Mercer

Government Human Services Consulting

Capitation Rate Development and Certification

Dental Managed Care

January 1, 2022–December 31, 2022

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

December 20, 2021

Contents

Section 1

Executive Summary

The State of California Department of Health Care Services (DHCS) contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to develop actuarially sound capitation rates for use during the Medi-Cal Dental Managed Care (DMC) model calendar year 2022 (CY 2022). The CY 2022 rating period encompasses the time period of January 1, 2022 through December 31, 2022.

This document describes the rate development process and provides the certification of actuarial soundness required by Title 42, Code of Federal Regulations (CFR), part 438.4 (42 CFR §438.4). This document was developed to provide the requisite rate documentation to DHCS and to support the Centers for Medicare & Medicaid Services' (CMS) rate review process. This report follows the general outline of the CMS July 2021 through June 2022 Medicaid Managed Care Rate Development Guide, which is applicable to contract periods beginning on or after July 1, 2021. The credentialed actuary is certifying to a final rate as federally required.

Multiple attachments are also included as part of this rate certification package. These attachments include summaries of the CY 2022 capitation rates and capitation rate calculation sheet (CRCS) exhibits. The final capitation rates by county and category of aid (COA) can be found in the attached file titled *CY 2022 Dental Managed Care Final Rates_2021_12_20.xlsx*.

The CY 2022 rates represent a rate rebase, which used a blend of the two-year base of CY 2019 and CY 2020 data.

Overall, across all populations and both counties, the CY 2022 capitation rate (excluding Proposition 56) per member per month (PMPM) is projected at $11.86. This $11.86 PMPM is an approximate 11.0% increase from the corresponding CY 2021 figure. With a projected 10.6 million member months, total capitation dollars excluding Proposition 56 are projected to be approximately $126.0 million in CY 2022. Including Proposition 56, total projected dollars are $165.3 million and the approximate PMPM increase is 5.2%.

There is a potential that future amendments to this certification will be submitted to CMS. The rates in this certification will be evaluated for the impact of the unsatisfactory immigration status population. These members are currently embedded within the covered Medi-Cal managed care population. Through communications with CMS, it has come to DHCS and Mercer's attention that these members should be separated from the population with satisfactory immigration status for capitation rate development purposes. If the removal of members and/or services ineligible for full scope federal funding has a material impact on these capitation rates, an amendment will be submitted accordingly.

Section 2

General Information

This section provides a brief overview of California's DMC program and an overview of the rate setting process, and includes the following elements:

- Program history
- DMC organization 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 DMC contract information for additional detail.

Program History

The DMC program was established in the 1990s to provide dental services to Medi-Cal beneficiaries. These services are provided through contracts that DHCS has with dental plans licensed by the Department of Managed Health Care (DMHC), pursuant to the Knox-Keene Health Care Services Plan Act of 1975. DHCS pays the contracted dental plans a capitation payment PMPM to provide oral health care to DMC beneficiaries. DMC beneficiaries receive dental services from providers within the plan's provider network. DMC covered dental services are the same as services provided under the Dental fee-for-service (FFS) program.

The DMC program provides a comprehensive approach to dental health care, combining clinical services and administrative procedures that are organized to provide timely access to primary care and other necessary services in a cost effective manner. DHCS contracts with three Geographic Managed Care (GMC) Plans and three Prepaid Health Plans (PHPs) that provide dental services to Medi-Cal beneficiaries in Sacramento and Los Angeles Counties, respectively. Those plans are Access Dental Plan, Health Net of California, and Liberty Dental Plan of California.

DMC Organization Participation

Dental GMC is a mandatory program in Sacramento County. Medi-Cal recipients in Sacramento County who are eligible to receive dental services must select one of the available GMC plans for their dental care. Dental PHP is a voluntary program in Los Angeles County. This program was established to allow Medi-Cal recipients the option to enroll in DMC as an alternative to the Medi-Cal Dental FFS program.

Covered Services

Medi-Cal beneficiaries aged under 21 (Child population) receive comprehensive dental coverage, which includes, but is not limited to, diagnostic and preventive services, tooth extractions, root canal treatment, prosthetic applications, emergency services and orthodontics. Medi-Cal dental coverage for beneficiaries aged 21 and over (Adult population) includes the Federally Required Adult Dental Services and the Restored Adult Dental Services. After January 1, 2018, all Adult dental benefits that were previously eliminated have been fully restored; therefore, both the Child and Adult populations have the same covered dental benefits beginning on January 1, 2018.

