MERCER

Program of All-Inclusive Care for the Elderly Amount that Would Otherwise be Paid

Capitation Rate Development and Certification

January 1, 2021–December 31, 2021

State of California
Department of Health Care Services
Capitated Rates Development Division
December 21, 2020

Mercer Government
Ready for next. Together.

Mr. Rafael Davtian
Division Chief
California Department of Health Care Services
Capitated Rates Development Division
1501 Capitol Avenue, PO Box 997413
MS 4413
Sacramento, CA 95899-7413

December 21, 2020

Subject: Program of All-Inclusive Care for the Elderly and Amount that would Otherwise be Paid — Rate Range Development and Certification for January 1, 2021 through December 31, 2021

Dear Mr. Davtian:

The California Department of Health Care Services (DHCS) contracted with Mercer Government Human Services Consulting (Mercer), as part of Mercer Health & Benefits LLC, to develop actuarially sound[1] capitation rate ranges for Program of All-Inclusive Care for the Elderly (PACE) and Amount that would Otherwise be Paid (AWOP) during the calendar year 2021 (CY 2021) period. This letter presents an overview of the methodology and analyses used in Mercer's AWOP and experience-based rate range development that complies with the requirements set forth by Centers for Medicare & Medicaid Services (CMS). The PACE AWOP, as defined by CMS, is "the amount that would otherwise have been paid under the State plan if the participants were not enrolled under the PACE program" and "takes into account the comparative frailty of participants." To meet CMS approval, the PACE capitation rates cannot exceed the AWOP.

[1] Actuarially sound/actuarial soundness — Medicaid capitation rates are "actuarially sound" if, for 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.
http://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049_179.pdf

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PACE Program Overview

PACE Eligibility

The PACE program enrolls eligible Medi-Cal members age 55 and older meeting nursing facility (NF) clinical criteria and living within the PACE service area. PACE AWOPs were developed to be consistent with the counties covered by each participating PACE Organization (PO). Each PO has a corresponding AWOP that was developed using data for the counties covered by that PO. PACE AWOPs were developed covering the following PACE program counties/county combinations.

Counties/County Combinations	
Alameda	Contra Costa
Fresno	Humboldt*
Los Angeles	Kern/Tulare
Fresno/Kings/Madera/Tulare	Orange
Riverside/San Bernardino	Sacramento
Sacramento/El Dorado/Placer/San Joaquin/Sutter/Yuba	San Diego
San Joaquin/Stanislaus	San Francisco
Santa Clara	

**Due to credibility concerns with the population size in Humboldt County, the AWOP for Humboldt leveraged data from the following counties: Humboldt, Sonoma, Mendocino, Del Norte, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity. This county grouping is consistent with the county grouping used in developing the managed care rate for Humboldt County.*

In addition, a PACE experience-based rate range was developed for each PO operating in the above counties/county combinations.

This certification includes rates for four new POs, with two expected to be operational on January 1, 2021, one in San Francisco county and one in Orange county, and another two on July 1, 2021, one in Orange county and another in Riverside/San Bernardino counties. AWOPs and experience-based rate ranges developed for these new POs were developed consistent with the methodology described below. Because no current experience exists, the experience-based rates were developed based on cost information submitted by other POs in the same or neighboring counties deemed to be similar in terms of geography or cost of living.

Covered Benefits

The PACE program encompasses a comprehensive benefit package, including NF, long-term services and supports (LTSS) including home- and community-based services (HCBS), inpatient hospital, outpatient hospital, physician services, laboratory and x-ray services, pharmacy, transportation, durable medical equipment (DME) and hospice services. A comprehensive list of covered benefits and coordinated access services can be viewed in the State of California PACE State Plan Amendment.

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Overview of Medi-Cal PACE Rate Setting

Beginning in CY 2018, per California Welfare & Institutions Code 14301.1, DHCS began setting PACE capitation rate ranges using an experience-based rate approach, in addition to developing the required AWOP, per the CMS Capitation Rate Setting Guide released in December 2015 and federal regulation. The PACE capitation rates paid to each PO will be determined by the state, within the experience-based rate range and less than the AWOPs.

