain services are an expected outcome of DHC visits, it was necessary to include an estimate for the increase in existing services beyond the DHC visit resulting from the DHC 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. Mercer then assumed a growth percentage of 10% for these existing services as a result of the DHC policy, and included this growth within the expected new utilization from the DHC program change. Per DHCS' DHC policy, only services provided during the DHC visit are billable under the child's Medi-Cal ID. Given that this category of new utilization occurs outside of the DHC visit, this increased utilization of existing services was allocated to the various COA groups according to the baseline amounts initially determined in the CY 2019 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 DHC 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 2022 reimbursement rates provided by DHCS for certain services, where available, supplemented by aggregate CY 2019 Medi-Cal managed care unit cost data (for applicable procedure codes) trended forward to the CY 2022 time period. Using these various unit costs and the expected new utilization of services, Mercer determined a fully ramped-up prospective impact of the DHC program change for CY 2022. To account for the July 1, 2022 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.

Populations Transitioning from Fee-for-Service to Managed Care

Certain Medi-Cal populations within the FFS deliver system, including some designated by the CalAIM initiative, will transition to managed care effective January 1, 2022.

The populations identified to transition from FFS to managed care are as follows:

- TCVAP, excluding the share of cost population
- AE
- CHDPI
- Pregnancy-related Medi-Cal

- BCCTP
- Beneficiaries with Other Healthcare Coverage (OHC)
- Beneficiaries in rural zip codes (Rural)

As outlined in the CalAIM initiative, the TCVAP, AE, pregnancy-related Medi-Cal, OHC, and Rural populations will mandatorily transition and/or enroll into managed care starting January 1, 2022. For pregnancy-related Medi-Cal members, only newly enrolled members will enroll in managed care in CY 2022, and members who are already in FFS prior to 2022 will not be transitioned.

Although not specifically indicated by CalAIM, DHCS has identified the CHDPI and BCCTP populations as additional FFS populations transitioning to managed care.

Within these populations, certain populations were excluded from transitioning:

- LTC aid code members
- LTC Utilizers in non-LTC aid codes
- Mandatory FFS populations as outlined in the CalAIM initiative
- Members with waiver exclusions (ICF-DD, HCBS Waiver, and Veteran's Home of California)
- Dual members (partial or full Medicare eligibility) identified within the BCCTP, OHC, and Rural populations

General Methodology

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

Members were identified in the CY 2019 FFS data by aid code, 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 utilizing LTC services that were not in a LTC aid code, and were excluded from the analysis.

Claims for the transitioning populations identified in the CY 2019 FFS data were then 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. Each population was analyzed separately in order to isolate any inherent population differences. The PMPM relativity impacts, weighted by the membership volume for each population (at the county level), were then aggregated and applied as a single program change for each county.

More details for each population are provided below:

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, Adult, and WCM 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. 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 AE population was assumed to have no material rate impact.

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. Within the COHS model, no rate impact was assumed since this population volume was very small compared to their corresponding COAs. In Two-Plan, GMC, and Regional counties, it is anticipated this population will increase the Child COA membership by 1.0%. However, the aforementioned PMPM relativity analysis showed this population to have a similar expected PMPM relativity compared to the Child COA. As a result, no rate impact was assumed as well for the Two-Plan, GMC, and Regional models.

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 will enroll 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 in all models, the volume of the members transitioning into managed care is expected to be approximately 0.5% of the existing Adult managed care members. Based on the aforementioned PMPM relativity methodology used to analyze each population, Mercer found it appropriate to assume a 2.0 PMPM relativity in COHS counties and a 2.5 PMPM relativity in Two-Plan, GMC, and Regional counties when aggregating this population's impact into the total transitioning population impact.

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 will move into the SPD COA group. For the COHS model, this population was generally already covered under managed care, and as a result, no rate impact is assumed. For the Two-Plan, GMC, and Regional models, this population is expected to increase the SPD managed care population size by approximately 0.5%. Based on the aforementioned methodology used to analyze each population, Mercer found it appropriate to assume a 1.4 PMPM relativity when aggregating this population's impact into the total transitioning population impact.

Beneficiaries with Other Healthcare Coverage

Beneficiaries with OHC are FFS members who have been 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. In the COHS model, this population was already covered in managed care, and as a result, no rate impact was assumed.

In Two-Plan, GMC, and Regional counties, it is anticipated this population will increase managed care membership by approximately 0.6% to 1.2%, depending on the COA. Based on the aforementioned methodology used to analyze each population, Mercer found it appropriate to assume a 0.25 PMPM relativity for this population when aggregating this population's impact into the total transitioning population impact. Since this population has OHC, it is expected they will be less costly than the base managed care population. It should also be noted that in addition to pulling FFS claims data for this population, encounter data was reviewed for members already in managed care with OHC. Both data sources showed similar relativities to the current managed care population.

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 will transition 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 is expected to be very small, and as a result, no rate impact was assumed.

In Kern, Riverside, and San Bernardino counties, the membership volume impacts for each County compared to the base managed care population were as follows (note the SPD/Full-Dual COA is not included as dual eligible beneficiaries will not be mandatorily enrolled into managed care in CY 2022):

COA	Kern	Riverside	San Bernardino
Child	3.4%	0.8%	5.3%
Adult	4.0%	1.0%	6.9%
ACA Expansion	4.2%	0.9%	7.4%
SPD	3.1%	1.1%	5.3%

Based on the aforementioned methodology used to analyze each population, Mercer found it appropriate to assume the PMPM relativity factors for each applicable county were as follows:

COA	Kern	Riverside	San Bernardino
Child	0.90	0.80	0.80
Adult	0.85	0.85	0.85
ACA Expansion	0.80	0.80	0.80
SPD	0.95	0.85	0.85

The factors assumed above were used when aggregating this population's impact into the total transitioning population impact.

Undocumented Population Aged 50 and Older

Effective May 1, 2022, the State will transition Medi-Cal members aged 50 and older to full-scope Medi-Cal and move 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 all COAs, the membership volume impacts for each model and COA compared to the corresponding managed care population were as follows:

COA	COHS	Two-Plan/GMC
Adult	1.6%	1.8%
ACA Expansion	1.6%	2.4%
SPD	1.8%	2.3%

As this population is restricted scope, Mercer pulled multiple data points to understand the potential cost profile of this population.

- CY 2019 managed care encounter data was reviewed for the age 50 and older population currently in managed care compared to encounter data for the total populations by COA group.
- CY 2019 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.
- CY 2019 FFS data for the actual population transitioning was also reviewed. However, since this population was restricted scope in CY 2019, 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 three data sources described above, Mercer found the following PMPM relativities (by COA) to be appropriate:

COA	Program Change Adjustment
Adult	1.15
ACA Expansion	1.35
SPD	1.15

These PMPM relativity factors were used in combination with the expected increase in managed care enrollment to derive the program change adjustment applied for this transitioning population.

It should also be noted this population will be included in the rates for the UIS population when rates are separated by the UIS and SIS populations. This will occur in a future rate amendment after the original capitation rates are set and certified prospectively.

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 2022 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 are 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 2018 and CY 2019 FFS data and identified individuals who received a MOT by each transplant type listed above through 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.

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 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, 2019) to the midpoint of the contract period (July 1, 2022) for a total duration of 42 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 mainstream 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 $217 million for the CY 2022 rating period.

Enhanced Care Management

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

The impact of the program to the CY 2022 capitation rates was developed at a statewide level, with county-specific adjustments, for a health plan and county specific PMPM add-on 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.

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 CHWs at varying severity levels, the distribution of these severity levels over the course of the rating period, as well as the distinction between "new" ECM enrollees and "grandfathered" ECM enrollees (individuals transitioning from WPC and HHP, labeled "WPC/HHP ECM Members").

Medi-Cal Enhanced Care Management
ECM Monthly Service Hours Per Enrollee Development

"New" ECM Members	Months 1-6 for Enrolled Members				Months 7-12 for Enrolled Members			
Severity Level	Percent Distribution	Hours per ECM Enrollee per Month			Percent Distribution	Hours per ECM Enrollee per Month		
		CM	CHW	Combined		CM	CHW	Combined
Level 1	35%	3.0	7.4	10.5	20%	3.0	7.4	10.5
Level 2	30%	2.3	4.6	6.9	35%	2.3	4.6	6.9
Level 3	20%	1.2	2.2	3.5	35%	1.2	2.2	3.5
Level 4	15%	0.9	1.2	2.1	10%	0.9	1.2	2.1
	100%	2.1	4.6	6.7	100%	1.9	4.0	5.9
	% of "New" ECM Member Enrollment			27%	% of "New" ECM Member Enrollment			73%

6.1

CY22 Average Monthly Service Hours Per "New" ECM Enrollee

WPC/HHP ECM Members	Months 1-6 for Enrolled Members				Months 7-12 for Enrolled Members			
Severity Level	Percent Distribution	Hours per ECM Enrollee per Month			Percent Distribution	Hours per ECM Enrollee per Month		
		CM	CHW	Combined		CM	CHW	Combined
Level 1	15%	3.0	7.4	10.5	20%	3.0	7.4	10.5
Level 2	30%	2.3	4.6	6.9	30%	2.3	4.6	6.9
Level 3	30%	1.2	2.2	3.5	30%	1.2	2.2	3.5
Level 4	25%	0.9	1.2	2.1	20%	0.9	1.2	2.1
	100%	1.7	3.5	5.2	100%	1.8	3.8	5.6
	% of WPC/HHP ECM Member Enrollment			64%	% of WPC/HHP ECM Member Enrollment			36%

5.3

CY22 Average Monthly Service Hours Per WPC/HHP ECM Enrollee

As all WPC/HHP participating counties will rollout ECM starting January 1, 2022 and all other counties starting ECM on July 1, 2022, the following flow chart shows the separate assumptions for counties starting ECM on July 1, 2022.