Covered Populations

The DMC program currently covers or is available to all eligible Medi-Cal populations (except specific populations) in Los Angeles and Sacramento counties. In Sacramento County, Medi-Cal beneficiaries are mandatorily enrolled (with the exception of specific populations) into a contracting dental plan. Approximately 415,000 beneficiaries (2019, members with at least 90 days of continuous enrollment) were enrolled in DMC plans in Sacramento County. In Los Angeles County, Medi-Cal beneficiaries have the option to enroll into the DMC program or the Medi-Cal Dental FFS program. Approximately 380,000 (2019, members with at least 90 days of continuous enrollment) were enrolled in DMC plans in Los Angeles County.

As part of the CalAIM initiative, various additional populations are expected to increase enrollment 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
- Individuals participating in accelerated enrollment
- Child Health and Disability Prevention Infant Deeming
- Pregnancy-related Medi-Cal

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.

Adjustments were made to account for any assumed differences in acuity/underlying risk of the populations increasing their DMC enrollment.

Rate Structure

In the past, DHCS developed separate DMC capitation rates for the Child and Adult populations because of their different Medi-Cal dental coverages during different periods, and variations in utilization and cost due to their different mix of services. Starting with the SFY 19-20 rating period, Mercer updated the rate structure and developed separate DMC capitation rates for the Child, Adult and Affordable Care Act (ACA) Optional Expansion

populations. The ACA Optional Expansion aid codes were previously included with either the Child COA (member ages 19–20) or the Adult COA (member ages 21 and above).

The base data sets used to develop the DMC CY 2022 capitation rates were divided into cohorts that represent consolidated COAs, which inherently represent differing levels of risk. Mercer developed rates for each of these three COA cohorts:

- Child (age 0–20)
- Adult (age 21+)
- ACA Optional Expansion (age 19+)

DMC plans are compensated through monthly capitation payments for the three COA cohorts noted above. The capitation rates for the three COA cohorts include all services under the DMC contract.

FMAP

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 that are subject to a different FMAP and show this information. Furthermore, if there are proposed differences among the capitation rates to covered populations, CMS requires that valid rate development standards are applied and are not based on the rate of FMAP associated with the covered populations. This section 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 who meet federal standards, the Children's Health Insurance Program (CHIP) child population, and the ACA Expansion population. The BCCTP and CHIP populations receive 65% FMAP, while the ACA Expansion population receives 90% FMAP for CY 2022.

DHCS uses aid codes in its capitation payment system to identify qualifying recipients for higher FMAP. 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 implementation of the Families First Coronavirus Response Act (H.R. 6021) provides a temporary 6.2 percentage point increase for certain populations effective beginning January 1, 2020, and extending through the last day of the calendar quarter in which the public health emergency, declared by the Secretary of Health and Human Services for Coronavirus (COVID-19), including any extensions, terminates. The 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.

Rate Methodology Overview

Capitation rates for the DMC model were developed in accordance with rate setting guidelines established by CMS. As required by 42 CFR §438.4(b)(9), the actuary continues certifying to a single capitation rate for each rate cell. As communicated earlier, DHCS and Mercer utilized a rate rebase approach for the CY 2022 DMC capitation rate development.

For the DMC program rate development process, Mercer used a 75/25 blend of the CY 2019 and CY 2020 data reported by the DMC plans in their Rate Development Template (RDT) response as base data. The most recent Medi-Cal-specific financial reports submitted to DMHC, and the dental-specific financial statements submitted to DHCS and available at the time of the rate development were considered in the rate development process. Mercer adjusted the selected base data to match the covered population risk and the State Plan approved benefit package for CY 2022. Then Mercer applied additional adjustments to the selected base data to incorporate:

- Prospective and historic (retrospective) program changes not reflected (or not fully reflected) in the base data.
- Trend factors to project the expenditures and utilization to the rating period.
- Administration and underwriting gain loading.

The above approach has been utilized in the development of the rates for the CY 2022 DMC model. DHCS will offer the final certified rates as developed by the actuary to each DMC plan. Each DMC plan 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 development are described in the following sections.

