Mercer

Government Human Services Consulting

Capitation Rate Development and Certification

Dental Managed Care

January 1, 2023–December 31, 2023

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

December 23, 2022

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 the Medi-Cal Dental Managed Care (DMC) program for use during calendar year 2023 (CY 2023). The CY 2023 rating period encompasses the time period of January 1, 2023 through December 31, 2023.

Actuarially sound is being defined by Mercer as follows: Medicaid capitation rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For the purpose of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop loss cash flows, governmental risk adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, cost of capital, and government mandated assessments, fees, and taxes.

Per Section 4.2 of ASOP 49, capitation rates for Medi-Cal DMC were developed in accordance with the Centers for Medicare & Medicaid Services (CMS) requirements, and this report provides the certification of actuarial soundness, as defined and required in 42 CFR §438.4. Any proposed differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations comply with 42 CFR §438.4(b)(1), are based on valid rate development standards that represent actual cost differences to the covered populations, and these differences do not vary with the rate of federal financial participation associated with the covered populations in a manner that increases federal costs.

This report was developed to provide the requisite rate documentation to DHCS and to support the rate review process performed by CMS. This report follows the general outline of the CMS 2022–2023 Medicaid Managed Care Rate Development Guide (RDG) dated April 2022, which is applicable to contract periods beginning on or after July 1, 2022. A copy of the RDG, with documentation references, is attached with this report (please see the attached file titled *DMC CY 2023 Rate Development Guide 2022 12.pdf*).

Multiple exhibits are also included as part of this rate certification package (please see the attached file titled *DMC CY 2023 Rate Certification Appendices 2022 12.xlsx*). This attachment includes summaries of the CY 2023 capitation rates by county and category of aid (COA), including the final and certified capitation rates and a comparison to the prior calendar year 2022 (CY 2022) rating period certified rates, and capitation rate calculation sheet (CRCS) exhibits.

Mercer developed this rate certification package exclusively for DHCS; subject to this limitation, DHCS may direct this rate certification package be provided to CMS. It should be read in its entirety and has been prepared under the direction of Katharina Katterman, ASA, MAAA, and Jie Savage, ASA, MAAA, who are members of the

American Academy of Actuaries and meet its US Qualification Standards for issuing the statements of actuarial opinion herein.

To the best of Mercer's knowledge, there are no conflicts of interest in performing this work.

The suppliers of the data are solely responsible for its validity and completeness. Mercer has reviewed the data and information for internal consistency and reasonableness, but did not audit it. All estimates are based upon the information and data available at a point and are subject to unforeseen and random events, and actual experience will vary from estimates.

Mercer expressly disclaims responsibility, liability, or both for any reliance on this communication by third parties or the consequences of any unauthorized use or disclosure other than as mutually contemplated when Mercer was first retained to perform this work.

Certified Rate Change

Mercer has not trended forward the previous year's rates, but has completed a comprehensive exercise of rebasing using more recent program experience. The rebasing means that rates for various groups do not always move similarly, even with similar prospective trend forces operating on them. The new adjusted base may, and did, emerge differently than expected in the prior year's rate development.

The State of California (State) provides Medi-Cal coverage to certain members with unsatisfactory immigration status (UIS), referred to as the UIS population. UIS members are eligible to receive the same State Plan services as members with satisfactory immigration status (SIS), but federally eligible to only receive emergency and pregnancy-related services. Through communication with CMS, DHCS is required to set capitation rates for the UIS and SIS populations separately. Further, the capitation rates for the UIS population are required to be separated by federally eligible services (namely, emergency and pregnancy-related services) and services paid by the State alone (all other services). For the CY 2023 DMC capitation rates, no portion of the UIS population capitation rate was determined, at this time, to be federally eligible[1]. Therefore, this rate certification covers only rates applicable to the SIS population. For CY 2022 and prior rating periods, the DMC rates were developed in total across the UIS and SIS populations for all DMC-covered services. For CY 2023, the split of the UIS and SIS populations occurs within the base data, and capitation rates are developed after this split occurs. Unless otherwise noted in this report, all references to the CY 2023 capitation rates are assumed to be for the SIS population only.