Medi-Cal Enhanced Care Management
ECM Monthly Service Hours Per Enrollee Development

"New" ECM Members	Months 1-6 for Enrolled Members				Months 7-12 for Enrolled Members			
Severity Level	Percent Distribution	Hours per ECM Enrollee per Month			Percent Distribution	Hours per ECM Enrollee per Month		
		CM	CHW	Combined		CM	CHW	Combined
Level 1	35%	3.0	7.4	10.5	20%	3.0	7.4	10.5
Level 2	30%	2.3	4.6	6.9	35%	2.3	4.6	6.9
Level 3	20%	1.2	2.2	3.5	35%	1.2	2.2	3.5
Level 4	15%	0.9	1.2	2.1	10%	0.9	1.2	2.1
	100%	2.1	4.6	6.7	100%	1.9	4.0	5.9
	% of "New" ECM Member Enrollment			100%	% of "New" ECM Member Enrollment			0%

6.7

CY22 Average Monthly Service Hours Per "New" ECM Enrollee

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.

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:

- Provider Cost Trend (applied to unit cost) — since the base per enrollee per month (PEPM) was developed using CY 2020 salary information, 24 months of 5.0% annual trend is applied to project costs to the CY 2022 contract period.
- County Wage Adjustment (applied to unit cost) — similar to HHP, an adjustment is applied to factor in wage differences for ECM providers between counties in California.
- Medicare Part B Chronic Care Management (CCM)/Behavioral Health Integration Services Adjustment (applied to utilization) — this adjustment accounts for Part B eligible ECM enrollees who are eligible for CMS' CCM or Behavioral Health Integration programs. ECM providers are expected to collaborate with the member's physician in order to pursue the appropriate CCM and Behavioral Health Integration payments from

CMS for their ECM enrollees with Part B coverage. As CMS will be covering ECM-like services through the CCM and Behavioral Health Integration 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.

- 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. For the first year of ECM, no adjustment will be applied as the state and health plans are navigating through systematic and operational data complications in properly identifying TCM enrollees. This adjustment will be reassessed for year two (CY 2023) of the ECM program.
- County Rural Adjustment (applied to utilization) — similar to HHP, a 25% upward adjustment factor is applied to account for the additional service hours required to serve ECM enrollees residing in a rural setting.

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 PMPM.

Identifying Enhanced Care Management "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 transitioning from other sunsetting care management programs such as WPC and HHP, the State and Mercer worked closely with WPC Lead Entities to better understand each county's WPC program and determine WPC and HHP members who would transition to ECM in January 2022. Specifically, the count of WPC and HHP enrollees is based on the most recent member list from these programs available at the time of rate development (4Q 2020 for WPC and 1Q 2021 for HHP) along with appropriate growth assumptions. It is assumed the entire group (after an initial adjustment) will transition into ECM in January 2022. Given this identification criteria for the HHP and WPC programs and the approach in identifying those who are ECM-eligible, 95% of transitioning WPC members and 65% of transitioning HHP members are assumed to remain in ECM after six months.

As for the "new" ECM Enrollees (counts and MMs), ECM-eligible individual counts (excluding HHP/WPC transitioning 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, it was assumed health plans will outreach to approximately 75% of the ECM-eligible population during the first 12 months and approximately 25% of those targeted will enroll in ECM. These ramp up assumptions are the basis for "new" ECM enrollee counts and MM projections.

Ultimately, accounting for the 25% uptake and ramp-up assumptions, the rate development assumes that by the fourth quarter of CY 2022, 0.8% of managed care members will be enrolled in ECM. After a full ramp up of the ECM program, it is expected that 1.1% of managed care members will be enrolled in ECM.

Consistent with CY 2022 mainstream rate-setting, full lower bound administrative and underwriting gain (2.0%) loads were used for ECM. This differs from other add-ons which typically use 50% of the lower bound mainstream administrative load but is deemed appropriate given the additional burden health plans will experience as they ramp up their ECM program.

Health Plan of San Mateo Dental

Effective January 1, 2022, dental services will be covered in San Mateo County. Given this is a new managed care benefit, the data utilized was CY 2019 Medi-Cal Dental FFS data in San Mateo County. The data was then adjusted for the following items:

- Removal of Prop 56 supplemental payments.
- Services provided at FQHCs were adjusted to an “arms-length” amount not inclusive of the full Prospective Payment System rate.
- Annualized trend factors were applied for 36 months to the midpoint of the CY 2022 rating period.
- Various managed care adjustments were made to price the benefit consistent with expectations within managed care.
- Items as part of the CalAIM initiative were addressed
  - DHCS is implementing 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.
  - An adjustment to reflect the Caries Risk Assessment new benefit.
  - An adjustment to reflect the Silver Diamine Fluoride new benefit.
- Lower bound administration and underwriting gain loads consistent with the broader rate development were utilized in the development of the PMPM add-on.

The Proposition 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 and is described later in this report.

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. While these two items are not program changes, they are included with other capitation rate add-ons noted previously in this subsection.

To develop the Kaiser Severe Mental Illness PMPM add-ons in Sacramento and Solano counties, Mercer utilized supplemental CY 2019 data that Kaiser submitted which isolated to MH services for members diagnosed as severe mental illness. 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 CY 2019 RDT data used for rate setting. Additionally, this data was trended forward to the CY 2022 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.

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 2022 capitation rates, but ultimately found these to have zero 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 (non-MAGI), 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, an explicit adjustment was not 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. Undocumented Young Adults Full-Scope Expansion — full-scope Medi-Cal coverage of adults 19–25 regardless of immigration status was expanded effective January 1, 2020.

Note this population will be included in the capitation rates for the UIS population, when the amendment is made.

2. 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..
3. 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.
4. County Children's Health Insurance Program Transition — County Children's Health Insurance Program beneficiaries were transitioned into managed care effective October 1, 2019 in select counties.
5. Rady Program Discontinuation — effective December 31, 2020, members in the Rady Children's program will transition into 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 require 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 2022 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 2019 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.

Inpatient Efficiency Adjustment

The IP component of the managed care base data also received an adjustment related to an efficiency analysis. This adjustment is applied to the IP Hospital COS within column (K) of the CRCS in the Excel file titled *FINAL CY 2022 Medi-Cal Detail CRCS Package LB Rate Smry 2021 12.xlsx*.

Efficiency Adjustment — Potentially Preventable Admissions

For CY 2022, DHCS is utilizing an adjustment to the managed care IP base data that analyzes levels of inefficiency and/or potentially avoidable expenses present in the MCO encounter data.

Potentially preventable admissions (PPA) were identified through the CY 2019 Medi-Cal MCO encounter data using criteria from the Agency for Healthcare Research and Quality

(AHRQ) Guide to Prevention Quality Indicators (PQI) and Pediatric Quality Indicators (PDI). Additional exclusions for enrollment duration and risk were made as part of the analysis.

This analysis represents a reasonable approach to identifying and quantifying potentially unnecessary expenditures utilizing the AHRQ definitions for each PQI and PDI and their specific exclusions (e.g., deaths and transfers to other facilities). Additionally, only individuals meeting specific Medicaid Rx risk score criteria and enrollment durations by PQI and PDI in the same Medi-Cal MCO are considered for the analysis. A benchmark methodology was utilized in order to apply an adjustment factor based on a PPA level that has been achieved by some of the MCOs. The adjustment is applied to the non-dual COA groups of Child, Adult, ACA Expansion, and SPD and varies by each MCO and county/region.

Emergency Department Efficiency Adjustment

Mercer performed a retrospective analysis of the CY 2019 encounter data to identify ED visits considered preventable or preemptive. For the CY 2022 rate development, Mercer analyzed preventable or preemptive low acuity non-emergent (LANE) visits. This analysis was not intended to imply members should be denied access to EDs or MCOs should deny payment for ED visits. Instead, the analysis was designed to reflect DHCS' objective that MCOs provide effective, efficient, and innovative managed care — care that could have prevented or preempted some members' need to seek care in the ED setting for low acuity, primary care treatable conditions.

The criteria used to define LANE ED visits were based on publicly available studies, as well as input and evaluation from Mercer's licensed clinicians, including practicing ED physicians and those with primary and urgent care experience. International Classification of Diseases (ICD)-10 primary diagnosis code information was the basis for identifying a LANE ED visit. Preventable percentages ranging from 5% to 90% (opioid codes were set at 0% and excluded from the analysis) were assigned to each diagnosis code to account for external factors that can influence and impact variation in ED use.

