# STATE OF TEXAS
# MEDICAID AND CHIP
# MANAGED CARE
# DENTAL RATE SETTING
# FY2025

Prepared for:
Texas Health and Human Services Commission
Texas Dental HHS0002879 A-13

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## I. Introduction

Rudd and Wisdom, Inc. has been retained by the Texas Health and Human Services Commission (HHSC) to develop premium rates for the period September 1, 2024 through August 31, 2025 (FY2025) for the Dental Health Maintenance Organizations (DHMOs) participating in the Texas Children's Medicaid Dental Services (Medicaid Dental) and Children's Health Insurance Program (CHIP Dental) programs. This report presents the rating methodology and assumptions used in developing the FY2025 Medicaid and CHIP Dental premium rates.

Effective March 1, 2012, the Medicaid and CHIP Dental programs provided dental benefits through a managed care model. Effective September 1, 2020 a new DHMO was added to the dental programs for a total of three DHMOs each operating statewide.

The Medicaid Dental program provides dental services for Medicaid children through age 20. The following Medicaid members are not eligible to participate in the Medicaid Dental program.

- Medicaid members age 21 and over.
- Medicaid members enrolled in the STAR Health program. Dental services for those members are provided by the STAR Health Managed Care Organization.
- Medicaid members residing in Medicaid paid facilities such as nursing facilities, state supported living centers, or intermediate care facilities for individuals with an intellectual disability or related condition.

The CHIP Dental program provides dental services for traditional CHIP members through age 18. The CHIP program expanded to provide benefits for unborn children of pregnant women on January 1, 2007 under the program name CHIP Perinate. CHIP Perinate members are not eligible to participate in the CHIP Dental program. Under CHIP Dental, children receive up to $564 in dental benefits per 12-month enrollment period, not including emergency dental services, to cover preventive and therapeutic services. Members can also receive certain medically necessary services beyond the annual limit through a prior authorization process.

Rudd and Wisdom has provided actuarial services to the Texas Medicaid program for over 40 years. We have participated in the state's Medicaid managed care rating process since its inception in 1993 and in developing premium rates for CHIP plans since that program's inception in 2000. We have worked closely with HHSC's staff in developing the premium rates documented in this report.

Rudd and Wisdom has relied on the following data sources as provided by HHSC, the participating dental plans and the agency's External Quality Review Organization (EQRO):

- Monthly enrollment by age group for each dental plan. This includes historical enrollment for the period March 2012 through March 2024 and a projection of future enrollment through August 2025. These projections were prepared by HHS Forecasting staff.

- Financial Statistical Reports (FSR) from the dental plan for FY2021, FY2022, FY2023 and the first six months of FY2024. The FSR contains detailed information regarding monthly

enrollment, revenue, incurred claims and administrative expenses, as reported by the DHMO. These reports are prepared by the dental plan and are audited by an external audit organization. A dental plan that participates in multiple programs and/or service areas submits a separate FSR for each individual area and program combination.

- Detailed DHMO encounter data for FY2023. The encounter data is a dataset that includes detail claim information for every claim incurred during FY2023 and paid through November 30, 2023. The dataset includes but is not limited to (1) individual member information – date of birth, risk group, dental plan; (2) provider information – type of provider, NPI, taxonomy code; (3) procedure information – procedure code, modifier, tooth number; and (4) payment information – paid amount, billed amount. This information is used to identify the providers and services which will receive or have received reimbursement changes in order to determine the cost impact of such changes.

- Claim lag reports by type of service and by age group for each dental plan for the period September 2020 through February 2024. These reports were provided by the dental plans and include monthly paid claims by month of service. These reports summarize the detail encounter data.

- Reports from the EQRO summarizing their analysis of the DHMO's encounter claims data.

- Information provided by HHSC regarding the default enrollment process.

- Information from both HHSC and the dental plans regarding changes in covered services and provider reimbursement under the Medicaid and CHIP dental programs.

- Current (FY2024) dental premium rates.

All data requested by the actuary was provided by HHSC and the participating DHMOs. Although the above data was reviewed for reasonableness, Rudd and Wisdom did not audit the data. Further discussion of the base data development and review is included in Section II.