In aggregate, across all COAs and both counties, the composite CY 2023 capitation rate (excluding Proposition 56 [Prop 56]) per member per month (PMPM) is projected at $12.42, and the composite CY 2023 certified rate PMPM (including Prop 56) is $15.57. This is an approximate 0.4% decrease from the CY 2022 certified rates. Composite values were calculated using projected member months for the CY 2023 rating period. With a projected 11.4 million member months, total capitation dollars excluding Prop 56 are projected to be approximately $142.2 million in CY 2023. Including Prop 56, total projected dollars are $178.3 million. Appendix A includes the final certified rates effective January 1, 2023 for each rate cell, and a comparison to the certified rates effective January 1, 2022.

[1] The State and Mercer expressly disclaim any inference that no portion of the UIS population capitation rate is federally eligible. The state continues to refine the parameters needed to distinguish federally eligible and ineligible dental services for the UIS population, and Mercer may revisit this determination in a rate amendment or in future rating periods.

As shown in Appendix A, there are some rate cells with negative changes in rates from the previous rating period, CY 2022. The primary driver of these rate changes is the base data change and/or decreases in the Prop 56 add-on PMPMs.

Section 2

General Information

This section provides a brief overview of California's DMC program and an overview of the rate setting process. This section 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 healthcare 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 healthcare, 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 ages 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 ages 21 and over (Adult population) includes the Federally Required Adult Dental Services (FRADS) and the Restored Adult Dental Services (RADS). 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.

As part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, various additional populations are expected to increase enrollment in managed care effective throughout CY 2022 and CY 2023. DMC will be voluntary for these populations in Los Angeles County and mandatory in Sacramento County.

The populations listed below transitioned January 1, 2022, and were previously non-mandatory in managed care (at least in some counties) and/or enrolled in the FFS delivery system:

- Individuals with other health coverage
- Individuals residing in certain rural zip codes
- Trafficking and Crime Victims Assistance Program (TCVAP)
- Individuals participating in accelerated enrollment (AE)
- Child Health and Disability Prevention Infant Deeming (CHDPI)
- Pregnancy-related Medi-Cal
- Breast and Cervical Cancer Treatment Program (BCCTP)
- Partial Dual beneficiaries in Two-Plan, GMC, and Regional Counties

The populations identified to transition January 1, 2023, who were previously non-mandatory in managed care (at least in some counties) and/or enrolled in FFS are as follows:

- Full Dual Beneficiaries
- Members previously subject to mandatory managed care, but not in managed care.
- Members residing in a long-term care (LTC) facility beyond the initial month of being institutionalized plus the following month (in certain counties including Sacramento County).

The Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DD) and Subacute (SA) populations will transition July 1, 2023. These populations were previously enrolled in FFS in some counties beyond the first month of admission plus the following month.

Adjustments were made to account for any assumed differences in acuity/underlying risk of the populations transitioning into managed care and enrolling in DMC, as described in Section 4.

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 State Fiscal Year (SFY) 2019–2020 (July 1, 2019 through June 30, 2020) 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 2023 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 (ages 0–20)
- Adult (ages 21+)
- ACA Optional Expansion (ages 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. Capitation rates for all COA groups listed above are for the SIS population only. The capitation rates also include a Prop 56 supplemental payment component. The supplemental payment is implemented as a Prop 56 Dental State directed payment under 42 CFR §438.6(c).

FMAP

Depending on the Medicaid managed care program, some services or populations may be subject to a different FMAP than California's regular FMAP. Recognizing this, CMS expects the signing actuaries 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 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 2023.

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, except for portions attributable to services subject to service-specific rates of 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 program were developed in accordance with rate setting guidelines established by CMS. The actuaries continue to certify to a single capitation rate for each rate cell. As communicated earlier, DHCS and Mercer utilized a rate rebase approach for the CY 2023 DMC capitation rate development.

For the DMC program rate development process, Mercer used CY 2021 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 2023. Then Mercer applied additional adjustments to the selected base data to incorporate:

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

The above approach has been utilized in the development of the rates for the CY 2023 DMC program. DHCS will offer the final certified rates as developed by the actuaries 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.