The percent preventable is only applied to a LANE ED event that includes an Evaluation & Management (E&M) Code of 99281–99283. E&M codes 99284 or 99285 are excluded due to the higher clinical complexity of the patients receiving this service.

Replacement cost offsets (average cost physician visit, and if applicable, average laboratory and radiology costs) were made for the majority of LANE visits deemed potentially preventable to reflect the costs associated with ambulatory OP care for the conditions. Replacement offsets vary depending on accepted clinical interventions expected for a LANE diagnosis.

The components of the replacement cost offset include:

- Physician office visit
- Laboratory
- Radiology

These replacement cost offsets are calculated by determining the cost of an average E&M visit (statewide) using CPT codes 99201–99215, average costs of common laboratory tests, and average costs of common radiology testing. The replacement cost offsets dampen the

value of potentially preventable LANE visits by adding costs back into the rate in recognition that care and services would still need to be rendered in an OP setting.

This adjustment is applied within column (K) of the CRCS in the Excel file titled *FINAL CY 2022 Medi-Cal Detail CRCS Package LB Rate Smry 2021 12.xlsx*.

Physician-Administered Drugs

The final efficiency adjustment Mercer completed was to identify potentially avoidable costs due to reimbursement inefficiencies for physician-administered medications. Mercer reviewed the MCO CY 2019 professional encounter data to identify drug-related HCPCS codes and potential savings associated with those codes.

To identify the potentially avoidable costs, Mercer compared the MCO per unit reimbursement rate to an industry benchmark. For the industry benchmark, Mercer used the Medicare Part B reimbursement rate (CMS average sales price plus 6%) for the same period. Prior to calculating the avoidable dollars, Mercer adjusted for outlier claims for which MCO unit prices were not consistent with the benchmark unit price or other MCO unit prices for a given HCPCS code.

Inefficient MCO spend is defined as the amount the MCO paid above the re-priced benchmark of average sales price plus 6%. Mercer recognizes MCOs may be able to price more aggressively than the benchmark for some drugs. In these cases, inefficient spend is offset. Total net potential savings reflect the overall inefficient spend by MCOs when compared to the benchmark.

This adjustment was applied to both the OP and SP COSs to reflect where physician administered drugs are expected to occur. Also, it is applied within column (L) of the CRCS in the Excel file titled *FINAL CY 2022 Medi-Cal Detail CRCS Package LB Rate Smry 2021 12.xlsx*.

Population Adjustments

For CY 2022, two additional adjustments based on population changes and trends were applied to the managed care data. Both of these adjustments are applied within column (K) of the CRCS in the Excel file titled *FINAL CY 2022 Medi-Cal Detail CRCS Package LB Rate Smry 2021 12.xlsx*. More detail on each adjustment is described in the next two subsections.

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. Due to the nature of the increasing enrollment driven largely by members remaining enrolled with Medi-Cal who otherwise would have been disenrolled, Mercer analyzed risk adjustment factors based on relevant population segments. A risk study was performed using a 12 month period from July 1, 2018 through June 30, 2019. The Medi-Cal managed care population was broken into three segments: leavers, joiners, and

constant members. Leavers were defined as members who left Medi-Cal, and were not enrolled in the six months following the study period. Joiners were defined as members who were not enrolled for the six months preceding the study period. The 'six month' criteria was used to ensure members who may have had temporary/short-term gap in enrollment were not included as leavers or joiners. Constant members were defined as those members who did not meet the leaver or joiner criteria. 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 CY 2019 base period to observed enrollment up through July 2021. Mercer projected how the distribution might further change into the CY 2022 rating period, with the assumption the PHE would only extend through December 2021. 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.

The COA groups that experienced the most significant enrollment changes from the start of the PHE were Child, Adult, ACA Expansion, and SPD; therefore, these were the populations included as part of the population acuity analysis. The SPD COA group was the exception, in that it did not experience a material increase in leavers and did not warrant an adjustment. The Child, Adult, and ACA Expansion populations did exhibit a larger increase in leavers and adjustments were applied to those populations. The adjustment varied by MCO based on MCO-specific enrollment observations, but the statewide average adjustments for Child, Adult, and ACA Expansion were -0.2%, -1.1%, and -1.2%, respectively. This adjustment is applied to all COS within column (K) of the CRCS in the Excel file titled *FINAL CY 2022 Medi-Cal Detail CRCS Package LB Rate Smry 2021 12.xlsx*.

Imperial County Full-Dual Community-Based Adult Services Adjustment

Within the SPD/Full-Dual COA group, CBAS dollars in Imperial County have remained relatively consistent (flat) throughout the past several years. However, MMs for this COA group have increased at a very high rate. This is likely due to the following factors:

- Effective December 2014, members utilizing CBAS in this county needed to enroll into managed care in order continue receiving the CBAS benefit. Prior to this, members could receive the CBAS benefit while enrolled in the FFS program. Due to this transition, all CBAS costs in this county moved into managed care. Additionally, there are only a limited number of CBAS facilities and these facilities have capacity limits. As a result, dollars in total have stayed relatively flat in this county through the years subsequent to this transition.
- In November 2013, this county began offering managed care as a delivery system option for its beneficiaries. Previously, beneficiaries in Imperial County could only be enrolled in the state FFS delivery system. Additionally, managed care enrollment is voluntary for dual members. It is likely that as managed care has become an option, more beneficiaries have begun to voluntarily enroll in managed care, which has increased enrollment in the years subsequent to this transition in November 2013.

As a result of this phenomenon, the CBAS members and dollars were all moved into managed care in December 2014, and these members represented a larger portion of the population in the period right after this transition. As more members have enrolled in managed care, the CBAS members now make up a lower portion of the total enrollment, and CBAS PMPM costs have subsequently decreased through the years. The increase in MMs is still occurring even after the CY 2019 base data period for Imperial County. The purpose of this adjustment is to account for the PMPM decline expected from the CY 2019 base data period to CY 2022 as a result of relatively consistent CBAS dollars and increasing MMs. This adjustment is based on a projection of CBAS dollars for each MCO by county/region divided by a projected MM count for CY 2022 to arrive at a projected CBAS PMPM for CY 2022. The projected CBAS dollars were based on a review of CY 2017, CY 2018, and CY 2019 RDT reported CBAS dollars validated by encounter data for the same period. The eligibility data used to project MMs was based on enrollment through July 2021 with supplemental information through August 2021, which was the latest known eligibility data at the time the adjustment was made. This projected CBAS PMPM figure was then divided by the trended base PMPM to arrive at the adjustment factors. This adjustment is applied to Imperial County, and impacts the SPD/Full-Dual COA and CBAS COS only. The adjustment factors can be found in column (K) of the CRCS.

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 2022 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 2022). 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 medical component of the “not subject to risk adjustment” carve-out amount is added back into the 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 $57.23 and $27.71 for 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 2022. The steps below describe the process utilized in the development of the CY 2022 maternity supplemental payment rates, as well as subsequent steps taken to remove costs associated with these payments from the capitation 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 2022 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 other supplemental payments 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 2022 capitation rates (2% at the lower bound, 3% at the midpoint, and 4% at the upper bound).
- Calculate delivery counts and birth rates by MCO:
  - Rely on Medi-Cal maternity supplemental payment count and birth count information generated by DHCS and CY 2019 RDT information provided by the MCOs.
  - Medi-Cal eligibility is the primary data source for Child, Adult, ACA Expansion, and WCM MMs.
  - Calculate historical birth rates by MCO (prior years reviewed for consistency) for the Child, Adult, ACA Expansion, and WCM COA groups.
  - Project number of delivery events based upon birth rates and CY 2022 projected MMs for applicable COA groups.
- Remove PMPM amount from Child, Adult, ACA Expansion, and WCM population costs by MCO.

Across all Two-Plan, GMC, Regional, and COHS model MCOs, the equivalent PMPM adjustment for the maternity supplemental payment is $0.94 for Child, $1.48 for WCM, $3.89 for ACA Expansion, and $54.13 for Adult at the lower bound of the rate range for CY 2022.

For the prior rating period (CY 2021), across all Two-Plan, GMC, and Regional model MCOs, the equivalent PMPM adjustment for the maternity supplemental payment was $0.97 for Child, $3.88 for ACA Expansion, and $48.89 for Adult at the lower bound of the rate range.

This methodology is budget-neutral, projecting the same total dollar outlays under a pre-and post-maternity supplemental payment approach.

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.

As such, Mercer initially reviewed potential encounter data information for making an appropriate adjustment. Unfortunately, the required information (a present on admission indicator, for example) is not currently part of the encounter data. This is an ongoing process without any current information available for a rate adjustment. Other studies and other state experience have shown limited needed adjustments related to these types of conditions. This issue will continue to be reviewed. No adjustments have been included within these rates. It should be noted that reductions related to potentially preventable IP admissions have been included as part of Mercer's efficiency adjustments related to the base managed care data, as noted previously.