AWOP Methodology

The PACE AWOP for CY 2021 was developed in accordance with the CMS PACE Medicaid Capitation Rate Setting Guide. Under the current context of the Medi-Cal program, in a non-county organized health system (COHS) and non-Coordinated Care Initiative (CCI) county, institutionalized members receive services almost exclusively through fee-for-service (FFS). Dual members in the community in a non-CCI, Two-Plan or Geographic Managed Care (GMC) county have the option to enroll in managed care, though the majority of members still receive services through FFS. Non-dual members in the community now participate in mandatory managed care. In a CCI county, where the State has expanded managed care to cover a wider range of LTSS, and in a COHS county, the alternative to PACE is primarily managed care; that is, Duals and Non-Duals participate in mandatory managed care programs that include many LTSS.

To develop the CY 2021 AWOP, Mercer utilized CY 2018 and CY 2019 managed care and FFS data, adjusted for the populations and services covered by the PACE program.

Experienced-Based Rate Ranges Methodology

Actuarially sound PACE experience-based rate ranges for CY 2021 were developed in accordance with generally accepted actuarial principles and practices, consistent with the approach utilized by DHCS in developing reasonable, appropriate and attainable capitation rates under Medi-Cal. To develop the rate ranges, Mercer collected claims data using a Rate Development Template (RDT) at the category of aid and category of service (COS) level. The final rate ranges were developed separately for each PO and county/county combination. Adjustments and credibility blending were applied as appropriate.

The following sections describe the program, base data and adjustments used to develop the AWOP and experience-based rate ranges.

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AWOP Development

Identification of PACE Eligible Population

The population meeting the PACE eligibility criteria emerged from the institutional and non-institutional populations who are nursing facility certifiable and ages 55 and older. These two broader groups (institutional/non-institutional) were further classified into Dual and Non-Dual, based on Medicare eligibility, for a total of four groups used to develop the CY 2021 AWOPs.

For the purpose of the AWOP development, the institutional members are defined as members with a long-term care (LTC) aid code or enrolled in a CCI plan with an institutional indicator in the eligibility file.

The non-institutional or HCBS members retained for the AWOP development met at least one of the following conditions:

- Members enrolled in CCI and considered HCBS High
- In-Home Supportive Services (IHSS) users with a severely impaired designation
- Users of Community-Based Adult Services (CBAS)
- Members enrolled in the Multipurpose Senior Services Program (MSSP) waiver
- Members enrolled in the Assisted Living Waiver
- Members enrolled in the HCBS waiver.

These populations serve as the basis for the PACE AWOP development.

Category Groupings

The base data sets used to develop the PACE AWOP were divided into initial population groups, which have inherently different levels of risk. The initial population groups for the CY 2021 AWOP are as follows:

- Institutional Dual
- HCBS – Dual
- Institutional Non-Dual

- HCBS – Non-Dual

Non-Dual members are defined as individuals with Medicare Part A Only or Part B Only or Medi-Cal Only coverage. Dual eligible members are individuals with Medicare Part A and Part B coverage.

AWOP Methodology

County level CY 2018 and CY 2019 FFS claims and managed care encounters were used to develop the base data for the 2021 AWOP. When necessary, adjustments were made to the base data to match the covered population risk and benefit package for the CY 2021 period. These adjustments consisted of the following:

- Completing encounters to account for:
  - Missing encounters
  - Zero-pay claims resulting from capitated payment arrangements
  - Incurred but not reported (IBNR)
  - Costs such as utilization management, incentives and reinsurance that would not be captured in encounter reporting
- Smoothing to correct for utilization and unit cost outliers

Additionally, the following adjustments were applied to base data to obtain the final AWOP rates:

- Prospective program changes
- Trend factors to project the expenditures and utilization to the contract period
- Acuity adjustment to HCBS members to reflect the frailty difference between the PACE population and the PACE-like population used to develop the AWOP
- Administration and underwriting gain loading
- Proposition 56 payment add-ons
- Coronavirus 2019 (COVID-19) vaccination administration add-on

