Mercer

Government Human Services Consulting

Program of All-Inclusive Care for the Elderly

Amount that Would Otherwise be Paid and Capitation Rate Development Certification

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

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Contents

Section 1

Executive Summary

The California Department of Health Care Services (DHCS) contracted with Mercer Government Human Services Consulting (Mercer), as part of Mercer Health & Benefits LLC, to develop actuarially sound[1] capitation rate ranges for the Program of All-Inclusive Care for the Elderly (PACE) and also PACE Amounts that Would Otherwise be Paid (AWOPs), during the calendar year 2022 (CY 2022) 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 the 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

Section 2

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[2]
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	

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 one expected to be operational on January 1, 2022 in Orange County, and another three on July 1, 2022, all in Los Angeles county. 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,

[2] 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.

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.

Section 3

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 as per the CMS PACE Medicaid 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 2022 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. With limited exceptions, 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 2022 AWOP, Mercer utilized 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 2022 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 and other 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.

Section 4

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 and 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 2022 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 2022 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 2019 FFS claims and managed care encounters were used to develop the base data for the CY 2022 AWOP. This base data period aligns with the CY 2022 Medi-Cal managed care rate development. When necessary, adjustments were made to the base data to match the covered population risk and benefit package for the CY 2022 period. These adjustments included 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 the base data to obtain the final AWOPs:

- 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 Disease 2019 (COVID-19) vaccine administration add-on

The projected base data was summarized to obtain the CY 2022 utilization per 1,000, 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 2022 AWOP. This assumption was compared to the current 35/65 institutional and HCBS distribution of members in the base and deemed appropriate for CY 2022 rates. A breakout of CY 2019 member months by county and rate cell for the population covered by managed care versus FFS in the base data period can be found on the [Enrollment] tab of the accompanying spreadsheet "*CA CY 2022 PACE Additional Exhibits 2021 12.xlsx*". Further, 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. Mercer has leveraged this, along with available historical experience, and actuarial judgement to arrive at a standard 40/60 institutional/community assumption, which is evaluated for reasonableness each year.

AWOP Base Data Sources and Analysis

The 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 primarily were added to ensure the base data was complete and reflective of the services otherwise covered for a PACE member in the CY 2022 rating period.

Base Data Completion

CY 2019 data was used in the development of the AWOP base data. CY 2019 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. The IBNR factors, provided on the [IBNR] tab of the accompanying spreadsheet "*CA CY 2022 PACE Additional Exhibits 2021 12.xlsx*", were built from the claims triangle reported by the Managed Care Organizations (MCOs) as part of the data collected for managed care rate development. The factors were applied to the managed care experience used in AWOP development. As the pure FFS data used in AWOP development is assumed to be more complete than the managed care data, it received 75% of the managed care adjustment.

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. The cost reports submitted by MCOs in the development of the managed care rates include separately identified costs associated with utilization management, provider incentives, Third Party Liability (TPL), and reinsurance. This data was leveraged to determine proportionally how much of the managed care costs are represented by these categories. That proportion was then summarized and applied to the managed care encounter data 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 2022 AWOP development. This impacts the FFS Non-Dual population only.

Data Smoothing

In certain situations, 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 used to inform the base was adjusted downward by 50% to account for pharmacy rebates. Managed care pharmacy encounters were adjusted downward between 0.5% - 6.9%, varying by county/plan based on pharmacy rebates as reported by the MCO. Managed care rebates are reflective of the costs to MCOs 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 2022 AWOP was obtained by applying the following components to the adjusted base data:

- Program changes (covered below with the experience-based rates methodology).
- Trend factors to project the expenditures and utilization to the contract period (covered below with the experience-based rates methodology).
- A 1.5 acuity adjustment factor was applied to the HCBS population to reflect the assumed frailty difference between the actual PACE-eligible population and the PACE-like population used to develop the AWOPs. As most HCBS programs under Medi-Cal used in the AWOP development do not require a member to meet NF LOC criteria (for example, IHSS is a personal care-like service, but is available through the State plan),

the only services whereby a member is required to be NF LOC in the same way as PACE are waiver programs. Further, not all MSSP members meet the same LOC criteria as PACE necessitating the application of the 1.5 acuity adjustment factor to bring the overall costs of the base population up to the levels of an HCBS population that better represent true NF LOC members 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) loads (covered below with the experience based rates narrative).

