Mercer

Government Human Services Consulting

Capitation Rate Development and Certification

Dental Managed Care

January 1, 2024–December 31, 2024

State of California
Department of Health Care Services
Capitated Rates Development Division
December 19, 2023

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 2024 (CY 2024). The CY 2024 rating period encompasses the time period of January 1, 2024 through December 31, 2024.

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 2023–2024 Medicaid Managed Care Rate Development Guide (RDG) dated May 2023, which is applicable to contract periods beginning on or after July 1, 2023. A copy of the RDG, with documentation references, is attached with this report (please see the attached file titled *DMC CY 2024 Rate Development Guide 2023 12.pdf*).

Multiple exhibits are also included as part of this rate certification package (please see the attached file titled *DMC CY 2024 Rate Certification Appendices 2023 12.xlsx*). This attachment includes summaries of the CY 2024 capitation rates by county and category of aid (COA), including the final and certified capitation rates and a comparison to the prior CY 2023 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 Jim Meulemans, ASA, MAAA, FCA, and Dave Dombrowski, ASA, MAAA, CERA, 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 in time 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 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). 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. Furthermore, 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 2024 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. Beginning with CY 2023, the split of the UIS and SIS populations occurred within the base data, and capitation rates were developed after the split occurred. Unless otherwise noted in this report, all references to the CY 2024 capitation rates are assumed to be for the SIS population only.

In aggregate, across all COAs and both Los Angeles County and Sacramento County, the composite CY 2024 capitation rate (excluding Proposition 56 [Prop 56]) per member per month (PMPM) is projected at $12.89, and the composite CY 2024 certified rate PMPM (including Prop 56) is $16.27. This is an approximate 3.7% increase from the CY 2023 certified rates. Composite values were calculated using projected member months for the CY 2024 rating period. With an approximate projected 9.8-million-member months, total capitation dollars excluding Prop 56 are projected to be approximately $126.7 million in CY 2024. Including Prop 56, total projected dollars are $159.9 million. Appendix A includes the final certified rates effective January 1, 2024 for each rate cell, and a comparison to the certified rates effective January 1, 2023.

[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 2023. The primary driver of these rate changes is the base data change and/or decreases in the Prop 56 add-on PMPMs.

It should be noted there are no known items that would warrant a rate amendment at this time. The state of California is currently developing a program change that involves shortening the continuous enrollment requirement from 12 months to 90 days for a member to attend an annual dental visit with their network provider. It is unknown at this time if this program will be implemented, or the exact start date of intended implementation. Utilization data for affected members will be monitored to determine if a future amendment is warranted. This program change will not necessarily require a capitation rate amendment unless an amendment is deemed necessary.

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 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.

Dental Managed Care Organization Participation

Dental GMC was historically a mandatory program in Sacramento County. Beginning in November 2023, DHCS will send notices to members currently enrolled in DMC plans in Sacramento County informing them of their option to either stay with their current plan or disenroll and join FFS. This disenrollment will be effective on December 1, 2023. Medi-Cal members in Sacramento County who do not opt out must select one of the available GMC plans for their dental care. Additionally, effective December 1, 2023, newly eligible Medi-Cal

members in Sacramento County will be enrolled by default into dental FFS. Due to the numerous population shifts also occurring with the PHE unwinding, as well as transitioning populations, no adjustment was made to the rates. Dental PHP is a voluntary program in Los Angeles County; which 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 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 members enrolled prior to December 1, 2023 who choose to select and maintain their current DMC provider will remain in managed care. Effective December 1, 2023, newly eligible Medi-Cal members in Sacramento County will be enrolled by default into dental FFS. These members may opt to select a DMC plan if they are able to establish access to care issues within the dental FFS delivery system.

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 2023 and CY 2024.

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 populations identified to transition January 1, 2024, who were previously non-mandatory in managed care (at least in some counties) and/or enrolled in FFS are as follows:

- January 1, 2024 — LTC Intermediate Care Facility for Developmentally Disabled (ICF/DD) and Subacute (SA) Beneficiaries.

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 2024 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).

Federal Medical Assistance Percentage

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 certifying 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 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 2024.

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.

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 2024 DMC capitation rate development.