The projected base data was summarized to obtain the CY 2021 utilization per 1000, unit cost and per member per month (PMPM) by initial population group and COS. Lastly, for the Dual and Non-Dual populations, the resulting PMPMs for the institutional and HCBS populations were blended at 40% and 60%, respectively, to arrive at the CY 2021 AWOP. The 40/60 institutional/community assumption used in AWOP development was compared to the current mix of members in the base data used in CY 2021, which was a 36/64 institutional/community mix, and deemed appropriate for CY 2021 rates. Corresponding with the HCBS Acuity adjustment detailed below, Mercer's analysis has shown that not

all members meeting criteria to qualify for programs used in AWOP base data, such as IHSS, MSSP and CBAS, will meet PACE level of care (LOC) criteria. There is no standard NF LOC definition that spans across the various programs. Therefore, the mix within the base data used for rate setting purposes is likely skewed towards a higher mix of community members. Due to this, Mercer has leveraged available historical experience as well as actuarial judgement to arrive at a standard 40/60 institutional/community assumption, which is evaluated for reasonableness each year. Additional details of the AWOP development are described below.

AWOP Base Data Sources and Analysis

The CY 2018 and CY 2019 Medi-Cal FFS claims and managed care encounters for the four initial population groups were collected and segmented into the 18 COS shown in the table below. In addition to the Medicaid paid amount, the coinsurance amount, patient liability and copayment amount were included in the base data such that the AWOP would include the full cost of providing State Plan services.

COS

Inpatient Hospital	Physician Primary Care	Mental Health Outpatient	CBAS	HCBS Other
Outpatient Facility	Physician Specialty	Pharmacy	Hospice	All Other
Emergency Room	FQHC	Laboratory and Radiology	MSSP	
LTC	Other Medical Professional	Transportation	IHSS	

These COS are consistent with the grouping used to develop the capitation rates for other Medi-Cal programs. Additional Medicaid covered services (such as dental) covered under FFS exclusively were added to ensure the base data was complete and reflective of the services expected to be covered under the PACE program in CY 2021.

Base Data Completion

The CY 2018 and CY 2019 data were used in the development of base data with run out through April 30, 2020. Base data utilization levels were compared to reasonable rate setting benchmarks to estimate missing encounters and adjusted accordingly. Zero-pay claims resulting from capitated payment arrangements were identified and adjusted to reflect the true costs of providing those services. IBNR was estimated and added to the base to reflect the fully incurred services and payments. Finally, managed care reported data was leveraged to determine a reasonable estimate of costs for utilization management, provider incentives and reinsurance that were not included in

encounter reporting and subsequently included in the AWOP base data. This adjustment was summarized and applied on a statewide basis by Dual status, Institutional/HCBS status and COS.

Non-Federal Share Costs in Designated Public Hospitals

The FFS claims for designated public hospitals (DPHs) in California are processed through a Certified Public Expenditures methodology in which the federal government covers the Federal share and the county covers the non-federal share of costs. The FFS hospital claims in the base data contained only Federal share costs for DPHs and so adjustments to account for the non-federal share of costs for DPHs were included in the CY 2020 AWOP development. This impacted the FFS Non-Dual population only.

Data Smoothing

In certain situations, the unit cost or utilization data for certain counties and COS was deemed to be an outlier. In those situations, the unit cost or utilization was smoothed to be more reasonable. Reasonableness was based on comparison to other surrounding counties' data and actuarial judgement.

Pharmacy Rebates

The historical FFS pharmacy data was adjusted downward by 50% to account for pharmacy rebates. Managed care pharmacy encounters were adjusted downward between 0.6% - 6.9%, varying by county/plan based on pharmacy rebates as reported by the managed care organizations (MCO). Managed care rebates are reflective of the costs to managed care plans if a PACE member were in managed care rather than PACE.

Third Party Liability

The base data was net of third party liability (TPL); therefore, TPL amounts were excluded from the base data pull.