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, COHS, and CCI model managed care contracts regarding GMED. The Two Plan, GMC, Regional, COHS, and CCI 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, COHS, and CCI 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 Mental Health Parity and Addiction Equity Act (MHPAEA), DHCS staff has confirmed there are no provisions in the Two-Plan, GMC, Regional, COHS, and CCI model managed care contracts in violation of MHPAEA.

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

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 2022. Note there was a change to the administrative load development process due to the pharmacy carve-out as planned by DHCS for CY 2022. The administrative load was first developed in a consistent manner as the prior rate period (CY 2021) assuming no change to pharmacy services as a covered benefit in the rates. Then Mercer converted the initially developed "Rx In" administrative load to a "Rx Out" administrative load in a cost neutral manner based on Mercer's established pharmacy specific administrative load assumption (2% of Rx component of the rate) as informed by the Mercer pharmacy sector's experience and industry knowledge. To facilitate year-over-year comparison of administrative load assumptions with the prior rate period, "Rx Out" administrative load assumptions are listed in the table below which were used for both current (CY 2022) and prior (CY 2021) periods of rate development. Please note the table below also includes "Rx Out" administrative load assumptions for all applicable CY 2022 supplemental payments including maternity supplemental payment, BHT supplemental payment, and various non-Rx related add-on rates. They represent the variable component of the applicable regular administrative loads, which are equal to 50% of the applicable "Rx Out" regular administrative loads. All quoted figures below are mid-point administrative loadings. 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, +/- 0.5% for the COHS model and +/- 0.25% for the CCI Institutional rates.

Model or COHS Plan	CY 2021 "Rx Out" Administrative Load	CY 2022 "Rx Out" Administrative Load	CY 2022 "Rx Out" Administrative Load For Supplemental Payments and Non-Rx Related Add-On Rates
Two-Plan/GMC/Regional	8.65%	8.95%	4.475%
CenCal Health	7.55%	7.75%	3.875%
HP of San Mateo	8.10%	8.35%	4.175%
Central California Alliance	9.05%	8.90%	4.450%
CalOptima	5.30%	5.50%	2.750%
Gold Coast HP	9.20%	9.00%	4.500%
PHC	5.65%	5.55%	2.775%
COHS Total	6.69%	6.72%	3.361%
All Two-Plan/GMC/Regional/ COHS	8.15%	8.35%	4.177%
CCI Institutional	2.50%	2.60%	N/A

The following describe the data, methodology, and assumptions used to develop CY 2022 administrative loads with a focus on "Rx In" administrative loads.

For CY 2022, the administration loading for the Two-Plan, GMC, Regional, and COHS model MCOs is developed in aggregate across all COA groups, including ACA Expansion. The administration loading for COHS counties is developed using MCO/county-specific experience due to material differences in the covered populations compared to the other model types. In COHS counties, LTC, and WCM both account for a material portion of the covered populations, and has different administrative needs compared to general acute populations covered by the other model types. To recognize such differences, Mercer used each COHS MCO/county's experience as the primary data source to develop MCO-specific administration loading for the covered populations. Across the MCOs in the COHS model, the MCO-specific administrative loadings ranged from a low mid-point value of 4.75% to a high mid-point value of 7.95%. For the remaining model types (Two-Plan, GMC, and Regional), the same administration loading is developed across all plans given their similarities in covered populations as opposed to the COHS model. 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 of course 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 annual RDTs used for rate setting (base calendar 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.

As has been previously discussed, there has been administration percentage variation by commercial MCO, Local Initiatives, Two-Plan, GMC, COHS plan, etc., for a wide variety of reasons based on the plan reported actual experience. The following table provides a percentile distribution of actual reported administrative percentage experience on a unique combination of plan and county basis for the most recent base period.

Percentile	CY 2019 RDT Administrative Cost
25th	5.56%
50th	7.28%
75th	9.04%
100th	31.02%
Weighted Average	6.75%

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 increase of administration percentage from multiple data sources including the most recent quarterly financial data through the last quarter of CY 2020, Mercer raised the assumed administration percentage level accordingly for CY 2022 rates for Two-Plan, GMC, Regional, and most COHS plans.

While the above is the overall targeted aggregate administrative percentage, the administrative expense associated with each COA group 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 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.

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 was adjusted from 2.5%, used in the prior (CY 2021) rating period, to 3% for the CY 2022 rating period across all Two-Plan, GMC, Regional, and COHS model MCOs, with the exception of the CCI Institutional rates (adjusted from 1.25% to 1.50% at the mid-point). The range for the underwriting gain component is +/- 1.0% at the upper/lower bounds from the mid-point value for all models with the exception of the CCI Institutional rates (which have a range of +/- 0.25% at the upper/lower bounds). 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-approved[3] MCO tax for applicable full service health care plans and their various lines of business. This tax approval expired on June 30, 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, 2022. To calculate the total tax liability for each MCO, DHCS utilized enrollment from CY 2018. Based on this enrollment period, each MCO's 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 that summarizes the submitted tax structure for the applicable two tax years within CY 2022 (SFY 2021–2022 and SFY 2022–2023).

[3] http //www.dhcs ca.gov/services/medi-cal/Documents/CAMCOTaxlett51716.pdf

SFY 2021–2022 MCO Tax Structure

Medicaid		Non-Medicaid	
Member Range	Tax per member	Member Range	Tax per member
0–675,000	$0.00	0–675,000	$0.00
675,001–4,000,000	$50.00	675,001–4,000,000	$1.50
4,000,001+	$0.00	4,000,001+	$0.00

SFY 2022–2023 MCO Tax Structure

Medicaid		Non-Medicaid	
Member Range	Tax per member	Member Range	Tax per member
0–675,000	$0.00	0–675,000	$0.00
675,001–4,000,000	$55.00	675,001–4,000,000	$1.50
4,000,001+	$0.00	4,000,001+	$0.00

For the CY 2022 calculations, Mercer used projections for July 2021 through December 2021 (informed by enrollment observed through July 2021) to estimate the proportion of the SFY 2021–2022 MCO tax liability that remains for January 2022 through June 2022. However, with the MCO tax liability being approved through the end of CY 2022, the entirety of the MCO tax liability meant for the first half of SFY 2022–2023 (July 2022 through December 2022) was applied to the CY 2022 MCO tax PMPMs calculations. Using this total tax liability across both six month time periods, a singular PMPM was calculated for CY 2022 for each MCO across all COA and all counties in which they operate.

The MCO tax is added to the rate ranges after the blend of the plan-specific and risk-adjusted county average rates, which is described in Section 7. Please also note that under the approved tax model, Aetna and United are not subject to any MCO tax for Medi-Cal members.

Section 6

Risk Adjustment

Capitation rates for DHCS' Two-Plan, GMC, and Regional models are risk-adjusted using the most recently available version of the Medicaid Rx health-based payment model developed by University of California, San Diego (UCSD). The risk adjustment applies to 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 not applied to the Institutional capitation rates in CCI counties, since no readily available model exists for this population and the capitation rate is specific to members residing in a LTC facility, which in itself matches payment to risk appropriately. Similarly, risk adjustment is not applied to the WCM rates since no readily available model exists for this population and there is only one MCO per county/region.

Capitation rates for the SPD/Full-Dual COA group are not risk-adjusted. The application of risk adjustment to the capitation rates is to better match the payment to the risk. For the SPD/Full-Dual COA, there are two main reasons these populations are not risk-adjusted. First, the Medicaid Rx model utilizes pharmacy data within the process of producing risk scores. The dual populations have very limited pharmacy experience within the Medi-Cal program, as the vast majority of their pharmacy claims are covered by Medicare Part D. Further, even when using a non-pharmacy (that is, diagnosis) based risk-adjustment model, much of the claims history is captured through Medicare, further complicating 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 populations 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.

The individual acuity factors and final plan factors in effect for January 2022 through December 2022 were based on pharmacy encounters and claims incurred February 1, 2020 through January 31, 2021 (referred to as the study period), using encounter data submitted by the MCOs to DHCS by April 30, 2021. 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 September 2021 to calculate the unadjusted risk factors for each Two-Plan, GMC, and Regional model MCO.

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. The risk-adjusted county average rates for each MCO are then blended at a 75% weight, with the historical MCO "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.

DHCS continues to validate encounter data and is working with the MCOs to support and monitor their efforts to continually improve the collection and reporting of encounter data. For example, prior to running the pharmacy encounter data through the Medicaid Rx classification system, the reasonableness of the pharmacy claims and encounter data volume were reviewed by calculating the monthly average number of claims per recipient across the MCOs. Analyses and reviews were performed on the pharmacy claims and encounters to measure claims without National Drug Code (NDC) information and to evaluate the validity of reported NDCs.

DHCS and Mercer used the prospective Medicaid Rx model to evaluate risk differences between the participating Two-Plan, GMC, and Regional model MCOs. 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 Medicaid Rx age and gender demographic groups.

The most recently available version of the Medicaid Rx health-based payment model was updated by UCSD to include a recent set of NDC codes and 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 Medicaid Rx model were developed assuming a comprehensive acute care and BH benefit package, 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 documents *CY 2022 CA RAR Methodology Letter FINAL 2021 12.pdf*.