Medical Loss Ratio

Mercer confirms the capitation rate development process and resulting rates, as outlined in this certification and supporting documentation are reasonable, appropriate, and attainable and that managed care organizations (MCOs) are assumed to reasonably achieve medical loss ratios (MLRs) at or greater than 85%.

The CY 2023 rates utilize a rate rebase methodology, updating the base time period to use CY 2021 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 2023.

Section 3

Data

Base Data

The DMC plans submitted enrollment, dental experience data, and other financial information in the prescribed RDTs for services incurred in CY 2020 and CY 2021. Services incurred in CY 2021 and completed with payment lag factors were used to form the base data for DMC rate development. The CY 2021 time period was selected as the base data period for CY 2023 rate development, as it is the most recent and complete year of experience available at the time of this certification and reflects historical member utilization, managed care protocols, and provider reimbursement contracted amounts as reported by the DMC plans. In accordance with 42 CFR §438.5(c)(2), the base data period is no older than the three most recent and complete years before the rating period. The RDT data included utilization and unit cost details by COA group, by county, and by three categories of service (COS) which are:

- Preventive Services
- FRADS & RADS
- All Other Services

Mercer reviewed the utilization and unit cost data reported in the RDTs 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.

The RDT-reported data encompassed all DMC-enrolled members, including both SIS and UIS populations. A supplemental data request (SDR) template was submitted by each DMC plan to report CY 2021 experience specific to the UIS population. The CY 2021 UIS experience in these SDR templates was reviewed and compared against the aggregate RDT-reported experience to develop UIS membership percentages, and utilization and unit cost relativity factors, where UIS population sizes were credible. The CY 2021 base data for the total population was then split out by the SIS and UIS populations using these membership percentages and relativity factors by county, COA, and COS. The impact of adjusting the aggregate base data to represent the SIS population ranged by rate cell from -0.1% to -0.3%. The base data displayed in Appendix C columns labeled (A) through (C) represents the adjusted base data specific to the SIS population.

CY 2021 Prop 56 supplemental payments reported in the DMC RDTs (Prop 56 base data) were removed from the base data and projected separately. Prop 56 base data were reviewed and adjusted similarly for UIS and SIS members.

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

The DMC contract details the Indian Health Care Providers (IHCPs) 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 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 2023 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.

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:

- Trend
- Program changes

The adjustments listed above by county and COA group are shown in Appendix C.

Trend

Trend is an estimate of the change in the overall cost of providing healthcare benefits over a finite period. Trend factors are necessary to estimate the expenses of dental services in the prospective rating period. As part of the CY 2023 dental rate development, Mercer developed trend factors by utilization and unit cost components for each COS. Mercer's selected trends were applied for 24 months, from the midpoint of the base data period (July 1, 2021) to the midpoint of the rating period (July 1, 2023).

Multiple sources of data and information were used in the development of the prospective trend factors. Historical factors utilized were reviewed. Data reported in the RDT year-over-year were analyzed. DMC plan-reported projected trends were considered. Other available data/information such as current Dental Consumer Price Index factors, and reporting data for other states with similar Medicaid managed care dental programs were gathered. These sources provide broad perspectives of industry trends in the United States and in the West. Each source was reviewed for its potential applicability and was utilized collectively with other data and information via actuarial judgment to inform the final trend factors.

The trend factors are applied in columns (D) through (F) of Appendix C. Aggregate utilization trends by rate cell were used to project the Prop 56 supplemental payment component.

The annualized trend factors by COS are provided in the table below:

COS	Annual Utilization Trend	Annual Unit Cost Trend	Annual PMPM Trend
Preventive	3.0%	1.0%	4.0%
FRADS & RADS	2.0%	1.0%	3.0%
All Other Services	2.0%	1.0%	3.0%

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 and were reviewed, analyzed, and evaluated by Mercer with the assistance of DHCS.

The next several subsections are the program change adjustments that were explicitly accounted for within the CY 2023 capitation rates. A summary showing the CY 2023 PMPM impact by county and COA group can be found in Appendix B. Additionally, the aggregate program change adjustments identified below are applied in columns (G) through (I) in Appendix C.