No explicit adjustment was made for the COVID-19 public health emergency within the CY 2022 DMC rate development process. Factors contributing to this decision include:

- CY 2020 experience was included in the base data, at a 25% weighting. This implicitly factored in COVID-19 experience, where generally lower utilization but higher unit cost was observed.
- The DMC plans have a significant level of provider subcapitation. The dental providers contracted with the DMC plans were paid by the DMC plans; therefore, access to dental care remains.
- DHCS' continued and emphasized focus on enhanced utilization of dental services provided belief of return to levels relatively consistent with those prior to the COVID-19 public health emergency. CMS has of course subsequently issued a "Call to Action" to reverse the decline in care for Medicaid and CHIP children, including dental care declines.
- The DMC non-benefit load assumption is 15%, meaning the priced-for Medical Loss Ratio (MLR) is the same as the minimum MLR, 85%. Hence, if actual dental claims

expenses by the DMC plans were below priced-for, the difference would be recovered through remittance.

- DHCS and Mercer regularly review emerging financial experience of the DMC plans, which would include any related impacts due to the COVID-19. As stated above, DHCS also has in place an 85% minimum MLR remittance provision to mitigate risk of overpayment associated with COVID-19, and/or other factors.

MLR

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 managed care organizations (MCOs) are assumed to reasonably achieve MLRs at or greater than 85%.

The CY 2022 rates utilize a rate rebase methodology, updating the base time period to use CY 2019 and CY 2020 experience. This rate rebase, along with the non-benefit loads, result in aggregate priced-for effective MLRs at or greater than 85%.

The State has chosen to impose remittance provisions related to the 85% minimum MLR for CY 2022.

Section 3

Data

Base Data

The DMC plans submitted enrollment, dental experience data, and other financial information in the prescribed RDTs. Services incurred in CY 2019 and CY 2020 and completed with payment lag factors were used to form the base data for the DMC model rate development. The RDT data included utilization and unit cost details by COA group, by county and by three categories of service (COS), which are:

- Preventative Services
- Full Adult Benefits Restoration
- All Other Services

Mercer reviewed the utilization and unit cost information in the RDT data at the COA group and COS detail levels for reasonableness. Mercer also reviewed the completion factors and financial statement information the DMC plans reported in their RDTs. The Medi-Cal dental experience separately submitted to DMHC and DHCS were crosschecked with the RDTs. Aggregate experience for each of the three DMC plans appeared reasonable. Where appropriate, budget-neutral adjustments were made to the base data to account for unusual or unreasonable utilization and/or unit cost figures. As previously mentioned, a 75/25 blend of the adjusted CY 2019 and CY 2020 PMPM data was selected as the base.

With regard to overpayments to providers and 42 CFR §438.608(d), claims experience provided by the DMC plans and utilized by DHCS and Mercer was on a net-payment basis, after any recoveries. For the remaining requirements of 438.608(d), please see the DMC contract.

The base data utilized was dental managed care data that did not include any disproportionate share hospital payments or include any adjustments for Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs) reimbursement. Any FQHC costs considered in rate development are the costs incurred by the DMC plans, net of any wrap-around payment by DHCS to reimburse the FQHC at their Prospective Payment System rate.

Indian Health Care Providers

DMC model contract Exhibit A, Attachment 10, Provider Compensation Arrangements, details the Indian Health Care Providers (IHCP) reimbursement required, as it does for FQHCs and RHCs. Any IHCP costs would be contained within the underlying base data component in the capitation rate development process.

Cost Sharing

There are no copayments, coinsurance, or deductibles in DMC. Hence, no data adjustment for any of these items was necessary.

Third Party Liability

Medicaid is the payer of last resort. RDT and independent financial statement data were net of any Third Party Liability data, and so no base data adjustment was necessary.

Graduate Medical Education

DHCS staff has confirmed there are no provisions in the DMC model contracts regarding Graduate Medical Education (GME). The DMC plans do not pay specific rates that contain GME or other GME-related provisions. GME expenses are not part of the capitation rate development process.

In Lieu of Services

There were no in lieu of services included in the CY 2022 rates since none was part of the underlying base costs. In lieu of services will continue to be monitored in future base data and rating periods.