Proposition 56 Directed Payments

Consistent with rate setting for other Medi-Cal programs, a Proposition 56 (Prop 56) PMPM add-on was included in the AWOP final rates. This add-on represents the Prop 56 Physician Directed Payments which enhances payments to providers for specific evaluation and management current procedural terminology (CPT) codes, as well as the Value-Based Purchasing (VBP) Prop 56 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, for full dual and Part B partial dual members, are excluded from these initiatives; therefore, Prop 56 PMPM add-ons were only applied to the Non-Dual population.

The first set of six-month rates, applicable for the time period of January 1, 2022 through June 30, 2022, include Prop 56 add-on amounts for Physician Directed Payments and VBP, whereas the second set of six-month rates, applicable for the time period of July 1, 2022 through December 31, 2022, do not include the VBP Prop 56 add-on amounts. The amounts associated with these add-ons are displayed in the AWOP rate detail provided with this certification letter.

These Prop 56 add-ons are contingent on appropriations of funds provided by the California Legislature. Currently, all components are effective for the entire CY 2022 rating period, except for VBP, which is effective January 1, 2022 through June 30, 2022. Regardless of if the budget appropriations are provided, the final PACE organization payment rates are set and will not change.

COVID-19 Vaccine Administration Add-on

While the cost of the 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 the vaccine booster shot has been included. Costs for the administration of the booster are based on the CMS COVID-19 Vaccine Toolkit, *"Coverage and Reimbursement of COVID-19 Vaccines, Vaccine Administration, and Cost Sharing under Medicaid, the Children's Health Insurance Program, and Basic Health Program"*. Per Section I.9., *"UPDATED: Medicare Payment",* Medicare will cover the vaccine administration payments at $40.00 per dose. This amount is thus only applied to the Non-Dual population and spread across the entire 12-month rating period. This PMPM add-on amount is displayed in the AWOP rate detail provided with this certification letter.

Section 5

Development of Experience-Based Rate Ranges

Base Data

The data and information used to form the base data for the PACE experience-based rate ranges was CY 2019 and CY 2020 PO-submitted RDT data and financial reporting. The CY 2019 and CY 2020 RDT data includes 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

Claims/expense experience for PACE Center Services was collected in the RDT separately, with additional detailed breakouts for 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 and to provide 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.

The experience-based rates utilized a modeled CY 2020 base data period, leveraging a weighted average of an adjusted CY 2019 PACE RDT data (at 75%) and adjusted CY 2020 PACE RDT data (at 25%) to form the modeled base data period. 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, Medicare Part B Only, and Medi-Cal Only members)
- Duals (members covered by Medicare Parts A and B)

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 and rating category, that were the responsibility of Medi-Cal. It was assumed that Medicare would be responsible for the remainder of the cost and the provided Medi-Cal cost distribution percentages can thus be applied to the total reported costs for dual eligible members' experience.

The reported Medi-Cal allocations were reviewed for reasonableness and consistency across POs. Where necessary, a reasonable estimation of Medi-Cal's percentage of costs was developed based on reporting by other POs.

Credibility Blending and Data Smoothing

POs vary in size, as well as in years of operation. Due to 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 adjusted base period (CY 2019 and CY 2020), cost data from POs in the same or nearby counties were blended together.