II. Base Period Data

The actuarial model used to derive the FY2025 Medicaid and CHIP dental premium rates relies primarily on historical dental plan experience. The historical claims experience for the program was analyzed and estimates for the base period were developed. The base period was defined as FY2023 (September 1, 2022 through August 31, 2023). Estimates of the base period include an estimate of incurred but unpaid claims (IBNR). Given that there are six months of runout beyond the base period, the IBNR are immaterial. The IBNR estimate is based on claims paid through February 2024 and represents the following percentage of claims by dental program:

- Medicaid Dental – ~0.03%
- CHIP Dental – ~0.06%

The rating analysis primarily relies on three data sources: (i) Financial Statistical Report (FSR), (ii) DHMO Supplemental Data and (iii) Encounter Data.

- Financial Statistical Report – The FSR provides high-level, summary information of paid claims, subcapitated expenses, reinsurance expenses and administrative costs. The FSRs are used to determine the experience rebate for each DHMO and the allowability of expenses which impact the calculation of the FSR-reported net income for experience rebate purposes. As a result, the DHMOs are required to only report "allowable" expense on the FSRs. The FSRs are subject to audit by an external auditor.

- DHMO Supplemental Data – The DHMO supplemental data provides HHSC-specified data such as claim lag data by type of service, other dental expenses and subcapitated expenses by type of service. All expense items such as claim lag, capitation, other dental expense, etc. are reconciled to the FSR by risk group for each DHMO to ensure the accuracy and consistency of the data sources. DHMOs are asked to explain any material difference between the two data sources and, if necessary, provide revised supplemental data. Once all issues have been resolved, Rudd and Wisdom aggregates the information from the DHMO Supplemental Data into a "Data Book" and provides all information to the DHMOs in order to confirm the accuracy. The Data Book is used to determine base year data used in the rating analysis.

- Encounter Data – The detail encounter data provides claim data at the most granular level including information for individual claims such as provider, procedure code, date of service, etc. The encounter data is primarily used to develop rating adjustment factors for various provider reimbursement and benefit revisions. For each rating adjustment, the applicable base period encounter data is repriced using the FFS reimbursement in place during the base period, the FFS reimbursement that will be in place during the rating period and the applicable percentage change determined.

HHSC employs the Institute for Child Health Policy (ICHP) as an External Quality Review Organization. ICHP reviews the detail encounter data and provides certification of the data quality. ICHP performs the following types of analyses:

- Volume analysis based on service category

- Data validity and completeness analysis
- Consistency analysis between encounter data and FSRs provided by the DHMO by service area

Below is an excerpt from their data certification report:

*The EQRO considers the required data elements for all MCO-SA combinations in all programs to be accurate and complete, meeting the following components of Texas Government Code § 533.0131 for data certification purposes:*

1. *The encounter data for the most recent measurement year are complete, accurate, and reliable.*
2. *No statistically significant variability in the encounter data is attributable to incompleteness, inaccuracy, or other deficiency as compared to equivalent data for similar populations and when evaluated against professionally accepted standards.*

The ICHP encounter data to FSR reconciliation is done at an aggregate level by Medicaid and CHIP dental programs and DHMO. In addition to ICHP's encounter data to FSR comparison, Rudd and Wisdom performs a similar analysis by risk group to review for reasonableness. Risk group codes are added to the encounter data by mapping Medicaid ID from the encounter data to the eligibility files.

After accumulating all of the information to be used in the rate setting process, a comparison of the various sources of claims data was performed to check for consistency. The comparison includes (i) the claim lag reports provided by the DHMOs in the supplemental data request, (ii) the claim amounts reported in the FSRs and (iii) the claim amounts included in the encounter data files. The three data sources are compared to ensure consistent results such that the three are considered interchangeable in aggregate. The use of these multiple data sources allows for a dynamic, flexible rating model that is not constrained to the data limitation of a single source.

Based on the review of the data by the EQRO, HHSC and Rudd and Wisdom, we have concluded that all data sources are consistent, complete and accurate. It is our opinion that the data collected for the rate development is of high quality and we have no concerns over the availability or applicability to the FY2025 rate development. The accumulation of data sources noted above have been assigned full credibility. Given the history of managed care data available for the Medicaid and CHIP dental programs, the rate development is based exclusively on managed care data.