Retrospective Eligibility Services

DMC plans are not required to cover retrospective eligibility periods for their enrollees. These periods are covered in the Medi-Cal FFS program. Since DMC data serves as the base data for the rates, retrospective eligibility periods are not part of the capitation rate development process. No adjustments are necessary.

Data Smoothing

As discussed above, the aggregate experience for each of the three DMC plans appeared reasonable. However, in some instances utilization and/or unit cost figures appeared out of alignment on a relative basis. Where appropriate, budget-neutral adjustments were made to the base data to account for these situations. No dollars were gained or lost in the process.

Section 4

Projected Benefit Costs and Trends

Mercer projected the adjusted base data (described in Section 3) to the rating period. The adjustments used to produce the projected benefit trended costs are described within this section and are listed below:

- Trends from the midpoint of the base data period (July 1, 2020) to the midpoint of the CY 2022 contract period (July 1, 2022); CY 2019 data was also trended forward to the projected CY 2020 base, which was then blended with CY 2020 actual data
- Program changes

The adjustments listed above are shown within the various rows of the CRCS exhibits *(*SAC Rate Sheet and LA Rate Sheet in the attached *CY 2022 Dental Managed Care Final Rates_2021_12_20.xlsx*) by county and COA group.

Trend

Trend is an estimate of the change in the overall cost of providing health care benefits over a finite period. A trend factor is necessary to estimate the expenses of dental services in the defined contract period. As part of the CY 2022 dental rate development, Mercer developed trend factors by utilization and unit cost components. Multiple sources of data and information were used in the development of the prospective trend factors. Historical factors utilized were reviewed. Trends developed from the RDT Schedules 1.1, 1.2, and 1.3 were analyzed. DMC plan RDT Schedule 4 projected trends were considered. Other available data/information such as current Dental Consumer Price Index factors were gathered. Actuarial judgment was applied to determine the final trend factors. The average annual trend factors were applied from the midpoint of the base data period to the midpoint of the rating period. For the Child, Adult, and ACA Optional Expansion populations, the base data reflects the 24-month period of projected CY 2019 data and actual CY 2020, with a midpoint of July 1, 2020. The rating period is January 1, 2022 to December 31, 2022 with a midpoint of July 1, 2022. Therefore, annual trend factors were applied for 24 months.

Age Group	Annual Utilization Trend	Annual Unit Cost Trend	Annual Total Trend
Child (Age 0–20)	1.0%	0.0%	1.0%
Adult (Age 21+)	1.0%	0.0%	1.0%
ACA OE (Age 19+)	1.0%	0.0%	1.0%

The annual utilization and unit cost trends were reduced each by 1.0% compared to those used in CY 2021 rate development.

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 available at the time of rate development. The program changes detailed below were viewed to have a material impact on capitation rates. The next several subsections are the program change adjustments that were explicitly accounted for within the CY 2022 capitation rates. A summary showing the DMC impact by county and COA group can be found within the program change charts that are provided within the Excel file titled *CY 2022 Dental Managed Care Final Rates_2021_12_20.xlsx*. Per DHCS, there are no current finalized amendments that will be provided to CMS in the future.

Dental Transformation Initiative

Effective January 1, 2016, through the Medi-Cal 2020 waiver, and ending December 31, 2021, DHCS implemented and is overseeing four dental efforts (domains), which are collectively referred to as the Dental Transformation Initiative (DTI) program. DHCS offers payments as financial incentives for dental service providers who meet the goals determined for each domain in an effort to improve the overall dental utilization for children. The incentive payments themselves are not part of; therefore, not included, in the capitation rates. This program change estimates the utilization increase generated by the DTI Domain 1 payments.

The goal of Domain 1 was to increase the statewide utilization of preventive services by at least ten percentage points over the five years (CY 2016–CY 2020) of the Medi-Cal 2020 waiver period for Medi-Cal beneficiaries ages zero to 20, as aligned with the CMS Oral Health Initiative. It is believed the utilization impact as measured through CY 2021 will carry into CY 2022. There was an assumed 2% annual increase in the number of preventive services users, and a 0.5% annual increase assumed in the number of procedures utilized by each user.

Proposition 56 Directed Payments

The preprint for this payment initiative will be submitted to CMS no later than December 31, 2021.