When POs from different counties were used in the credibility 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 assumed 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 organizations starting in CY 2022 and decreases to 1.5% at the start of the second year of operation, prorated as necessary. For example, POs beginning July 1, 2021, received a 2.25% increase, the average of the first and second year factors, 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

At the time of rate setting, the Public Health Emergency (PHE) was expected to end December 31, 2021, as such 10 months of a 10% LTC cost increase associated with the PHE was carved out of the CY 2020 base data. Further, while the cost of the COVID-19 vaccination is expected to be covered by the federal government, an add-on to the Non-Dual rates associated with the administration of the vaccine booster shot has been included. Costs for the administration of the booster are based on the CMS COVID-19 Vaccine Toolkit, *"Coverage and Reimbursement of COVID-19 Vaccines, Vaccine Administration, and Cost Sharing under Medicaid, the Children's Health Insurance Program, and Basic Health Program"*. Per Section I.9., *"UPDATED: Medicare Payment"*, Medicare will cover the vaccine administration payments at $40.00 per dose. This amount is thus only applied to the Non-Dual population and spread across the entire 12-month rating period. Further, impacts of COVID-19 testing and treatment as well as acuity changes to mental health needs in relation to COVID-19 were taken into account. These are described in further detail in the "Program Changes" section.

No other explicit adjustments were made for the COVID-19 PHE within the CY 2022 PACE experience-based rate development process. Factors contributing to this decision included that CY 2020 experience was part of the base data, at a 25% weighting. This implicitly factored in COVID-19 experience, where generally aggregate lower utilization but higher unit cost was observed, with the net of the two components combined being a lower CY 2020 PMPM. Although it is impossible to predict the COVID-19 PACE CY 2022 impact, DHCS, Mercer, and the queried POs, believe there will be at least some, and hence have incorporated the lower CY 2020 base data.

Section 6

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 2022 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.

For the experience-based rate ranges, the 75%/25% weighted and adjusted CY 2019 (trended 12 months to CY 2020) and CY 2020 base data made the modeled CY 2020 base. This modeled base was trended forward 24 months to the mid-point of CY 2022 with POs starting July 1, 2022 receiving an additional 3 months of trend. The CY 2019 AWOP base was trended 36 months to the mid-point of CY 2022.

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 corner of the CRCS. The number of trend months is determined by comparing the mid-point of the modeled CY 2020 base period to the mid-point of the rating period, CY 2022.

Annual lower bound claim cost trends, across all COS range (varying by PO) from 2.6% to 3.9% for Duals and 2.8% to 3.7% for 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 1.0% to 1.3% for Duals and 1.8% to 2.4% 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 program changes incorporated in the development of the rates were based on information provided by DHCS staff as of November 4, 2021. The following program changes were accounted for in the development of the CY 2022 AWOP and capitation rates:

- **LTC Rate Increase:** This increase to LTC and NF unit costs accounts 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 2022. The county-specific percentage program change is calculated by comparing the average cost level in the base data period (CY 2019 for both AWOP and experience-based; CY 2020 for experience-based) to the contract period (CY 2022).
- **IHSS Wage Increase:** The IHSS wage increase is an increase to unit costs for the Personal Care COS from the base period data to CY 2022 wage levels. The county-specific program change was developed by comparing the average IHSS hourly rate in the base data period (CY 2019 for both AWOP and experience-based; CY 2020 for experience-based) to the projected average hourly rate in the contract period (CY 2022). As Medicare does not cover IHSS services, the change in hourly rate affected both the Non-Dual and Full-Dual populations.
- **Hospice Rate Increase:** The hospice adjustment takes into account annual rate increases to hospice services and room and board. An adjustment was applied to all populations, consistent with the managed care rates.
- **COVID-19 Testing and Treatment:** An assumed testing rate for current infection and antibodies was developed through a combination of statewide-expected testing outcomes and rate cell demographic information. Costs were included for the test, as well as associated administrative costs and any corresponding services (e.g., ED or office setting). COVID-19 treatment costs were estimated 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 then weighted based on an assumed distribution of incidence rate and severity of cases, which varied by rate cell.
- **COVID-19-related Mental Health Outpatient (MHOP) 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 mental health needs, Mercer is forecasting a 5% increase in Behavioral Health-related services relative to the base data time period.