Application of Risk Adjustment in the Rate Calculation

In an effort to encourage and reward cost efficiencies and effectiveness, DHCS is using a blended plan-specific and risk-adjusted county average rates approach for CY 2022, which is consistent with the approach used for prior rate development periods. As mentioned in the prior subsection, the CY 2022 blend is 75% of the risk-adjusted county average approach, and 25% of the MCO plan-specific approach. 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 25% blend in the CY 2021 rate development has been utilized for the 25% blend portion for CY 2022. 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 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 Average Rates

County-specific rates are developed on a weighted average basis using projected CY 2022 MMs. 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 2022, 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

The final (budget neutral) risk-adjustment plan factors are applied to the capitation rates after the application of administrative and underwriting gain loads, but before the addition of several add-on PMPM amounts, which include the following:

- MCO Tax PMPMs.
- Kaiser Sacramento MH add-on PMPMs.
- The LA County CBRC medical component "not subject to risk adjustment" carve-out PMPM amount, which contains full utilization for the CBRCs and costs above and beyond typical professional services costs that are paid to these clinics.
- Prop 56 Physicians Directed Payment PMPMs (described in the next section).
- Pass-Through Payment PMPMs (described in the next section).
- MOT PMPMs (described in previous section).
- ECM PMPMs (described in previous section).
- SPD CBAS add-on PMPMs (described in previous 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.

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: 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 and United in San Diego County: Since these MCOs are exhibiting considerable ramp up, which is expected to continue into CY 2022, a decision was made to not apply risk adjustment to these two MCOs in these counties. This will be re-evaluated for the next rating period.

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. 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 will be blended together using projected CY 2022 enrollment to arrive at the final CY 2022 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 2022 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).

Behavioral Health Integration Incentive Program

The state implemented the BHI Incentive Program during CY 2021, which provides incentive payments to MCOs for achievement of specified milestones and measures.

The purpose of the BHI Incentive Program is to incentivize Medi-Cal MCOs to improve physical and BH outcomes, care delivery efficiency, and patient experience by establishing or expanding integrated care in the MCO's network using teams who deliver coordinated comprehensive care for the whole patient.

Twenty-two MCOs submitted BHI Incentive Program applications to the DHCS. The MCOs collected and scored proposals from network providers for individual projects, and associated milestones and measures, which advanced one or more BHI Incentive Program goals. After initial scoring of proposals by the MCOs, DHCS received approximately 200 applications representing over 500 individual projects broken out by county. DHCS reviewed all MCO-proposed projects and approved those that most closely aligned with, and were deemed most likely to advance, BHI Incentive Program goals. DHCS provided determination letters to each MCO identifying the particular projects and maximum earnable funding amounts approved. The total maximum incentive funding that may be earned across all participating MCOs and the full duration of the program is $204 million. Additionally, the BHI Incentive Program has no effect on the development of capitation rates.

The BHI Incentive Program will be for a fixed period of two program years (PYs):

- PY 1 will be January 1, 2021 through December 31, 2021, which aligns with California's CY 2021 rating period.
- PY 2 will be January 1, 2022 through December 31, 2022, which aligns with California's CY 2022 rating period.

The enrollees covered by the BHI Incentive Program include Medi-Cal populations that are impacted by the BHI projects. Approved projects cover a wide distribution across the state with balanced inclusion of rural, suburban, and urban counties.

The project options covered by the BHI Incentive Program include options that can be applied in pediatric, adolescent, and/or adult practices:

- Basic BHI
- Maternal Access to MH and Substance Use Disorder Screening and Treatment
- Medication Management for Beneficiaries With Co-Occurring Chronic Medical and Behavioral Diagnoses
- Diabetes Screening and Treatment for People With SMI
- Improving Follow-Up After Hospitalization for Mental Illness
- Improving Follow-Up After ED Visit for BH Diagnosis

The providers covered by the BHI Incentive Program include primary care, specialty care, perinatal care, hospital based and BH providers, FQHCs/RHCs, AIHS providers, public providers, and others.

Additional detail regarding the BHI Incentive Program is available through the managed care contract, associated All Plan Letters, and similar instruction issued to MCOs.

Student Behavioral Health Incentive Program

The state will implement the Student Behavioral Health Incentive Program (SBHIP) during 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 behavioral health departments and schools, to build infrastructure, partnerships, and capacity statewide to increase the number of students receiving preventive and early intervention behavioral health services.

The SBHIP 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 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:

- Behavioral health wellness programs
- Telehealth infrastructure to enable services and/or access to technological equipment
- Behavioral health 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
- Behavioral health public dashboards and reporting
- Technical assistance support for contracts and/or agreements
- Behavioral health workforce
- Care teams
- IT enhancements for behavioral health 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 behavioral health departments, local schools districts, and school-linked community based providers.

Additional detail regarding the SBHIP is available through the managed care contract, associated All Plan Letters, and similar instructions issued to MCOs.[4]

COVID-19 Vaccination Incentive Program

COVID-19 vaccination incentive payments are being utilized to encourage vaccinations among Medi-Cal's beneficiaries. The new program to boost COVID-19 vaccination rates will allow Medi-Cal MCOs to earn incentive payments for activities that are designed to close vaccination gaps with their enrolled members, based upon lessons learned so far in the pandemic. MCOs provide case and care management services for Medi-Cal members and are well positioned to provide enhanced coordination services, partner with primary care providers, and conduct outreach for vaccine distribution to their members. The vaccination

[4] All Plan Letter 21-010 and supplemental Attachment A are available at https://www.dhcs.ca.gov/Documents/COVID-19/APL-21-010-Vaccine-Incentive.pdf and https://www.dhcs.ca.gov/Documents/COVID-19/APL-21-010-Attachment-A-Vaccination-Incentive-Program-Outcome-Metrics.pdf respectively.

incentive program will also encourage significantly expanded outreach in underserved communities.

Funding will incentivize outreach programs and activities by MCOs and their providers, particularly primary care providers and pharmacies, as well as engagement with trusted community organizations, such as food banks, advocacy groups, and faith-based organizations.

The vaccination incentive program runs from September 2021 through February 2022. The funding for these incentives that will be paid in accordance with 42 CFR §438.6(b) will not exceed $250 million across all applicable managed care contracts and certifications. The vaccination incentive program has no effect on the development of capitation rates.

Additional detail regarding the vaccination incentive program is available through the managed care contract, All Plan Letter 21-010 and any subsequent revisions, and similar instruction issued to MCOs.

CalAIM Incentive 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 will launch January 1, 2022, requiring significant investments in care management capabilities, ECM and Community Supports infrastructure, information technology (IT) and data exchange, and workforce capacity across MCOs, city and county agencies, providers and other community-based organizations.

The state will implement the CalAIM Incentive Payment Program (IPP) 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 $1.5 billion. The IPP has no effect on the development of capitation rates.

The purpose of IPP is to build appropriate and sustainable capacity, drive MCO investment in delivery system infrastructure, bridge current silos across physical and behavioral health 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

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.[5]

Housing and Homeless Incentive Program

As part of the state's overarching home and community based services (HCBS) spending plan, the state will implement the Housing and Homeless 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 behavioral health, public hospitals, county social 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; and
- 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.

[5] All Plan Letter 21-016 is available at https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-016.pdf.

The enrollees covered by the HHIP include, but are not limited, to: aging adults; individuals with disabilities; individuals with serious mental illness and/or SUD 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 behavioral health, public hospitals, and others.

Additional detail regarding the HHIPP is available through the managed care contract, associated All Plan Letters, 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

The state is continuing two-sided risk corridors associated with the five Prop 56 directed payment initiatives that had such mechanism in the prior rating period (CY 2021). 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.

Enhanced Care Management

Effective for CY 2022, DHCS will use a symmetrical, two-sided risk corridor as part of the 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 a 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 sub-capitation payments made by MCOs to global subcontractors that aligns with assumptions used in the CY 2022 rate development (see Base Data Adjustments related to Global Non-Medical Expense Adjustment), such payments will be reduced by 7 percent, or 5 percent for global subcapitation to Kaiser. 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 2022 capitation rates for the provision of a risk corridor. The CY 2022 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 2022 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

Effective for CY 2022, DHCS will implement a risk corridor for the portion of the MOT PMPM add-on associated with the directed payment that directs MCOs to pay for the transplant event itself at established Medi-Cal FFS rates. The risk corridor will not apply to plans in COHS counties and Cal MediConnect duals demonstration plans.