For the DMC program rate development process, Mercer used CY 2022 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 2024. Mercer then 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 2024 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 managed care organizations (MCOs) are assumed to reasonably achieve medical loss ratios (MLRs) at or greater than 85%.

The CY 2024 rates utilize a rate rebase methodology, updating the base time period to use CY 2022 experience. This rate rebase, along with the non-benefit loads, result in aggregate priced-for effective MLRs at or greater than 85%.

For CY 2024, the State will impose remittance provisions related to this MLR. Any revenue will need to be remitted to the State up to 85% MLR, if the calculated actual MLR is less than 85% for an MCO.

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 2021 and CY 2022. Services incurred in CY 2022 and completed with payment lag factors were used to form the base data for DMC rate development. The CY 2022 time period was selected as the base data period for CY 2024 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, capitated arrangements, 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 and 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. Plans reported their UIS and SIS experience separately from one another. SIS reported base data was used for CY 2024 rates. The base data displayed in Appendix C columns labeled (A) through (C) represents the adjusted base data specific to the SIS population.

CY 2022 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 DMC 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 2024 rates since none were 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 2024 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, 2022) to the midpoint of the rating period (July 1, 2024).

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 by quarter were analyzed. DMC plan-reported projected trends were considered. Other available data/information such as managed care experience data and FFS data were gathered and used to inform trend development. 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. The aforementioned data was also gathered for Prop 56 supplemental payment information where available to establish separate Prop 56 utilization trends. Aggregate PMPM trends by rate cell were used to project the Prop 56 supplemental payment component. Trends were applied at a PMPM level for Prop 56 supplemental payments.

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

COA	COS	Annual Utilization Trend	Annual Unit Cost Trend	Annual PMPM Trend
Child	Preventive	5.0%	1.0%	6.0%
Child	FRADS and RADS	0.0%	0.0%	0.0%
Child	All Other Services	3.0%	1.0%	4.0%

COA	COS	Annual Utilization Trend	Annual Unit Cost Trend	Annual PMPM Trend
Child	Prop 56	N/A	N/A	3.0%
Adult	Preventive	1.5%	1.0%	2.5%
Adult	FRADS and RADS	1.5%	1.0%	2.5%
Adult	All Other Services	3.0%	1.0%	4.0%
Adult	Prop 56	N/A	N/A	3.0%
ACA OE	Preventive	1.5%	1.0%	2.5%
ACA OE	FRADS and RADS	1.5%	1.0%	2.5%
ACA OE	All Other Services	3.0%	1.0%	4.0%
ACA OE	Prop 56	N/A	N/A	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 2024 capitation rates. A summary showing the CY 2024 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 (J) through (L) in Appendix C.

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. Mercer reviewed the emerging experience for lab processed crowns. Review of this data showed that this benefit is still ramping up. Comparing the emerging data to mature individual commercial statistics, shows the possibility for additional ramp up. Mercer projected the ramp up seen in the emerging experience to continue through the contract period. 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 Fee-From-Service 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 2023, or will be transitioning within CY 2024

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 an LTC facility

The populations identified to transition from FFS to managed care in certain counties (including Sacramento County) on January 1, 2024, designated as part of CalAIM — Phase II, are as follows:

1. ICF/DD and SA beneficiaries

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 2021–2022 (July 1, 2021 through June 30, 2022) eligibility data by aid code, dual status, LTC accommodation codes, zip code, and enrollment indicators for Other Health Coverage 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.

Managed Care Adjustment

Mercer made no managed care adjustment factor for the CY 2024 rating period due to the continued use of DMC plan-specific experience. This represents no change from the CY 2023 rating period.

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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 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 2024 rating period was developed considering the prior CY 2023 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 2023 rating period percentage of 13.0%. The actuaries consider the CY 2024 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 2024 rate certification.

Withhold Arrangements

For CY 2024, there are no withhold arrangements between DHCS and the DMC plans. Hence, this subsection is not applicable to the CY 2024 rate certification.