Preventive Services

Effective January 1, 2022, DHCS implemented a State directed payment under 42 CFR §438.6(c) imposing 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. 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).

An adjustment was applied to applicable preventive services to increase the unit cost from base expected managed care levels to 75% above the State's Schedule of Maximum Allowances (SMA), consistent with the State directed payment.

Caries Risk Assessment

Effective January 1, 2022, the State added coverage for the Caries Risk Assessment (CRA) bundle that includes nutritional counseling for young children ages 0–6. The Medi-Cal Dental FFS program reimbursement to providers is $61 under CalAIM. CalAIM permits the dental provider to bill the bundle two to four times a year per patient, depending on the patient's risk level. Mercer reviewed utilization of CRA in FFS for young children eligible for the service and assumed similar utilization for DMC members. Utilization by rate cell was based on the underlying member age mix.

Silver Diamine Fluoride

Effective January 1, 2022, the State added coverage of Silver Diamine Fluoride (SDF) for children ages 0–6 and persons with underlying conditions such that non-restorative 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. In coordination with DHCS's dental division, 0.5% of children ages 0–6 and 0.1% of members ages seven and over were assumed to utilize the SDF benefit in CY 2023. Utilization by rate cell was based on the underlying member age mix.

Laboratory-Processed Crowns

Effective July 1, 2022, the State added coverage of laboratory-processed crowns for adults ages 21 and older who require laboratory-processed crowns on posterior teeth to normally

function. The benefit provides one procedure in a five-year period, and only for third molars when the third molar occupies the first or second molar position. DHCS and the DMC plans provided data for the CY 2021 base period on the number of alternative services provided (pre-fabricated crowns and alternatives to crowns) and the number of denied claims for laboratory-processed crowns for which no alternative service was provided. In coordination with DHCS' dental division, Mercer assumed that 98% of previously denied treatment authorization requests, 98% of pre-fabricated crowns, and 90% of 4+ surface restorations would be replaced by laboratory-processed crowns. Where services were assumed to be replaced by the new benefit, Mercer reviewed the difference in SMA for the alternative benefit compared to the new benefit. As the new benefit is subject to Prop 56 supplemental payments, a program change was also applied to the Prop 56 component of the rates.

Populations Transitioning from FFS to Managed Care

Certain Medi-Cal populations within the FFS delivery system, including some designated by the CalAIM initiative, transitioned to managed care in CY 2022 or will be transitioning within CY 2023.

The populations that transitioned from FFS to managed care on January 1, 2022, designated as part of CalAIM — Phase I, are as follows:

1. TCVAP, excluding the share of cost population
2. AE
3. CHDPI
4. Pregnancy-related Medi-Cal
5. BCCTP
6. Beneficiaries with other health coverage (OHC)
7. Beneficiaries in rural zip codes (Rural)
8. Partial Dual beneficiaries in Two-Plan, GMC, and Regional counties

For pregnancy-related Medi-Cal members, only newly enrolled members enrolled in managed care in CY 2022 and members who were already in FFS prior to CY 2022 did not transition.

The populations identified to transition from FFS to managed care in certain counties (including Sacramento County) on January 1, 2023, designated as part of CalAIM — Phase II, are as follows:

1. Full-Dual beneficiaries
2. Members previously subject to managed care, but not transitioned
3. Beneficiaries residing in a LTC facility

The populations identified to transition from FFS to managed care in certain counties (including Sacramento County) on July 1, 2023, designated as part of CalAIM — Phase II, are as follows:

1. ICF/DD and SA beneficiaries

Members transitioning from FFS to managed care will also be eligible for DMC, on a mandatory basis in Sacramento County and on a voluntary basis in Los Angeles County.

For these transitioning populations, both expected membership volume and dental costs in Los Angeles County and Sacramento County were taken into account in estimating the program change adjustment. Members were identified in the SFY 2020–2021 (July 1, 2020 through June 30, 2021) eligibility data by aid code, dual status, LTC accommodation codes, zip code, and enrollment indicators for OHC and waiver status. LTC utilizers were also identified using a 90-day look back logic to identify members with LTC stays, not in an LTC aid code. Member volume for each transitioning population was pulled by county, COA, and immigration status.