There were no changes to the dental codes and percentage or dollar adjustments to the State's Schedule of Maximum Allowance for CY 2022. The Proposition 56 adjustment was

developed based on adjusted RDT data. The DMC-reported experience from CY 2019 and CY 2020 were reviewed and then projected forward 30 months to the midpoint of CY 2022.

Proposition 56 add-ons are contingent on appropriation of funds being provided by the California Legislature. It is believed that the funds will be approved and the rates certified in this report reflect the Proposition 56 add-ons for the entire CY 2022 contract period.

Preventive Services

A preprint is not required and will not be submitted to CMS for this payment initiative in accordance with 42 CFR §438.6(c)(2)(ii).

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.

A flat positive 1.0 percent utilization adjustment was assumed due to higher provider reimbursement levels.

Caries Risk Assessment

The State has added coverage for the Caries Risk Assessment Bundle that includes nutritional counseling for young children ages 0–8. The Medi-Cal Dental FFS program reimbursement to providers will change from $126 under DTI to $61 under CalAIM, as CalAIM removed motivational interviewing services from the bundle. CalAIM and DTI both permit the dental provider to bill the bundle two to four times a year per patient, depending on the patient's risk level.

Silver Diamine Fluoride

The State has added coverage of Silver Diamine Fluoride for children ages 0–6 and persons with underlying conditions such that nonrestorative treatment may be optimal (e.g., adults living in a SNF/ICF). The benefit provides two visits per member per year, for up to 10 teeth ($12/tooth in the Medi-Cal Dental FFS program) and a maximum of four treatments per tooth. The coverage for Silver Diamine Fluoride was offered under DTI Domain 2, payable per mouth ($35 in the Medi-Cal Dental FFS program) and limited to high risk children.

Managed Care Adjustment

Mercer set the managed care adjustment factor to 1.000 for the CY 2022 rating period due to the continued use of DMC plan-specific experience. This represents no change from the CY 2021 rating period.

However, DHCS and Mercer have retained the factor as a placeholder for potential future use around utilization and/or unit cost efficiency/effectiveness, or other appropriate adjustments.

Section 5

Projected Non-Benefit Costs

The projected costs as described through Section 4 represent 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

Capitation rates appropriately include provision for the administrative expenses that DMC plans incur as they operate under the risk contract requirements, as well as for the DMC plans' risk and cost of capital.

Administration

The administration loading for the CY 2022 rating period was developed considering the prior CY 2021 rate load, DMC plan financial administrative performance and trends over the last several years and DMC projections via their RDT Schedule 4 response. The administration percentage is applied as a percentage of the total premium for DMC. This percentage is unchanged from the CY 2021 rating period percentage of 13.0%. The actuary considers the CY 2022 13.0% administration percentage to be reasonable, appropriate and attainable. Historically, one DMC plan has reported administration at or somewhat below the 13% level while the other two have been above that mark.

Underwriting Gain

The underwriting gain was established at 2.0% across all DMC plans. This percentage is unchanged from the prior rating period, and is consistent with the internal range of values for the overall Medi-Cal MCO at-risk program capitation rate development. Mercer has implicitly and broadly considered the cost of capital within our rating assumptions. Mercer has concluded the assumptions surrounding the underwriting gain, as well as income that a DMC plan generates from investments, are sufficient to cover at least the minimum cost of capital needs for a typical dental plan.

Section 6

Special Contract Provisions Related to Payment

This section describes the following contract provisions that would impact the capitation rates and the final net payments to the DMC plans under the DMC contract:

- Incentive arrangements
- Withhold arrangements
- Risk-sharing mechanisms
- Stated directed payments
- Pass-through payments

Only the State Directed Payments explicitly appear within the CRCS exhibits.

Incentive Arrangements

No incentive or bonus arrangements between DHCS and the DMC plans have been, or are assumed to be, achieved or paid. Hence, this subsection is not applicable to the CY 2022 rate certification.

Withholding Arrangements

In conjunction with the DMC plans, DHCS has made a policy decision not to implement the 10% withhold of the monthly capitation payment for compliance with performance requirements under the contract. However, DHCS does withhold 3% of the monthly capitation payment for compliance with general operational requirements under the contract. Based on the DMC plans' compliance with these general operational requirements in prior contract years, the payment of the full amount of the 3% withheld funds was typically achieved.