Patient Liability/Share of Cost

The amount of patient liability was identified in the data and incorporated into the development of the AWOP base data. This was done to ensure that program change and trend adjustments were applied to the total costs of services. The last step of the AWOP development process included removing the patient liability from the final gross AWOP.

Adjustments to Develop the AWOP

Once the base data was adjusted, the CY 2021 AWOP was obtained by applying the following components to the adjusted base data:

- Program changes (covered below with the experience-based rates narrative).

- Trend factors to project the expenditures and utilization to the contract period (covered below with the experience base rates narrative).

- An acuity adjustment was applied to the HCBS population to reflect the frailty difference between the actual PACE-eligible population and the PACE like population being used to develop the AWOPs. As mentioned earlier, Mercer's analysis has shown that not all members meeting criteria to qualify for programs used in AWOP base data, such as IHSS, MSSP and CBAS will meet PACE LOC criteria. There is no standard NF LOC definition that spans across the various programs. Therefore, an adjustment is required in order to ensure the HCBS population used in AWOP development truly reflects members eligible for PACE. Mercer reviewed historical comparisons between the various HCBS populations with consideration for how those HCBS members would compare to members eligible for PACE. Because these populations are sometimes small (especially at the county level) and are subject to year-to-year fluctuation, Mercer ultimately relied on actuarial judgement to finalize an acuity adjustment that would be reasonable to apply to the HCBS population, which has recently been redefined compared to the base population identified in prior years. Mercer applied an adjustment of 1.5, or 150%, to account for acuity differences between the members identified in the base data and those that would ultimately be eligible for PACE. Mercer intends to revisit this assumption, leveraging available data, and evaluate reasonableness on an ongoing basis.

- Administration and underwriting gain (not applied to FFS portion of the AWOP) loading (covered below with the experience based rates narrative).

Proposition 56 Directed Payments

Consistent with rate setting for other Medi-Cal programs, a Proposition 56 (P56) PMPM add-on was included in the AWOP final rates. This add-on represents the P56 Physician Directed add-on which enhances payments to providers for specific evaluation and management current procedural terminology (CPT) codes, as well as the Value-Based Purchasing P56 initiative which provides enhanced payments to providers for certain CPT codes associated with conditions commonly seen in a PACE population. Services where Medicare would be the primary payer, full dual and Part B partial dual members, are excluded from these initiatives; therefore, P56 PMPM add-ons were only applied to the Non-Dual population.

Proposition 56 (Prop 56) add-ons are contingent on appropriations of funds being provided by the California Legislature. Absent continued appropriations, some elements of Prop 56 add-ons will sunset on June 30, 2021.

The first six-month rates, applicable for the time period of January 1, 2021–June 30, 2021, include P56 add-on amounts, whereas the second six-month rates, applicable for the time period of July 1, 2021– December 31, 2021, do not include P56 add-on amounts. The FFS dental data used to complete the AWOP base data contains a P56 component specific to dental rates. Therefore, the second six-month rates have a slightly downward adjusted base reflecting the removal of the P56 portion of the dental data. The first six-month AWOP rates are applicable for as long as P56 initiatives remain in place.

The amounts associated with this add-on are displayed in the AWOP rate detail provided with this certification letter.

The final PACE organization payment rates are set and will not change, regardless if the budget appropriations are provided.

COVID-19 Vaccination Add-on

While the cost of the forthcoming COVID-19 vaccination is expected to be covered by the federal government, an add-on to the Non-Dual rates representing the expected FFS costs associated with the administration of this vaccine has been included. The add-on amount is displayed in the AWOP rate detail provided with this certification letter.

Mercer worked closely with their managed care rate setting team to determine if any further adjustments to the AWOP rates were warranted due to the expected impact of COVID-19 in CY 2021. After analyzing numerous data sources showing both upward and downward expected cost impacts due to COVID-19, and realizing that the ultimate impact of COVID-19 is highly dependent on numerous unknown variables, it was determined that no further COVID-19 adjustment would be applied to the CY 2021 PACE rates.