Mercer analyzed the aggregated anticipated dental PMPM impact of adding these transitioning populations into the existing managed care population for each COA in each county. Material rate impact was only anticipated for the Adult COA. As a result, utilization adjustments for the Adult COA were applied in both counties.

COVID-19 Considerations

No explicit adjustment was made for the COVID-19 public health emergency within the CY 2023 DMC rate development process. Factors contributing to this decision include:

- CY 2021 experience was used as the base data. The base period encompasses experience after the start of the public health emergency. Comparing to CY 2020 experience, where generally lower utilization but higher unit cost was observed due to COVID-19 impact, utilization and unit cost in CY 2021 were returning to pre-COVID levels and are deemed as appropriate base period data for projecting CY 2023 benefit expenses.
- The annualized trend factors are adjusted as compared to CY 2022 to reflect that the CY 2021 base period reflects some suppressed utilization and slower growth from the onset of the public health emergency and into the base period, but a consistent return to normal is expected into the CY 2023 rating period.
- 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 subsequently issued a "Call to Action" to reverse the decline in care for Medicaid and CHIP children, including dental care declines.
- The DMC plans are not at risk for any direct COVID-19 costs, as the program scope is limited to dental services; therefore, there were no considerations for these costs in the rate development. DHCS did not implement any material policy changes to covered populations, covered services, or payment methodologies specific to COVID-19 public health emergency requirements; accordingly, there were no additional adjustments required.

- The DMC non-benefit load assumption is 15%, meaning the priced-for 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.

Managed Care Adjustment

Mercer set the managed care adjustment factor to 1.000 for the CY 2023 rating period due to the continued use of DMC plan-specific experience. This represents no change from the CY 2022 rating period.

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.

Non-benefit load percentages and PMPMs by rate cell are provided in Appendix C.

Administration

The administration loading for the CY 2023 rating period was developed considering the prior CY 2022 rate load, DMC plan financial administrative performance and trends over the last several years and DMC projections via their RDT responses, and regional and national administrative expense benchmarks for similar Medicaid dental programs. The administration percentage is applied as a percentage of the total premium for DMC. This percentage is unchanged from the CY 2022 rating period percentage of 13.0%. The actuaries consider the CY 2023 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 2023 rate certification.

Withhold Arrangements

For CY 2023, there are two withholds applicable to the DMC program.

DHCS will continue a 3% withhold 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.

DHCS will implement a new withhold arrangement under which 3.0% of the capitation rate will be withheld from the DMC plans, and a portion of, or all of, the withheld amount will be paid to the DMC plan for meeting the targets outlined in the DMC contract, effective for the entirety of the CY 2023 contract period of January 1, 2023 through December 31, 2023. The DMC contract included a withhold arrangement provision for the prior rating period but was not implemented; therefore, the parameters are new for CY 2023. The 3.0% will be withheld from each capitation rate cell, and this withhold arrangement provision applies to all of the DMC plans.

The CY 2023 withhold arrangement aligns with the State's quality strategy to increase access to, and use of, dental preventive services.

The State set DMC plan-specific performance targets for six measures. The performance targets represent incremental improvement over performance from the 2021 measurement year baseline. Through a review of measure results from the baseline period and the prior

two periods for each DMC plan and the corresponding measure results in the FFS program statewide and by county, the targets for CY 2023 were determined to be reasonably achievable for each target for each DMC plan. The incremental improvements needed to achieve the CY 2023 targets relative to the baseline period were consistent with rate development assumptions for the CY 2023 projected benefit cost for utilization trend across relevant service categories.

The DMC plans are therefore reasonably expected to achieve 100% of the 3.0% withhold for CY 2023. As no portion of the withhold was determined to not be reasonably achievable, the capitation rates gross of the withhold are considered actuarially sound.

There is no impact on the CY 2023 projected benefit or administrative cost for the provision of a withhold arrangement. The CY 2023 capitation rates reflect Mercer's best estimate projection of reasonable, appropriate, and attainable costs. The withholds were determined to be reasonable given the DMC plans' financial operating needs, the size and characteristics of the populations covered under the contract, and the DMC plans' capital reserves. The withhold arrangement was taken into consideration in evaluating the cost of capital requirements when developing the CY 2023 underwriting gain assumption.