## III. Overview of the Rate Setting Methodology

The actuarial model used to derive the FY2025 Medicaid and CHIP Dental plan premium rates relies primarily on dental plan financial experience. The historical claims experience for the program was analyzed and estimates for the base period were developed. The base period was defined as FY2023 (September 1, 2022 through August 31, 2023). Estimates of the base period included an evaluation of incurred but unpaid claims (IBNR). These estimates were then projected forward to FY2025 using assumed trend rates and other adjustment factors. These adjustment factors are described in more detail in Section IV. We added a reasonable provision for administrative expenses, taxes, and risk margin in order to project the total cost for the rating period. The results of this analysis were then combined for all dental plans in order to develop a set of statewide community rates that vary by dental program and the following age groups:

Medicaid Dental Program
- Children Under Age One Year
- Children Ages 1 – 5
- Children Ages 6 – 14
- Children Ages 15 – 18
- Children Ages 19 – 20

CHIP Dental Program
- Children Under Age One Year
- Children Ages 1 – 5
- Children Ages 6 – 14
- Children Ages 15 – 18

The statewide community rates are developed by a weighted average of the projected FY2025 cost for each dental plan. The weights used in this formula are the projected FY2025 number of clients enrolled in each dental plan by risk group. Exhibits A-1 and B-1 of Attachment 1 present the summary statewide community rating exhibit for the Medicaid and CHIP Dental programs.

Effective September 1, 2020, a new DHMO was added to the dental programs for a total of three DHMOs each operating statewide. In order to increase enrollment in the new plan, all default enrollments without prior history were assigned to the new DHMO until a minimum threshold was met. Default members average cost is significantly less than that for non-default members. The statewide community rates were adjusted to reflect the health status, or acuity, of the population enrolled in each dental plan resulting from the default enrollment process. Additional information regarding the default enrollment acuity adjustment is included in Attachment 6.

The FY2025 Medicaid and CHIP dental premium rates were then defined as the statewide community rate with default enrollment acuity adjustment for all risk groups. Exhibits A-2 and B-2 of Attachment 1 present the derivation of the FY2025 premium rates by dental plan and risk group for the Medicaid and CHIP Dental programs.

IV. Adjustment Factors

This section contains a description of the adjustment factors used in the Medicaid and CHIP Dental plan rate setting process.

***Trend Factors***

The rating methodology uses assumed trend factors to adjust the base period claims cost to the rating period. The cost trend factors used in this analysis are a combination of utilization and inflation components. The projected trend rate assumptions were developed by the actuary based on an analysis of recent experience. Orthodontia claim experience was excluded from the Medicaid Dental trend analysis in order to not skew results due to Medicaid policy changes that resulted in large reductions to orthodontia claims experience. Dental experience after February 2020 has been excluded from the trend analysis due to the significant reduction in cost caused by the COVID-19 pandemic and the corresponding PHE declaration. A single trend assumption by dental program was used for all age groups in order to reduce fluctuation from year to year and to increase credibility. The annual trend assumption used in the rating analysis for all dental services was 0.50% for Medicaid Dental and 1.30% for CHIP Dental.

Exhibits A and B of Attachment 3 provide details regarding the calculation of the trend assumptions applicable to the Medicaid and CHIP Dental programs.

***Federally Qualified Health Center (FQHC) Wrap Payment Removal***

Effective March 1, 2018, DHMOs were no longer required to reimburse FQHCs the full encounter rate. The DHMOs are expected to reimburse FQHCs at a rate that is comparable to the reimbursement of all other non-FQHC providers providing similar services. Subsequently, the FQHC will be reimbursed up to their full encounter rate through the FQHC wrap payments outside of the capitation rate. The base period data includes the full reimbursement rate paid to the FQHCs. As a result, an adjustment is necessary to remove the FQHC wrap payment portion from the base period data. The rating adjustment was calculated by collecting the FQHC wrap payments paid by the DHMOs during the base period. Attachment 4 provides details regarding the calculation of the FQHC wrap payment adjustment factor for the Medicaid and CHIP Dental programs.

***Public Health Emergency (PHE) Related Cost Adjustment***

Beginning in March 2020 and continuing into 2023, the PHE has had a significant impact on average dental expenditures. Average enrollment for Medicaid dental during the FY2023 base period is about 40% larger than the expected enrollment during the FY2025 rating period. The PHE officially ended May 11, 2023 and the PHE unwind process begun with disenrollment in the Medicaid dental program beginning in June 2023. The majority of Medicaid dental disenrollment is expected to occur during June 2023 through February 2024 and the entire unwinding process will be complete prior to September 1, 2024. Given the disenrollment during FY2024, the dental average cost during the FY2025 rating period will be impacted as the disenrollment process has disproportionally impacted the lower cost members. A rate adjustment was calculated in order to

estimate the impact of the PHE unwinding process and the associated disenrollment on average cost in FY2025. Attachment 5 presents a summary of the derivation of this adjustment factor.