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Development of Experience-Based Rate Ranges

Base Data

The information used to form the base data for the PACE experience-based rate range development was CY 2018 and CY 2019 PO-submitted RDT data and financial reporting. The CY 2018 and CY 2019 RDT data included utilization and unit cost detail by Rating Group, county, and eighteen consolidated provider types or COS, including:

- Inpatient Hospital
- Emergency Room
- Rehab Post-Acute Care Skilled Nursing Facility
- Outpatient Facility
- Laboratory, Radiology and Diagnostics
- Pharmacy
- DME
- Physician Specialty Services
- Psychiatric and Behavioral Health Services
- Primary Care Services
- Other Medical Professional (Non-Physician)
- PACE Center Services
- Transportation
- Home Health
- In-home Services
- Residential Care Services

- LTC (Custodial Skilled Nursing Facility)
- Dialysis

PACE Center Services were collected in the RDT separately, with additional detail breakouts including Social Services, Routine Nursing, Recreational Therapy, Personal Care/Chore Services, Meals, Escort and Transportation, Nutritional Counseling and Physical/Occupational/Speech Therapy. This data was reviewed for reasonableness as well as confirmation that PACE Center Services were not included with other medical services/COS. For final base data development and all adjustments, PACE Center Services were consolidated into one COS.

Final base data was developed by blending CY 2018 and CY 2019 RDT data equally (50%/50%). Credibility, as described below, was developed based on 24 months.

Where provided, utilization and unit cost information from the PO-specific RDT data was reviewed at the rating group and COS detail levels for reasonableness. Ranges of reasonable and appropriate levels of utilization and unit cost were then established for each COS within each rating group. Data reporting for utilization at the COS level continues to be challenging for the newer POs. In these cases, cost information at the total cost level was deemed more reliable than at the unit cost level.

Rate Category Groupings

The base data used to develop the PACE capitation rate ranges were divided into cohorts that represent consolidated rate groupings, which inherently represent differing levels of risk due to payment for Medicare covered services. Rate ranges are developed for two different cohorts:

- Non-Duals (includes Medicare Part A Only and Medicare Part B Only members)
- Duals (members covered by Medicare Part A, B, and D)

Medi-Cal versus Medicare Cost Distribution

Each PO was asked to provide an actual distribution or an allocation estimate of the percentage of costs, by COS, that were the responsibility of Medi-Cal. It was assumed that Medicare would be responsible for the remainder of the cost and therefore the total costs reported were multiplied by the assumed Medi-Cal percentage for those members eligible for Medicare. The reported Medi-Cal allocations were reviewed for reasonableness and consistency across POs. Certain POs were not able to provide the requested Medi-Cal actuals or allocations. Where this was the case, a reasonable estimation was developed based on information reported by other POs.

Credibility Blending and Data Smoothing

POs vary in size, as well as in years of operation. Because of this, a credibility blending methodology was used for those POs that were not deemed fully credible. Full credibility was defined to be 18,000 member months. For each PO with less than 18,000 member months for the two-year base period (CY 2018 and CY 2019), cost data from the same or nearby counties were blended together until full

credibility was reached. When data from surrounding counties were factored into the blending, a cost of living factor was applied to the external county to account for any cost of living/cost of health care differences. Credibility was adjusted in certain instances where the underlying cost structure of the POs being blended was deemed inconsistent, such as where a relatively small PO is being blended with a much larger PO.

New PO Adjustment

To account for the somewhat relatively higher acuity and operational costs in a new PACE center, Mercer applied a “New PO factor” to POs in operation for less than two years. This factor begins at 3.0% for PACE centers starting in CY 2021 and decreases to 1.5% at the start of the second year of operation, prorated as necessary. For example, POs beginning July 1, 2020, received a 2.25% increase, the average of the abovementioned 3.0% and 1.5%. This adjustment factor was applied to the final rate, after credibility blending and across all COS. Mercer developed this factor by comparing available PO encounter data and PO-submitted RDT data for plans that became effective within the past three years.

Further, to acknowledge cost information provided by the new POs starting in CY 2019, Mercer leveraged the credibility formula and heavily blended their CY 2019 costs as reported by these POs with cost data from POs in the same or nearby counties until full credibility was reached. This adjustment, similar to the new PO adjustment mentioned above, was applied as a factor to the final rate, after credibility blending and across all COS.