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 a 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 2022 capitation rates for the provision of this risk corridor. The CY 2022 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 2022 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 2022 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 Dental	Uniform dollar and percentage increases	Uniform percentage and dollar increases for specific dental services	Rate adjustment
Control Name TBD–Prop 56	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	
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 Physician Services	Uniform dollar increase	Uniform dollar increases for specific Physician and other professional services	Rate adjustment
Prop 56 Trauma Screening	Minimum fee schedule using State Plan approved rates	Minimum fee schedule for specific ACEs Screening services	Rate adjustment
Control Name TBD–Prop 56 VBP	Value based payment	Value-based enhanced payments to providers for specific events tied to performance on 17 core measures across four domains.	Rate adjustment
Dental Preventive Services	Minimum fee schedule using State Plan approved rates	Minimum fee schedule for specific Dental Preventive services.	Rate adjustment
Control Name TBD – MOT	Delivery system reform	FFS-equivalent payment requirement for network and non-network providers for newly transitioning 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	Uniform dollar or percentage increases	Uniform percentage increase to capitation payments and	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?
Payment Program (EPP)		uniform dollar increase for FFS services limited to predetermined pool amounts by DPH class and IP/non-IP service sub-pools	
CA 438.6(c) Proposal J–2021–DPH QIP	Quality/performance payments	Payments based on performance on designated measures with specified maximum allowable payments for each DPH	Separate payment term
CA 438.6(c) Proposal I–2021–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 2022 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.

Proposition 56 Directed Payments

Consistent with 42 CFR §438.6(c), DHCS is utilizing the following six provider directed payment initiatives. All of them share the same designation of "Proposition 56" as all six payment initiatives are 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 are listed as follows:

- Physician Prop 56
- Trauma Screening (Adverse Childhood Experiences Screening as named in the Preprint) Prop 56
- Developmental Screening Prop 56
- Family Planning Prop 56

- VBP Prop 56
- Dental Prop 56

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 2022 period (January 1, 2022 through December 31, 2022), except for VBP, which is effective 1H 2022 (January 1, 2022 through June 30, 2022). 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 2022 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.

To facilitate CMS rate review for each of the Prop 56 payment initiatives, the table below summarizes the Prop 56 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 as well, 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 Dental	All COAs	See "Sum – Add-On Details" tabs in file titled *FINAL CY 2022 Medi-Cal Detail CRCS Package LB Rate Smry 2021 12.xlsx*	Adjustment is applied as a PMPM add-on to the rates. A description of the data, assumptions and methodology is provided in the narrative below.	Confirmed. The preprint is anticipated to be submitted to CMS in December 2021.	Not applicable
Control Name TBD – Prop 56 Developmental Screenings	Child, Adult, ACA Expansion, SPD, and WCM	See exhibit referenced above	See prior description	Confirmed. The preprint is anticipated to be submitted to CMS in December 2021.	Not applicable

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 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 2021.	Not applicable
Control Name TBD – Prop 56 Physician Services	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 2021.	Not applicable
Control Name TBD – Prop 56 Trauma 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
Prop 56 VBP	All except SPD/Full-Dual and LTC/Full-Dual	See exhibit referenced above	See prior description	Confirmed	Not applicable
Dental Preventive Services	All	Impacts by COA: Child: 7.65% Adult: 0.33% ACA Expansion: 0.64% SPD: 1.25% SPD/Full-Dual: 0.33% LTC: 0.02% LTC/Full-Dual: 0.001%	Adjustment is described in HPSM Dental program change section	No preprint required.	Not applicable

Physician Proposition 56 Add-On Per Member Per Month

The Physician Prop 56 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 is anticipated to be submitted to CMS for approval no later than December 31, 2021, with no changes to major terms and conditions with the lone exception of the American Medical Association deactivating the 99201 E&M code. 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
99201	Office/OP Visit New	$18.00
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

Procedure Code	Description	Uniform Dollar Amount
99391	Preventive Visit Est	$75.00
99392	Preventive Visit Est	$79.00
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 2021), 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 2022–December 2022)				
COA	**Projected MMs**	**Prop 56 Add-on Projected Units**	**Total PMPM**	**Total Dollars**
Child	53,881,813	7,843,477	$8.36	$450,454,863
Adult	20,737,252	3,732,236	$9.50	$197,010,825
ACA Expansion	43,823,834	7,321,700	$8.98	$393,515,517
SPD	9,107,940	2,422,713	$15.08	$137,371,497
LTC	107,498	19,319	$10.31	$1,108,041
WCM	338,871	135,998	$24.21	$8,202,529
AIDS Non-Duals	4,980	1,375	$15.25	$75,945
All COAs	**128,002,188**	**21,476,820**	**$9.28**	**$1,187,739,217**

The PMPM adjustments were developed based upon MCOs' encounter data as well as MCO information submitted through the RDT. These two data sources, the encounters, and RDT data, were then utilized in developing a distribution and projected utilization of the impacted codes. Through a blended approach of the two data sources, 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 resulting needed add-on amount 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 PMPM amount was then further adjusted to include an administrative load (representing the variable administrative costs of the program, 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 the other supplemental payments as described further above. Further detail of these components, including MCO-specific amounts are included within the accompanying rate development detail provided in an 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, the add-on rate payment for this payment initiative will be subject to a two-sided risk corridor together with the Trauma Screening Prop 56 add-on rate payment and Developmental Screening Prop 56 add-on rate payment. As outlined in the preprint, the risk corridor will be based on the MEP achieved by each MCO. The MEP shall be calculated in aggregate as the qualifying directed payments made to eligible providers for qualifying services as a percentage of the medical portion of the add on rates across all applicable COAs and rating regions where the MCO operates. DHCS will perform the risk corridor calculation no sooner than 12 months after the end of the rating period. Further details can be found in the preprint.

Trauma Screening Proposition 56

The Trauma Screening Prop 56 directed payment is a payment arrangement, which directs MCOs to pay no less than a minimum fee schedule payment for specific Adverse Childhood Experiences 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 newly added in CY 2020, so there was no credible and complete claims experience data available in the base period. Similar to the rate development approach used

for the prior period, Mercer identified eligible enrollees in the most recent full year (CY 2019) of eligibility data based on their Medicare coverage status and specific age groups (age group 0–18 and age group 19–64) within each 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 calendar year rating period. Lastly, this PMPM amount was adjusted to include half of the plan-specific administrative load, which provides for the variable component of the expenses 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 included within the accompanying rate development detail provided in an Excel format.

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

Trauma Screening (January 2022–December 2022)				
COA	**Projected MMs**	**Prop 56 Add-on Projected Units**	**Total PMPM**	**Total Dollars**
Child	53,881,813	985,343	$0.56	$30,353,360
Adult	20,737,252	84,702	$0.13	$2,609,313
ACA Expansion	43,823,834	179,893	$0.13	$5,540,505
SPD	9,107,940	48,726	$0.16	$1,501,182
LTC	107,498	258	$0.07	$7,956
WCM	338,871	6,203	$0.56	$189,485
AIDS Non-Duals	4,980	27	$0.17	$847
All COAs	**128,002,188**	**1,305,152**	**$0.31**	**$40,202,647**

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, 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 Prop 56 add-on rate payment. As outlined in the preprint, the risk corridor will be based on the MEP achieved by each MCO. The MEP shall be calculated in aggregate as the qualifying directed payments made to eligible providers for qualifying services as a percentage of the medical portion of the add-on rates across all applicable COAs and rating regions where the MCO operates. DHCS will perform the risk corridor

calculation no sooner than 12 months after the end of the rating period. Further details can be found in the preprint.

Developmental Screening Proposition 56

The Developmental Screening Prop 56 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 is anticipated to be submitted to CMS for approval no later than December 31, 2021, 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 base period. Similar to the rate development approach used for the prior period, Mercer identified eligible enrollees in the most recent full year (CY 2019) of eligibility data based on their Medicare coverage status and specific age groups (age group 0–2 and age group 3–20) within each 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. Lastly, this PMPM amount was adjusted to include half of the plan-specific administrative load, which provides for the variable component of the expenses 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 included within the accompanying rate development detail provided in an Excel format.

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

Developmental Screening (January 2022–December 2022)				
COA	Projected MMs	Prop 56 Add-on Projected Units	Total PMPM	Total Dollars
Child	53,881,813	836,616	$0.99	$53,232,158
Adult	20,737,252	3,861	$0.01	$245,706
ACA Expansion	43,823,834	14,918	$0.02	$949,022
SPD	9,107,940	12,212	$0.09	$777,126
LTC	107,498	0	$0.00	$18
WCM	338,871	5,267	$0.98	$332,308
AIDS Non-Duals	4,980	0	$0.00	$0
All COAs	**128,002,188**	**872,874**	**$0.43**	**$55,536,339**

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, 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 Trauma Screening Prop 56 add-on rate payment. As outlined in the preprint, the risk corridor will be based on the MEP achieved by each MCO. The MEP shall be calculated in aggregate as the qualifying directed payments made to eligible providers for qualifying services as a percentage of the medical portion of the add-on rates across all applicable COAs and rating regions where the MCO operates. DHCS will perform the risk corridor calculation no sooner than 12 months after the end of the rating period. Further details can be found in the preprint.

Family Planning Proposition 56

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 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, 2021, 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[6]	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 IU COC SYS 19.5 MG	$2,727.00
J7297	LEVONORGESTREL-RLS INTRAUTERINE COC SYS 52 MG	$2,053.00
J7298	LEVONORGESTREL-RLS INTRAUTERINE COC SYS 52 MG	$2,727.00
J7300	INTRAUTERINE COPPER CONTRACEPTIVE	$2,426.00
J7301	LEVONORGESTREL-RLS 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

[6] Note: 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.

