MERCER

Dental Managed Care

Capitation Rate Development and Certification

January 1, 2021–December 31, 2021

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

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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 capitation rates for use during the Medi-Cal Dental Managed Care (DMC) model calendar year 2021 (CY 2021). The CY 2021 rating period encompasses the time period of January 1, 2021 through December 31, 2021.

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 2020 through June 2021 Medicaid Managed Care Rate Development Guide (RDG), which is applicable to contract periods beginning on or after July 1, 2020. 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 2021 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 2021 Medi-Cal DMC Rate Exhibits_2020_12_18.xlsx*.

Due to the timing of the CY 2021 rate development, DHCS and Mercer have utilized a rate update methodology, trending forward the previous year's rates, but have completed a thorough exercise of reviewing the 2H CY 2020 information for applicability to the CY 2021 rate development.

Overall, across all populations and both counties, the CY 2021 capitation rate per member per month (PMPM) is projected at $10.59. This $10.59 PMPM is an approximate 2.3% increase from the corresponding 2H CY 2020 figure. With a projected 9.7 million member months, total capitation dollars are projected to be approximately $102.8 million in CY 2021.

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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) include 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. There are no changes to covered populations for the CY 2021 rating period.

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 2021 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 2021.

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 update approach for the CY 2021 DMC capitation rate development.

For the DMC program rate development process, Mercer used a 50/50 blend of the CY 2018 and CY 2019 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 2021. 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 2021 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 2021 DMC rate development process. Factors contributing to this decision include:

- 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 quality 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.

- Although not explicitly tied to COVID-19, annual Utilization and Unit Cost trend factors were each reduced by 0.5% from SFY 19-20 rate setting levels with COVID-19 considerations partially in mind. This reduction to the 2H CY 2020 prospective trends has been held constant for the CY 2021 rates.
- 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 that 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 2021 rates utilize a rate update methodology, using a consistent base time period with the 2H CY 2020 rates (CY 2018 and CY 2019). This rate update, 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 2021.

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Data

Base Data

The DMC plans submitted enrollment, dental experience data and other financial information in the prescribed RDTs. Services incurred in CY 2018 and CY 2019 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 two categories of service (COS), which are:

- Preventative Services
- 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 50/50 blend of the adjusted CY 2018 and CY 2019 PMPM data was selected as the base.

With regard to overpayments to providers and Section 438.608(d) of the Medicaid Managed Care Final Rule, 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 that 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 2021 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 MCO 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.

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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 (January 1, 2019) to the midpoint of the CY 2021 contract period (July 1, 2021)
- 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 2021 Medi-Cal DMC Rate Exhibits_2020_12_18.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 2021 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 CY 2018 through CY 2019 with a midpoint of January 1, 2019. The rating period is January 1, 2021 to December 31, 2021 with a midpoint of July 1, 2021. Therefore, annual trend factors were applied for 30 months.

Age Group	Annual Utilization Trend	Annual Unit Cost Trend	Annual Total Trend
Child (Age 0–20)	1.02	1.01	1.03
Adult (Age 21+)	1.02	1.01	1.03
ACA OE (Age 19+)	1.02	1.01	1.03

The annual utilization and unit cost trends remain consistent with those used in 2H CY 2020 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 2021 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 2021 Medi-Cal DMC Rate Exhibits_2020_12_18.xlsx*. Per DHCS, there are no current known amendments that will be provided to CMS in the future.

Dental Transformation Initiative

Effective January 1, 2016, through the Medi-Cal 2020 waiver, 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 is to increase the statewide utilization of preventive services by at least ten percentage points over the five years (CY 2016–CY 2020) of the waiver 2020 period for Medi-Cal beneficiaries ages zero to 20, as aligned with the CMS Oral Health Initiative. There is 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 Pre-Print for this payment initiative will be submitted to CMS for review and approval by December 31, 2020.

There were no changes to the dental codes or percentage or dollar adjustments to the State's Schedule of Maximum Allowance for CY 2021. The Proposition 56 adjustment was developed based on adjusted RDT data. The DMC-reported experience from January 2019 to December 2019, was reviewed and then projected forward 24 months to the midpoint of CY 2021.

Proposition 56 add-ons are contingent on appropriation of funds being provided by the California Legislature. The final FY 2020-21 Budget Act suspends Proposition 56 add-ons for dental services for dates of service on or after July 1, 2021, unless specified conditions apply. The rates certified in this report reflect the Proposition 56 add-ons only for the portion of CY 2021 that is not subject to the suspension. As of the date of this report, the period that is not subject to the suspension is January 1, 2021 to June 30, 2021. However, if the California Legislature provides continued appropriations through December 31, 2021 – and, therefore, the period that is not subject to the suspension is extended – then the rates certified in this report will reflect Proposition 56 add-ons for that extended period.

To account for this uncertainty while setting prospective rates, Mercer developed these add-ons to be reasonable and appropriate for both six-month and twelve-month effective periods during the CY 2021 rating period. As such, Mercer is supplying two sets of capitation rates applicable for CY 2021, dependent upon Proposition 56 budget appropriations. Absent continued appropriations for the Proposition 56 add-ons, the credentialed actuary is certifying rates including the add-ons for January 1, 2021 to June 30, 2021, and rates excluding the add-ons for July 1, 2021 to December 31, 2021. If the California Legislature provides continued appropriations for the Proposition 56 add-ons, the credentialed actuary is certifying rates including the add-ons for January 1, 2021 to December 31, 2021.

Full Restoration of Adult Dental Benefits

Adult optional dental benefits were eliminated on July 1, 2009. Effective May 1, 2014, the eliminated optional dental benefits were partially restored. Beginning January 1, 2018, the rest of the eliminated dental benefits for Adults were fully restored. For consistency with prior rating periods, Mercer continues to display Adult restoration services as a program change facilitating year-over-year rate-setting component comparisons.

The full restoration of adult dental benefits adjustment was developed based on adjusted RDT data. Mercer examined the costs related to dental procedure codes impacted by the benefit restoration. The DMC-reported experience from January 2019 to December 2019, was reviewed and then projected forward 24 months to the midpoint of CY 2021.

Managed Care Adjustment

Mercer set the managed care adjustment factor to 1.000 for the CY 2021 rating period due to the continued use of DMC plan-specific experience. This represents no change from the 2H CY 2020

rating period. In previous rating periods, a factor of 0.975 was used when DHCS used FFS base data to develop the capitation rates.

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.

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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 2021 rating period was developed considering the 2H CY 2020 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 2H CY 2020 rating period percentage of 13.0%. The actuary considers the CY 2021 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 that 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.

Health Insurance Providers Fee

No adjustment is included within these CY 2021 capitation rates due to the discontinuation of Health Insurance Providers Fee after the CY 2019 premium year.

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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
- Pass-through payments
- Delivery system and provider payment initiatives

None of the items above explicitly appears within the CRCS exhibits, but were considered within the rate development process, if applicable.

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 2021 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 2021. 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.

Pass-Through Payments

There are no pass-through payments applied in the DMC model CY 2021 capitation rates.

Delivery System and Provider Payment Initiatives

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 2021 Medi-Cal DMC Rate Exhibits_2020_12_18.xlsx* for more details.

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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 2021 rating period, January 1, 2021 through December 31, 2021, were developed in accordance with generally accepted actuarial practices and principles, and are appropriate for the Medi-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]

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Partner

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