***Default Enrollment Acuity Adjustment***

Effective September 1, 2020, a new DHMO was added to the dental programs for a total of three DHMOs each operating statewide. In order to increase enrollment in the new plan, all default enrollments without prior history were assigned to the new DHMO until a minimum threshold was met. Default members' average cost is significantly less than that for non-default members. The purpose of the default enrollment acuity adjustment is to recognize the anticipated cost differential between multiple dental plans by analyzing the average cost per member of their respective memberships. The default enrollment acuity adjustment was applied in a budget neutral manner. Attachment 6 provides details on the default enrollment acuity adjustment.

V. Administrative Fees, Taxes and Risk Margin

The rating methodology includes an explicit provision for administrative services. The amount allocated for administrative expenses is $1.75 pmpm. This amount is intended to provide for all administrative-related services performed by the DHMO.

The data used in developing the administrative expense assumption are the detailed administrative costs reported by the dental plans in their audited financial statistical reports (FSRs) for the past five fiscal years. These reports provide a detailed breakdown of monthly administrative expenses by category including salaries, technology, equipment, marketing, legal and other expenses. These reports are provided quarterly and audited annually by an external auditor.

MCNA outsourced a significant portion of their administrative function to a related party resulting in an administrative expense rate that is more than double that for Dentaquest. In reviewing the administrative expense experience, the administrative cost pmpm for MCNA was adjusted using two methods. Method 1 excludes MCNA's external outsource services and Method 2 assumes MCNA's external administrative cost pmpm is the same as Dentaquest. The actual administrative expenses reported by year were adjusted for inflation by applying the annual growth in the Employee Cost Index (ECI) as reported by the US Bureau of Labor and Statistics. The table below summarizes the reported administrative expense pmpm for the past five fiscal years for the dental programs.

| | Administrative Expense PMPM | | | | |
|---|---|---|---|---|---|
| | Actual | | Average Annual ECI | Inflation Adjusted | |
| | Method 1 | Method 2 | | Method 1 | Method 2 |
| FY2019 | 1.49 | 1.61 | 3.80% | 1.79 | 2.05 |
| FY2020 | 1.50 | 1.49 | 4.10% | 1.76 | 2.11 |
| FY2021 | 1.56 | 1.71 | 4.10% | 1.76 | 2.08 |
| FY2022 | 1.38 | 1.79 | 3.60% | 1.48 | 1.78 |
| FY2023 | 1.51 | 1.85 | | 1.56 | 1.92 |
| Average | 1.49 | 1.69 | | 1.67 | 1.99 |

Notes:
Method 1 excludes MCNA outsource services.
Method 2 assumes external admin pmpm for MCNA is the same as Dentaquest.

Based on this analysis, the expected range of administrative costs for FY2025 was deemed to be $1.70-$2.00. The administrative expense included in the capitation rates of $1.75 pmpm is in line with the historical averages.

The premium rates also include an amount for premium tax (1.75% of premium), maintenance tax ($0.023 pmpm) and a risk margin (1.50% of premium).

VI. Summary

The chart below presents the resulting statewide FY2025 Medicaid and CHIP Dental Plan premium rates pmpm.

| | <1 | 1-5 | 6-14 | 15-18 | 19-20 |
|---|---|---|---|---|---|
| **Medicaid Dental** | | | | | |
| Dentaquest | 11.97 | 28.67 | 31.41 | 32.12 | 22.13 |
| MCNA | 11.97 | 28.67 | 31.41 | 32.12 | 22.13 |
| United | 11.65 | 26.68 | 30.84 | 31.32 | 20.93 |
| **CHIP Dental** | | | | | |
| Dentaquest | 2.42 | 19.35 | 24.49 | 23.02 | n/a |
| MCNA | 2.42 | 19.35 | 24.49 | 23.02 | n/a |
| United | 2.41 | 18.37 | 24.27 | 22.75 | n/a |

Attachment 1 presents a description of the calculation of the FY2025 Medicaid and CHIP Dental Plan premium rates.