COVID-19

Specific to this rating cycle, adjustments have been included to acknowledge challenges faced specifically by the POs due to the ongoing pandemic and resulting public health emergency (PHE). Specifically, the 10% LTC cost increase currently in effect through the PHE for Medi-Cal has been assumed for all 12 months of the rating period. Further, a PMPM add-on for administration of the COVID-19 vaccine has been applied to the Non-Duals rate range. Per guidance from CMS, the vaccine itself will be federally reimbursed and hence has not been included in the experience-based rate development.

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Components of Development that apply to both AWOPs and Experience-Based Rate Ranges

Trend

Trend is an estimate of the change in the overall cost of medical services over a finite period of time. Trend factors are necessary to estimate the expenses of providing health care services in a future period. As part of the CY 2021 AWOP and rate range development for the PACE program, Mercer developed trend rates for each provider type or COS separately by utilization and unit cost components. For experience-based rate development, trend rates for the different populations (Institutional, HCBS) were also blended at 40% and 60%, respectively, to be consistent with the underlying base data.

Trend information and data were gathered from multiple sources, including RDT data, PO financial statements, Medi-Cal MCO trend data, Medi-Cal FFS experience, Consumer Price Index, National Health Expenditures updates and multiple industry reports. Mercer also relied on professional judgment based upon experience in working with the majority of the largest Medicaid programs in the country. The CY 2018 and CY 2019 base data used was trended forward 30 months to the mid-point of CY 2021. For experience based rate development, the base data for new POs starting July 1, 2021 was trended forward 33 months.

For rate range development, the claim cost trend range component is +/- 0.25% per year for each of the utilization and unit cost components. The upper bound trend was applied in the development of the AWOPs.

The specific lower bound trend levels by utilization and unit cost for the 18 COS are displayed in columns (G) and (H) of the Experience-Based Capitation Rate Calculation Sheet (CRCS), respectively. These annual trend figures are applied for the number of months represented in the time periods section in the upper right hand corner of the CRCS. The number of trend months is determined by comparing the mid-point of the base period to the mid-point of the rating period.

Annual lower bound claim cost trends, across all COS range (varying by PO) from 1.5% to 2.1% for Part A&B Duals and 1.9% to 2.6% for Medi-Cal Only Non-Duals on a PMPM basis. For the AWOPs, upper bound claim cost trends were used and across all COS range (varying by AWOP) from 0.8% to

1.1% for Duals and 1.7% to 2.1% for Non-Duals on a PMPM basis (Institutional and HCBS combined). Note the trend figures exclude unit cost changes associated with the program changes listed below.

Program Changes

Program change adjustments recognize the impact of benefit, eligibility and/or reimbursement changes that have become effective since the beginning of the base period, or will become effective by the end of the contract period. The following program changes were accounted for in the development of the CY 2021 AWOP and capitation rates:

- Increase to LTC and NF unit costs to account for rate increases to AB 1629 facilities and other LTC facilities. LTC program changes are based on the historical increases of LTC daily rates and the projected increase for CY 2021. The county-specific percentage program change is calculated by comparing the average cost level in the base data period (CY 2018–CY 2019) to the contract period (CY 2021).

- IHSS wage increases to increase unit costs for the Personal Care COS from the base period data to CY 2021 wage levels. The county-specific program change was developed by comparing the average IHSS hourly rate in the base data period (CY 2018–CY 2019) to the projected average hourly rate in the contract period (CY 2021). As Medicare does not cover IHSS services, the change in hourly rate affected both the Non-Dual and Full-Dual populations.

- Hospice adjustment takes into account annual rate increases to hospice services and room and board. An adjustment was applied to all populations, consistent to the managed care rates.

  While POs are not required to pay at FFS levels for LTC, hospice or personal care, Mercer believes that the program change adjustments developed for the AWOP are reasonable approximations of the upward pressure on unit cost for similar services provided by the POs. Therefore, the same adjustment was applied for both AWOP and the experience based rate range development for the impacted services.