Risk-Sharing Mechanisms

The State will impose an 85% minimum MLR for CY 2024. 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 with 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 with 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 2024. 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 2024 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 increase for specific dental services	Rate adjustment
Dental Preventive Services	Minimum fee schedule using State Plan approved rates	Minimum fee schedule for specified preventive service codes at the equivalent of 75% above the State's Schedule of Maximum Allowances.	Rate adjustment

There are no additional directed payments in the program for CY 2024 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,	Confirmed. The preprint will be submitted to CMS in December 2023.	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
			assumptions and methodology is provided in the narrative below.		
Dental Preventive Services	All COAs	Adjustment is Included in the CY 2022 base data	Minimum fee schedule for specified preventive service codes at the equivalent of 75% above the State's Schedule of Maximum Allowances.	No preprint required (minimum fee schedule).	Not applicable

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 manner consistent 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 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 in the CY 2022 base data.

Pass-Through Payments

There are no pass-through payments applicable to the DMC CY 2024 capitation rates.

Section 7

Risk Adjustment and Acuity Adjustments

Public Health Emergency Acuity Considerations

An adjustment was made for the unwinding of the COVID-19 public health emergency (PHE) within the CY 2024 DMC rate development process. Due to the PHE, many less acute members remained enrolled in Medicaid, when they would typically have been disenrolled in the past. In order to assess the potential acuity impact of PHE unwinding, Mercer reviewed the projected enrollment for CY 2024, compared to the enrollment experienced during the base period. Mercer developed several scenarios reflecting various acuity factors amongst the populations that are leaving compared to those expected to remain to arrive at an adjustment. The table below shows the selected acuity adjustments made to the rates by county and COA.

County	COA	Acuity Factor
Los Angeles	Child	1.5%
Los Angeles	Adult	2.5%
Los Angeles	ACA OE	2.5%
Sacramento	Child	1.5%
Sacramento	Adult	2.0%
Sacramento	ACA OE	3.0%

Section 8

Certification of Final Rates

This certification assumes items in the Medicaid State Plan or Waiver, as well as the MCO contract, have been approved by CMS.

In preparing the capitation rates described, Mercer has used and relied upon enrollment, eligibility, claim, reimbursement level, benefit design, and financial data and information supplied by DHCS, its MCOs, and its vendors. DHCS, its MCOs, and its vendors are solely responsible for the validity and completeness of this supplied data and information. Mercer has reviewed the summarized data and information for internal consistency and reasonableness, but we did not audit it. In Mercer's opinion, it is appropriate for the intended rate-setting purposes. However, if the data and information are incomplete or inaccurate, the values shown in this report and associated exhibits may differ significantly from values that would be obtained with accurate and complete information; this may require a later revision to this report.

Because modeling all aspects of a situation or scenario is not possible or practical, Mercer may use summary information, estimates, or simplifications of calculations to facilitate the modeling of future events in an efficient and cost-effective manner. Mercer may also exclude factors or data that are immaterial in our judgment. Use of such simplifying techniques does not, in our judgment, affect the reasonableness, appropriateness, or attainability of the results for the Medicaid program. Actuarial assumptions may also be changed from one certification period to the next because of changes in mandated requirements, program experience, changes in expectations about the future, and other factors. A change in assumptions is not an indication that prior assumptions were unreasonable, inappropriate, or unattainable when they were made.

Mercer certifies that the DMC capitation rates for CY 2024 rating period, January 1, 2024 through December 31, 2024, were developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medi-Cal covered populations and services under the managed care contract. 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 actuaries are members of the American Academy of Actuaries and meet its qualification standards to certify to the actuarial soundness of these 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 MCO costs will differ from these projections. Mercer has developed these rates on behalf of DHCS 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 or reinsurance arrangements in these rates. Use of these rates for any purpose beyond that stated may not be appropriate.

MCOs 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 MCOs for any purpose. Mercer recommends that any MCO considering contracting with DHCS should analyze its own projected medical 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 secure 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.

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

DHCS agrees to notify Mercer within 30 days of receipt of this report if it disagrees with anything contained in this report or is aware of any information or data that would affect the results of this report that has not been communicated or provided to Mercer or incorporated herein. The report will be deemed final and acceptable to DHCS if nothing is received by Mercer within such 30-day period.

If you have any questions on the above certification document or attachments, please feel free to contact Jim Meulemans at james.meulemans@mercer.com, or Dave Dombrowski at dave.dombrowski@mercer.com.

Sincerely,

[redacted]

Jim Meulemans, ASA, MAAA, FCA

Partner

[redacted]

Dave Dombrowski ASA, MAAA, CERA

Principal

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