Risk-Sharing Mechanisms

The State is implementing an 85% minimum MLR for CY 2023. The formula for calculating the Contractor's MLR is *a/b*. Where *a* is the 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 the 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.

Although capitation rates are not directly affected by the minimum MLR requirement, the rates were developed in such a way that the DMC plans are reasonably expected to achieve an MLR of at least 85% for CY 2023. This risk mitigation mechanism has been developed in accordance with generally accepted actuarial principles and practices.

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

There are two State directed payments applicable to the DMC CY 2023 capitation rates as summarized in the table below:

Control Name of the State Directed Payment	Type of Payment	Brief Description	Is the Payment Included as a Rate Adjustment or Separate Payment Term?
Control Name TBD — Prop 56 Dental	Uniform dollar and percentage increases	Uniform percentage and dollar increases for specific dental services	Rate adjustment
Dental Preventive Services	Minimum fee schedule using State Plan approved rates	Minimum fee schedule for specific dental preventive services.	Rate adjustment

There are no additional directed payments in the program for CY 2023 that are not addressed in this rate certification. There are no requirements regarding the reimbursement rates the DMC plans must pay to any providers unless specified in the certification as a directed payment or pass-through payment or authorized under applicable law, regulation, or waiver.

To facilitate CMS rate review for each of the State directed payment initiatives, the table below summarizes the directed payments incorporated into the capitation rates as a rate adjustment. The following subsections provide more detail around each initiative.

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 Appendix C	Adjustment is applied as a PMPM add-on to the rates. A description of the data, assumptions and methodology is provided in the narrative below.	Confirmed. The preprint will be submitted to CMS in December 2022.	Not applicable
Dental Preventive Services	All COAs	See Appendix B	Adjustment is applied as a percentage	No preprint required	Not applicable

Control Name of the Directed Payment	Rate Cells Affected	Impact	Description of the Adjustment	Confirmation the Rates are Consistent with the Preprint	For Maximum Fee Schedules, Provide the Information Requested
			change to the rates, and is described in Section 4.	(minimum fee schedule).	

Prop 56 Dental

Consistent with 42 CFR §438.6(c), DHCS implemented a directed provider payment initiative that provides payment increases varying from 20% to 60% of the SMA, 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 PMPM add-on to the DMC capitation rates. Prop 56 PMPM add-on is developed in a consistent manner with the rest of the DMC capitation rate development. The projected benefit cost rate development components are described in Section 3. The Prop 56 add-on is loaded for the non-benefit component consistent with the rest of DMC rate development. The Prop 56 PMPM add-on rate development from adjusted base data through CY 2023 projected PMPM is provided in Appendix C.

Dental Preventive Services

Consistent with 42 CFR §438.6(c)(1)(iii)(A), DHCS 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 as described in Section 4.

Pass-Through Payments

There are no pass-through payments applicable to the DMC CY 2023 capitation rates.

Section 7

Risk Adjustment and Acuity Adjustments

There is no prospective or retrospective risk adjustment nor acuity adjustments applied in the CY 2023 DMC rate development.

Section 8

Certification of Final Rates

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

In preparing the capitation rates found in Appendix A for CY 2023 for the Medi-Cal DMC program, Mercer 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. Mercer reviewed the summarized data and information for internal consistency and reasonableness, but 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 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.

Mercer certifies that the DMC capitation rates for the CY 2023 rating period, January 1, 2023 through December 31, 2023, were developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medi-Cal covered populations and services under the DMC contract. The undersigned actuaries are members of the American Academy of Actuaries and meet its US 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.

DHCS understands that Mercer is not engaged in the practice of law, or in providing advice on taxation matters. This report, which may include commenting on legal or taxation issues or regulations, does not constitute and is not a substitute for legal or taxation advice. Accordingly, Mercer recommends that DHCS 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 Katharina Katterman at katharina.katterman@mercer.com, or Jie Savage at jie.savage@mercer.com.

Sincerely,

[redacted]

Katharina Katterman, ASA, MAAA

Principal

[redacted]

Jie Savage, ASA, MAAA

Senior Associate

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