The program changes outlined below apply to the Medi-Cal managed care program and were included in the base data developed for the AWOPs:

- **SB 523 Ground Emergency Medical Transportation (GEMT):** SB 523 established the GEMT Quality Assurance Fee (QAF) program provides for an annual GEMT QAF rate that will be imposed on each “emergency medical transport” provided by each GEMT provider subject to the QAF. The QAF collected will be used to provide increased reimbursement in the form of an add-on to the FFS fee schedule rate for the appropriate billing codes. The amount included in the AWOP was consistent with rate setting for other Medi-Cal programs.

- **Home Health:** This adjustment was necessary to account for the FFS fee schedule increase for twelve CPT effective July 1, 2018. The adjustment was applied to the AWOP FFS non-dual population.

- **Non-Emergent Medical Transportation (NEMT):** Effective July 1, 2019, Medi-Cal will be restoring payment rates for NEMT procedure codes to levels in effect prior to the AB 97 10% rate

reduction that was applied to the NEMT procedure codes. Additionally, certain NEMT codes received an additional 15% payment increase. These adjustments only apply to the Medi-Cal FFS fee schedule; therefore, this adjustment was only applied to the FFS data used for AWOP rate development.

- **Optional Benefits:** Effective January 1, 2020, DHCS is restoring certain adult optional benefits, including vision (excluding lens fabrication), audiology, speech therapy, incontinence creams and washes and podiatry. The amount included in the AWOP was consistent with rate setting for other Medi-Cal programs.

- **MSSP:** Effective July 1, 2019, DHCS increased payment rates for MSSP services by 25%. This adjustment was made in AWOP rate development.

- **CBAS:** Effective July 1, 2019, Medi-Cal will be restoring CBAS facility payment rates to levels in effect prior to the AB 97 10% rate reduction that was applied to certain CBAS facilities. CBAS is only covered under managed care; therefore, this adjustment was only applied to the managed care data used for AWOP rate development. The amount included in the AWOP was consistent with rate setting for other Medi-Cal programs.

Disproportionate Share Hospital, Graduate Medical Education and Indirect Medical Education Payments

The expenditure and utilization data did not include Disproportionate Share Hospital (DSH), Graduate Medical Education (GME) or Indirect Medical Education (IME) payments. The State processes DSH, GME and IME payments outside the PACE contract. Therefore, these payments are not part of the AWOP or capitation rate development process.

Administration

The administration loading for the POs was developed in aggregate across all rate groupings. The administration load factor is expressed as a percentage of the capitation rate (that is, percent of premium). For the experience-based rate ranges, this mid-point percentage was developed from a review of the POs' historical reported administrative expenses, which are submitted as part of their attested RDTs on an annual basis. The administrative costs are reviewed to ensure that they are appropriate and reasonable for the Medicaid eligible PACE members. Mercer also utilized its experience and professional judgment in determining the mid-point and lower/upper bound percentages to be reasonable. The mid-point administration load was established at 13% across all POs. The range for the administrative component is +/- 4% at the lower/upper bounds from the mid-point value. This wider range reflects the unique nature of POs in terms of member size and operating model, as well as a wide range of actual PO results.

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

The AWOPs were developed to include a provision for the State's administrative costs for that portion of the base data, which was derived from FFS, and an appropriate managed care factor for that

portion of the base data derived from managed care data. FFS includes a 2.0% load factor (as a percent of the total AWOP) to reflect historical State administrative costs. Managed care administrative costs, for both institutional and HCBS combined, were assumed to be 9.55% in Two-Plan and GMC non-CCI counties, between 3.0% and 4.75% for CCI counties and 6.15% for Humboldt, a COHS county, consistent with other capitated rate setting under Medi-Cal at the upper bound. These factors vary by model type and population; in other words, managed care administration varies in CCI counties and non-CCI COHS counties (as compared to Two-Plan and GMC non-CCI counties) as well as between institutional and HCBS members.