Risk-Sharing Mechanisms

The State is exercising its option under the DMC contract to implement an 85% minimum MLR for CY 2022. The formula for calculating the Contractor's MLR is a/b. Where "a" is: total covered benefit and service costs of Contractor, including incurred but not reported claim completion in accordance to 42 CFR 438.8(e). Where "b" is: total capitation payments received by Contractor, including any withhold payments, minus taxes, licensing, and regulatory fees, in accordance to 42 CFR 438.8(f). Remittance takes place when the Contractor's MLR is below the 85% minimum requirement, and is the difference (excess) between the two percentages. Further details of the MLR can be found in the approved DMC contract.

Besides the aforementioned MLR, there are no other risk-sharing mechanisms effective for the capitation rates being certified to in this rate certification.

State Directed Payments

Proposition 56

Consistent with 42 CFR §438.6(c), DHCS has implemented 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 are being made to all eligible providers who perform these services for DMC enrollees. The supplemental payments are included as a percentage increase to the DMC capitation rates through a prospective program change. See Program Changes above regarding Proposition 56, and Sacramento Rate Sheet, Los Angeles Rate Sheet, Program Change Chart exhibits in the workbook titled *CY 2022 Dental Managed Care Final Rates_2021_12_20.xlsx* for more details.

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 "LA Rate" and "Sacramento Rate" tabs in file titled *CY 2022 Dental Managed Care Final Rates_2021_12_20.xlsx*	Adjustment is applied as a percentage change to the rates. A description of the data, assumptions and methodology is provided in the narrative above.	Confirmed. The preprint is anticipated to be submitted to CMS in December 2021.	Not applicable

Preventive Services

A preprint is not required and has not been submitted. Consistent with 42 CFR §438.6(c)(1)(iii)(A), DHCS has implemented 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 DMC enrollees. These payments are included as a percentage increase to the DMC capitation rates through a prospective program change. See Program Changes above regarding

Preventive Services, and Sacramento Rate Sheet, Los Angeles Rate Sheet, Program Change Chart exhibits in the workbook titled *CY 2022 Dental Managed Care Final Rates_2021_12_20.xlsx* for more details.

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
Dental Preventive Services	All COAs	See "LA Rate" and "Sacramento Rate" tabs in file titled *CY 2022 Dental Managed Care Final Rates_2021_12_20.xlsx*	Adjustment is applied as a percentage change to the rates. A description of the data, assumptions and methodology is provided in the narrative above.	No preprint required.	Not applicable

Pass-Through Payments

There are no pass-through payments applied in the DMC model CY 2022 capitation rates.

Section 7

Certification and Final Rates

This certification assumes items in the Medicaid State Plan and waiver, as well as the DMC contract, have been approved by CMS.

In preparing the capitation rates described, the actuary has used and relied upon enrollment, eligibility, claim, reimbursement level, benefit design and financial data and information supplied by DHCS and its vendors. DHCS and its vendors are solely responsible for the validity and completeness of this supplied data and information. The actuary has reviewed the summarized data and information for internal consistency and reasonableness, but did not audit it. In the actuary'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 Medi-Cal Dental 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.

The actuary certifies that the DMC model capitation rates for the CY 2022 rating 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 DMC 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 actuary is a member of the American Academy of Actuaries and meets its qualification standards to certify to the actuarial soundness of 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 DMC plan costs will differ from these projections. Mercer has developed these rates to demonstrate compliance with the CMS requirements under 42 CFR §438.4 and in accordance with applicable law and regulations. There are no stop loss, reinsurance, or incentive arrangements assumed in these rates. Use of these rates for any purpose beyond that stated may not be appropriate.

DMC plans 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 DMC plans for any purpose. Mercer recommends that any DMC plan considering contracting with DHCS should analyze its own projected dental expense, administrative expense, and any other premium needs for comparison to these rates before deciding whether to contract with DHCS.

The actuary 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, the actuary 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 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.

If you have any questions on the above certification document or attachments, please feel free to contact Mike Nordstrom at [redacted].

Sincerely,

[redacted]

Michael E. Nordstrom, ASA, MAAA

Partner

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