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 upward cost pressures for similar services provided by the POs. Similarly, Mercer believes the cost and utilization impact of COVID-19 testing and treatment and COVID-19-related MHOP services would have similar impacts to a PACE center as to the

AWOP. Therefore, the same adjustments were applied for both AWOP and the experience based rate range development for the impacted services.

The program changes outlined below apply to one or both the Medi-Cal managed care and FFS programs and thus were included in the development of the AWOPs:

- **SB 523 Ground Emergency Medical Transportation (GEMT):** SB 523 established the GEMT Quality Assurance Fee (QAF) program, which 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. Both State law (Welfare & Institutions Code 14129.3(b)) and approved SPAs establish that the combination of the State's FFS fee schedule rates and the add-on payments constitutes the Rogers rates that MCOs must pay to non-contracted GEMT providers serving Medi-Cal managed care enrollees for those years in which the GEMT add-on is effective. The amount included in the AWOP was consistent with rate setting for other Medi-Cal programs.
- **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 restored 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%, but effective January 1, 2022, MSSP will be carved out of managed care. This adjustment was made in AWOP rate development to the FFS data used for AWOP rate development.
- **CBAS:** Effective July 1, 2019, Medi-Cal restored 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.
- **Continuous Glucose Monitoring:** Effective January 1, 2022, DHCS is adding continuous glucose monitoring systems as a benefit for 21+ beneficiaries. The system is comprised of three components: sensor (three 10-day sensors a month), transmitter (one transmitter every three months), and receiver (one receiver every three years). As this is considered a pharmacy benefit and hence carved-out from CY 2022 managed care rates, this adjustment only applied to the FFS data used for AWOP rate development.
- **Community Health Worker (CHW):** Effective July 1, 2022, Community Health Workers (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 in the managed care delivery

system through Enhanced Care Management (ECM), the impact of this program change is separate from ECM, leverages research on CHW staffing, and a build-up similar to the ECM model in identifying potential CHW utilizers.

- **Remote Patient Monitoring (RPM):** Included as an allowable telehealth modality in MC and FFS delivery systems as of July 1, 2021, CY 2022 Remote Patient Monitoring (RPM) treatment costs were determined through estimating average user utilization and provided estimated unit costs. The final adjustment was applied to the Specialty Physician and Primary Care Physician COS.

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 loads for the POs were developed in aggregate across all rate groupings. This 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 12% across all POs. The range for the administrative component is +/- 3% at the lower/upper bounds from the mid-point value. The range for CY 2022 was reduced (reduced mid-point and upper bound) from CY 2021. This PACE 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 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 9.85% in Two-Plan and GMC non-CCI counties, between 3.0% and 4.75% for CCI counties and 6.05% 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.

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

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 2.0% (lower bound), 3.0% (mid-point) and 4.0% (upper bound). Similar to administrative loads, there is a difference in the CCI counties in the AWOPs where the underwriting gain is 1.75% (lower bound), 2.0% (mid-point) and 2.25% (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 2022; 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 a 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.

Section 7

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 2022 time period, January 1, 2022 through December 31, 2022, were developed in accordance with generally accepted actuarial practices and principles, and are appropriate for the Medi-Cal covered populations and services under the managed care contract. 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 Mike Nordstrom at [redacted] or Ethel Tan at [redacted].

Sincerely,

Mike Nordstrom, ASA, MAAA
Partner

Ethel Tan, ASA, MAAA
Associate

Copy:
David Bishop, DHCS
Lindy Harrington, DHCS
Jon Jolley, Mercer
Branch McNeal, Mercer

Mercer Health & Benefits LLC
2325 East Camelback Road, Suite 600
Phoenix, AZ 85016
www.mercer-government.mercer.com