Procedure Code[6]	Description	Uniform Dollar Amount
58340	CATHETER FOR HYSTEROGRAPHY	$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.

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 most recent full year (CY 2019) of existing claims data using the list of 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 provider exclusion factors to develop the final claims PMPM, which vary by MCO and rating region.

Lastly, this PMPM amount was adjusted to include half of the plan-specific administrative load, which provides for the variable component of the expenses 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 included within the accompanying rate development detail provided in an Excel format.

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

Family Planning (January 2022–December 2022)				
COA	Projected MMs	Prop 56 Add-on Projected Units	Total PMPM	Total Dollars
Child	53,881,813	206,292	$0.68	$36,778,088
Adult	20,737,252	938,557	$10.71	$222,060,839
ACA Expansion	43,823,834	765,002	$3.09	$135,631,782
SPD	9,107,940	74,289	$0.97	$8,826,119
LTC	107,498	239	$0.24	$26,336
WCM	338,871	1,233	$0.64	$217,807
AIDS Non-Duals	4,980	45	$1.10	$5,478
All COAs	**128,002,188**	**1,985,657**	**$3.15**	**$403,546,448**

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, the add-on rate payment for this payment initiative will be subject to a two-sided risk corridor specific to Family Planning. As outlined in the preprint, the risk corridor will be based on the MEP achieved by each MCO. The MEP shall be calculated in aggregate as the qualifying directed payments made to eligible providers for qualifying services as a percentage of the medical portion of the add-on rates across all applicable COAs and rating regions where the MCO operates. DHCS will perform the risk corridor calculation no sooner than 12 months after the end of the rating period. Further details can be found in the preprint.

Value-Based Payment Proposition 56

VBP Prop 56 Directed Payment is a payment arrangement, which directs MCOs to make value-based enhanced payments to eligible network providers for specific events tied to performance on 17 core measures across four domains:

- Prenatal/postpartum care
- Early childhood preventive care
- Chronic disease management
- BH care

This arrangement directs MCOs to make additional enhanced payments for events tied to beneficiaries diagnosed with a substance use disorder, SMI, or who are homeless (also referenced as "At Risk Users" in the following VBP schedule). A multi-year preprint for this payment initiative was approved for the prior rating period and the renewal version applicable to the current rate period on May 5, 2020.

The following provides a brief description of this payment initiative:

- The type of this directed payment arrangement is a VBP initiative.
- MCOs are required to pay the eligible providers for the applicable incurred period using the following VBP schedule by core measure for specified services provided to eligible managed care enrollees.

Measure	Measure	Uniform Dollar Amounts for All Users	Uniform Dollar Amount for At Risk Users
1	Prenatal Pertussis ('Whooping Cough') Vaccine	$25.00	$37.50
2	Prenatal Care Visit	$70.00	$105.00
3	Postpartum Care Visit (First Visit)	$70.00	$105.00
3	Postpartum Care Visit (Second Visit)	$70.00	$105.00
4	Postpartum Birth Control	$25.00	$37.50
5	Well Child Visits in First 15 Months of Life (Six Month Visit)	$70.00	$105.00
5	Well Child Visits in First 15 Months of Life (Nine Month Visit)	$70.00	$105.00
5	Well Child Visits in First 15 Months of Life (12 Month Visit)	$70.00	$105.00
6	Well Child Visits Year Three	$70.00	$105.00
6	Well Child Visits Year Four	$70.00	$105.00
6	Well Child Visits Year Five	$70.00	$105.00
6	Well Child Visits Year Six	$70.00	$105.00
7	Childhood Vaccine — Two Year Olds (DTaP)	$25.00	$37.50
7	Childhood Vaccine — Two Year Olds (PCV)	$25.00	$37.50
7	Childhood Vaccine — Two Year Olds (IPV)	$25.00	$37.50

Measure	Measure	Uniform Dollar Amounts for All Users	Uniform Dollar Amount for At Risk Users
7	Childhood Vaccine — Two Year Olds (Hepatitis B)	$25.00	$37.50
7	Childhood Vaccine — Two Year Olds (Rotavirus)	$25.00	$37.50
7	Childhood Vaccine — Two Year Olds (Influenza)	$25.00	$37.50
7	Childhood Vaccine — Two Year Olds (HiB)	$25.00	$37.50
8	Blood Lead Screening	$25.00	$37.50
9	Dental Fluoride Varnish	$25.00	$37.50
10	Controlling Blood Pressure	$40.00	$60.00
11	Diabetes Care	$80.00	$120.00
12	Control of Persistent Asthma	$40.00	$60.00
13	Tobacco Use Screening	$25.00	$37.50
14	Adult Influenza ('Flu') Vaccine	$25.00	$37.50
15	Screening for Clinical Depression (CDF)	$50.00	$75.00
16	Management of Depression Medication	$40.00	$60.00
17	Screening for Unhealthy Alcohol Use	$50.00	$75.00

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, assumptions, and methodology used to develop these add-on rates.

There was limited claims experience data available in the base period to support add-on rate development. Similar to the rate development approach used for the prior period, Mercer leveraged existing eligibility data in the most recent full year (CY 2019) of eligibility data to identify the eligible group within each COA for each targeted service or event as defined under this payment initiative and then worked together with the State to develop the utilization assumption for each eligible group for each targeted service on a statewide basis. Given the assumed utilizations for each targeted service by each eligible group, eligible member mix within each COA, and the known enhanced payment (VBP schedule), Mercer calculated the expected claims PMPM on a statewide basis by COA for each core measure as the benefit cost component of the add-on rate. Services provided within FQHC/RHC facilities are also excluded from this add-on payment 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 provider exclusion factors to develop the final claims PMPM that varies by MCO and rating region. Lastly, this PMPM amount was adjusted to include half of the plan-specific administrative load, which provides for the variable component of the expenses 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 included within the accompanying rate development detail provided in an Excel format.

See the table below for detailed impacts for the six-month period:

VBP (January 2022–June 2022)				
COA	Projected MMs	Prop 56 Add-on Projected Units	Total PMPM	Total Dollars
Child	27,280,484	1,379,584	$2.29	$62,600,257
Adult	10,663,177	893,957	$3.61	$38,501,048
ACA Expansion	22,556,916	1,690,040	$3.02	$68,213,123
SPD	4,488,787	352,984	$3.59	$16,119,643
LTC	53,756	4,505	$3.69	$198,430
WCM	172,048	8,264	$2.16	$371,569
AIDS Non-Duals	2,490	217	$4.10	$10,209
All COAs	**65,217,658**	**4,329,552**	**$2.85**	**$186,014,279**

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.

According to the preprint, the add-on rate payment for this payment initiative will be subject to a two-sided risk corridor specific to VBP. As outlined in the preprint, the risk corridor will be based on the MEP achieved by each MCO. The MEP shall be calculated in aggregate as the qualifying directed payments made to eligible providers for qualifying services as a percentage of the medical portion of the add-on rates across all applicable COAs and rating regions where the MCO operates. DHCS will perform the risk corridor calculation no sooner than 12 months after the end of the rating period. Further details can be found in the preprint.

Dental Proposition 56

Consistent with 42 CFR §438.6(c), DHCS is implementing 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 percentage increase to HPSM's capitation rates through a prospective program change. See Program Changes above regarding Health Plan of San Mateo Dental for more details.

Dental Preventive Services

Consistent with 42 CFR §438.6(c)(1)(iii)(A), DHCS is implementing 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 capitation rates through a prospective program change. See Program Changes above regarding Health Plan of San Mateo Dental for more details.

Hospital Directed Payments

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 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	$3,708.34 million	The actuary certifies the incorporation of the separate payment term	See pink labeled columns in file titled *CY 2022 Medi-Cal Hospital Directed Payment Summary 2021 12.xlsx* for the PMPM estimates	Confirmed. The preprint is anticipated to be submitted to CMS in December 2021.	Confirmed
Control Name TBD–EPP	$1,878.64 million	The actuary certifies the incorporation of the separate payment term	See exhibit referenced above	Confirmed. The preprint is anticipated to be submitted to CMS in December 2021.	Confirmed

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)
CA 438.6(c) Proposal J–2021–DPH QIP	$1,896.66 million	The actuary certifies the incorporation of the separate payment term	See exhibit referenced above	Confirmed. The preprint is pending CMS approval	Confirmed
CA 438.6(c) Proposal I–2021–DMPH QIP	$161.35 million	The actuary certifies the incorporation of the separate payment term	See exhibit referenced above	Confirmed. The preprint is pending CMS approval	Confirmed

Information included in the attached spreadsheet *(CY 2022 Medi-Cal Hospital Directed Payment Summary 2021 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 is anticipated to be submitted to CMS for approval no later than December 31, 2021. The PHDP is a uniform dollar add-on payment for services provided by the class of network private hospitals, limited to a predetermined 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 2022 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 $3,708.34 million for the entire 12-month rating period. The IP uniform dollar add-on payment estimate of $972 and the OP/ER estimate of $104 produced impacts of $2,595.85 million and $1,112.48 million for the respective COS. The attached exhibit (*Exhibit I CY 2022 Directed Payments PHDP 2021 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 2022 Medi-Cal Hospital Directed Payment Summary 2021 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 §438.6(c) preprint.