Underwriting Gain

For experienced-based rate setting, the underwriting gain range was established across all POs at 2.0% (lower bound), 2.5% (mid-point) and 3.0% (upper bound). For AWOP rate setting, consistent with changes implemented in managed care rates, the underwriting gain range is 1.5% (lower bound), 2.5% (mid-point) and 3.5% (upper bound). Similar to administrative loads, there is a difference in the CCI counties in the AWOPs where the underwriting gain is 1.25% (lower bound), 1.5% (mid-point) and 1.75% (upper bound) for the institutional population and 2.0% (lower bound), 2.5%(mid-point) and 3% (upper bound) for the HCBS population. The development of the AWOP load was set using the upper bound. Mercer has implicitly and broadly considered the cost of capital within the rating assumptions. Mercer's conclusion is that assumptions surrounding underwriting gain, as well as the income a PO generates from investments, are sufficient to cover at least minimum cost of capital needs for the typical PO.

A managed care underwriting gain is applied to the AWOP only for the portion of base data derived from managed care data. That is, no underwriting gain was applied to FFS.

MCO Tax

No POs are subject to MCO tax for CY 2021; therefore, no MCO tax has been included in these rates.

Incentive Arrangements

There are no PO incentive arrangements in place.

Rate Ranges

To assist DHCS during its rate discussions with each PO, Mercer provides DHCS rate ranges for the experience-based rates that were developed using an actuarially sound process. The rate ranges were developed using a combination of a modeling process, which varied the medical expense (that is, risk) trend, the administration loading percentage and the underwriting gain loading percentage to arrive at both an lower/upper bound capitation rate. The final contracted rates agreed to between DHCS and each PO fall within the rate ranges provided by Mercer and below the AWOP.

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Rate and Rate Range Certification

In preparing the AWOPs and rate ranges described, Mercer has used and relied upon enrollment, eligibility, claim, reimbursement level benefit design and financial data and information supplied by DHCS, its POs and its vendors. DHCS, its POs 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 PACE model rate ranges for the CY 2021 time period, January 1, 2021 through December 31, 2021, were developed in accordance with generally accepted actuarial practices and principles, and are appropriate for the Medi-Ca-covered populations and services under the managed care contract. The undersigned actuaries are members of the American Academy of Actuaries and meet its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

AWOPs and rate ranges 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 PO costs will differ from these projections. Mercer has developed these rates and rate ranges on behalf of DHCS to demonstrate compliance with the CMS requirements identified in the CMS PACE Medicaid Capitation

Rate Setting Guide and are appropriate for the populations and services covered under the PACE program. Use of these rates and rate ranges for any purpose beyond that stated may not be appropriate.

POs are advised that the use of these rates and rate ranges may not be appropriate for their particular circumstance, and Mercer disclaims any responsibility for the use of these rate ranges by POs for any purpose. Mercer recommends that any PO considering contracting with DHCS should analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to these rate ranges 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 certification letter, which may include commenting on legal or taxation issues or regulations, does not constitute and is not a substitute for legal or taxation advice. Accordingly, Mercer recommends that DHCS secures the advice of competent legal and taxation counsel with respect to any legal or taxation matters related to this report or otherwise.

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

DHCS agrees to notify Mercer within 30 days of receipt of this report if it disagrees with anything contained in this report or is aware of any information or data that would affect the results of this report that has not been communicated or provided to Mercer or incorporated herein. The report will be deemed final and acceptable to DHCS if nothing is received by Mercer within such 30-day period. If there are any question regarding this report, please contact Marcie Gunnell at [redacted] or Cassidy Misbach at [redacted]

Sincerely,

[redacted]

Marcie S. Gunnell, ASA, MAAA, FCA
Principal

[redacted]

Cassidy Misbach, ASA, MAAA
Associate

Copy:
David Bishop, DHCS
Lindy Harrington, DHCS
Jon Jolley, Mercer
Branch McNeal, Mercer
Mike Nordstrom, Mercer
Gabe Smith, Mercer

Mercer Government
2325 East Camelback Road, Suite 600
Phoenix, AZ 85016
www.mercer-government.mercer.com