Enhanced Payment Program

The EPP directed payment preprint is anticipated to be submitted to CMS for approval no later than December 31, 2021. The EPP consists of two parts: (1) uniform dollar add-on payment for services provided by the four classes of DPHs and (2) 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 2022 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 and San Francisco counties
- Class B is comprised of non-UC DPHs in LA County
- Class C is comprised of non-UC DPHs in Alameda, San Bernardino, 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 §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 MMs 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 §438.6(c) preprint.

The total impact of the EPP directed payment across the classes is targeted to be approximately $1,878.64 million. The attached exhibits (*Exhibit II CY 2022 Directed Payments EPP 2021 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 2022 Medi-Cal Hospital Directed Payment Summary 2021 12.xlsx*).

Designated Public Hospital Quality Incentive Pool

The Quality Incentive Program (QIP) DPH directed payment preprint encompassing the CY 2022 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 2022 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 $1,896.66 million. The attached exhibits (*Exhibit III CY 2022 Directed Payments DPH QIP 2021 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 2022 Medi-Cal Hospital Directed Payment Summary 2021 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 §438.6(c) preprint.

District and Municipal Public Hospital Quality Incentive Pool

The QIP DMPH directed payment preprint encompassing the CY 2022 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 2022 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 QIP DMPH directed payment is targeted to be approximately $161.35 million. The attached exhibits (*Exhibit IV CY 2022 Directed Payments DMPH QIP 2021 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 2022 Medi-Cal Hospital Directed Payment Summary 2021 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 §438.6(c) preprint.

MOT Hospital Directed Payment

The MOT directed payment preprint encompassing the CY 2022 rating period is anticipated to be submitted to CMS for approval no later than December 31, 2021. 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
Control Name TBD-MOT	Child, Adult, ACA Expansion, SPD, SPD/Full-Dual	$0	Adjustment is applied in the base capitation rates and is a portion of the MOT PMPM add-on.	Confirmed. The preprint is anticipated to be submitted to CMS in December 2021.	Not applicable

Pass-Through Payments

Pass-through payments, as described below, are applied in the Two-Plan, GMC, Regional, and COHS Model CY 2022 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.

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 2022. The approach for making these adjustments within the capitation rates are being addressed through two paths: 1) 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). These calculations produced estimated private/DMPH PMPMs, by rate cell and in total. It should be noted the GME amounts utilized to produce the baseline amounts were prior to the removal of maternity costs. This approach was taken so these adjustments did not impact the maternity supplemental payments (this is consistent with historical practice). The private hospital/DMPH components of the capitation rates were increased by a uniform percentage increase to the IP component (13.69%) and a uniform percentage increase to the OP/ER

component (14.28%), such that 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. The DMPH total is a subset of the IP factor 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 2022 Private Hospital DMPH IP HQAF Pass-through 2021 12.pdf* and *Exhibit B CY 2022 Private Hospital OP ER HQAF Pass-through 2021 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 2022 Medi-Cal Detail CRCS Package LB Rate Smry 2021 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 MMs 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 final payments will be based upon actual encounters received by the State, 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 Senate Bill 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 were prior to the removal of 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 4.025% administrative load, which aligns with administrative costs assigned to supplemental payments such as the maternity 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 $29.15 million across CY 2022 based upon enrollment projections.

Included attachment labeled *Exhibit C CY 2022 MLK IP Pass-through 2021 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 2022 Medi-Cal Detail CRCS Package LB Rate Smry 2021 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 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 were prior to the removal of 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 4.025% administrative load that aligns with administrative costs assigned to supplemental payments such as the maternity 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 $24.90 million across CY 2022 based upon enrollment projections.

The detailed build-up of these adjustments are included in the attachment labeled *Exhibit D CY 2022 BCHO Pass-through 2021 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 2022 Medi-Cal Detail CRCS Package LB Rate Smry 2021 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 final payments will be based upon actual MMs 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 2022 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 § 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, § 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 § 438.6(d)(1)(i) is $2,405,046,774. This amount is unchanged from prior rating periods.

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

General Methodology

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

1. Sixty percent of the base amount defined at § 438.6(d)(2) applicable to the period of January 1, 2022 through June 30, 2022; and
2. Fifty percent of the base amount defined at § 438.6(d)(2) applicable to the period of July 1, 2022 through December 31, 2022.

The aggregate amount resulting from this calculation is $2,368,915,393 as displayed in the exhibit *CY 2022 Base Amount Calculation 2021 12.pdf*.

The § 438.6(d)(2)(i) component of the base amount is equal to the aggregate difference between the amounts calculated in accordance with § 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 IP and OP hospital services provided to eligible populations under the Medicaid managed care contracts for the 12-month period immediately two years prior to the CY 2022 rating period, which corresponds to CY 2020.

The § 438.6(d)(2)(i)(A) calculation includes two elements: unit cost and utilization. Unit costs were based on Office of Statewide Health Planning and Development (OSHPD) statewide data for Medicare FFS beneficiaries. CY 2019 data was leveraged to arrive at estimated CY 2020 average unit costs for IP and OP hospital services. To maintain consistency with the approach used for the § 438.6(d)(2)(i)(B) component, unit cost trend was applied to the CY 2019 data in order to determine a reasonable estimate of CY 2020 unit costs. The trend applied was based on the average Consumer Price Index for All Urban Consumers (CPI-U) for hospital related services over the five recent state fiscal years (SFY 2015–2016 through SFY 2019–2020). The resulting estimated IP and OP unit costs are 3.97% higher year-over-year compared to the CY 2019 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 2020. Distinct trends were applied for IP and OP hospital services based on the average base data utilization change over the previous four 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 IP and OP hospital services, respectively. The resulting IP and OP amounts were then summed to determine the total amount for the § 438.6(d)(2)(i)(A) component of the calculation.

The § 438.6(d)(2)(i)(B) calculation includes three elements: unit cost, utilization, and directed payments. CY 2019 data was trended to arrive at estimated CY 2020 average unit costs for IP and OP hospital services. The same trend used for the § 438.6(d)(2)(i)(A) component of the calculation was utilized here. Utilization is identical to that used for the § 438.6(d)(2)(i)(A) component of the calculation. Unit cost was multiplied by utilization for both IP and OP hospital services, respectively. The resulting amounts were then summed and further increased by the amount of applicable directed payments for IP and OP hospital services for the CY 2020 base period. The applicable directed payments were made as part of the EPP and PDHP. These directed payments were first implemented beginning on July 1, 2017.

Aggregate Difference

The aggregate difference between the total amounts of §§ 438.6(d)(2)(i)(A) and (d)(2)(i)(B) is $4,307,118,897. This amount was multiplied by a factor of 0.55 to account for the 60% and 50% phase-down levels associated with the fifth and sixth fiscal years, respectively, occurring after July 1, 2017.

Trend Adjustments

At the time of this calculation, CY 2020 cost and utilization data specific to Medi-Cal managed care was not readily available for use in this calculation. As per the standard Medi-Cal managed care rate development process, and to allow adequate time for claims completion and MCO reporting, CY 2020 base data had not been fully collected from MCOs and had not been reviewed, validated, or aggregated yet.

Therefore, both unit cost and utilization trends were applied in the calculation of the amount specified by § 438.6(d)(2)(i). Trends were applied consistently for both § 438.6(d)(2)(i)(A) and (d)(2)(i)(B).

The unit cost trend adjustment is based on the CPI-U: Hospital and Related Services. The average year-over-year growth from July 1, 2015 through July 1, 2020 was used to determine an annual trend percentage of 3.97%. 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 2019 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 = $2,368,915,393

Unit Cost Trend removed = $2,187,140,571

Utilization Trend removed = $2,180,768,969

Unit Cost Trend and Utilization Trend removed = $2,006,095,978

DHCS believes both the unit cost and utilization trends applied in this calculation are reasonable and appropriate. However, of note, 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 2022 rating period.

The 42 CFR 438.6(d)(2)(ii) component of the base amount is assumed to be equal to $0, 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 IP and OP hospital services provided to eligible populations through the Medicaid FFS delivery system for the 12-month period immediately two years prior to the CY 2022 rating period that have subsequently shifted to the Medicaid managed care delivery system. There were no major shifts of IP and OP hospital services, and of eligible populations, from Medicaid FFS to Medicaid managed care for the applicable time periods, such as for MOT services in Two-Plan, GMC, and Regional counties and for various transitioning populations as previously described in this certification. However, for simplicity, given the § 438.6(d)(2)(i) component on its own exceeds the projected aggregate amount of pass-through payments for the CY 2022 rating period, DHCS did not utilize a non-zero amount for the 438.6(d)(2)(ii) component at this time. The state reserves the right to utilize this component of the calculation in a future amendment of this certification 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 (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 (acknowledging the future UIS/SIS amendment) 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 [redacted], or Jim Meulemans at [redacted].

Sincerely,

[redacted]

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

[redacted]

James J. Meulemans, ASA, MAAA, FCA
Partner

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