Attachment 8 presents the required rating index summarizing the applicable sections from the 2024-2025 Medicaid Managed Care Rate Development Guide.

The implied medical loss ratio based on the FY2025 rate development and assumptions detailed in this report is 92% which exceeds the 85% minimum as required per 42 CFR 438.4(b)(9). The premium rates have been calculated such that they are adequate to cover all reasonable expenses projected under the CHIP program for FY2025.

The medical loss ratios have varied significantly in recent years due to the unprecedented volatility associated with the PHE and the unwinding process. The medical loss ratio for FY2023 was 77% due to the unexpected continuation of the PHE and the enrollment growth experienced in the Medicaid program. Through the first six months of FY2024 the medical loss ratio has increased to 92% due to the PHE unwinding process and the increase in average cost. The medical loss ratio is expected to continue increasing throughout the remainder of FY2024. While the FY2025 rates are not calculated based solely on the loss ratios of prior years, they have been calculated based on the actual expenditures that generated these loss ratios adjusted for expected changes in enrollment, reimbursement and program policy.

VII. Actuarial Certification of FY2025 Medicaid and CHIP Dental Plan Premium Rates

I, Khiem D. Ngo, am a principal with the firm of Rudd and Wisdom, Inc., Consulting Actuaries (Rudd and Wisdom). I am a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries. I meet the Academy's qualification standards for rendering this opinion.

Rudd and Wisdom has been retained by the Texas Health and Human Services Commission (HHSC) to assist in the development of the Medicaid and CHIP Dental Plan premium rates for the period September 1, 2024 through August 31, 2025 (FY2025) and to provide the actuarial certification required under Centers for Medicare and Medicaid Services (CMS) requirements 42 CFR 438.4.

I certify that the Medicaid and CHIP Dental Plan premium rates developed by HHSC and Rudd and Wisdom satisfy the following:

(a) The premium rates have been developed in accordance with generally accepted actuarial principles and practices;

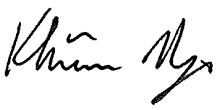
(b) The premium rates are appropriate for the populations and services covered under the managed care contract; and

(c) The premium rates are actuarially sound as defined in the regulations.

We have relied on historical experience data and program information provided to us by HHSC. We have reviewed the data for reasonableness but have not audited the data.

The assumptions, methodologies and factors used in developing the certified capitation rates are based on valid rate development standards and represent actual cost differences in providing covered services to the covered populations, and these differences do not vary with the rate of FFP associated with the covered populations. All rates have been developed based on the actual managed care experience of the covered populations. Any services subject to varying FFP have been separately identified and documented throughout this report.

Please note that actual health plan contractor experience will differ from these projections. Rudd and Wisdom has developed these rates on behalf of the State to demonstrate compliance with the CMS requirements under 42 CFR 438.3(c), 438.3(e), 438.4, 438.5, 438.6 and 438.7. Any health plan contracting with the State should analyze its own projected premium needs before deciding whether to contract with the State.



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## VIII. Attachments

Attachment 1 – Summary of FY2025 Medicaid and CHIP Dental Rating Analysis

Attachment 2 – Medicaid and CHIP Dental Incurred Claims Experience

Attachment 3 – Dental Rating Trend Analysis

Attachment 4 – Dental Rating Adjustment Factors

Attachment 5 – PHE Related Cost Adjustment

Attachment 6 – Default Enrollment Acuity Adjustment

Attachment 7 – Dental Pay-for-Quality (P4Q) Program

Attachment 8 – Index for 2024-2025 Medicaid Managed Care Rate Development Guide

***Attachment 1***

*Summary of FY2025 Medicaid and CHIP Dental Rating Analysis*

Attachment 1 presents summary information regarding the FY2025 Medicaid and CHIP Dental Plan rate development.

A summary of the statewide community rate development is presented in Exhibit A-1 for Medicaid Dental and Exhibit B-1 for CHIP Dental. The top of the exhibit shows summary base period enrollment, premium and claims experience. We projected the FY2025 cost for the dental plans by estimating their base period average claims cost and then applying trend and other adjustment factors. These adjustment factors are described in more detail in Section IV of this report. The rating methodology includes an explicit provision for administrative expenses ($1.75 pmpm), risk margin (1.50% of gross premium), premium tax (1.75% of gross premiums) and maintenance tax ($.023 pmpm). The bottom of the exhibit presents the projected FY2025 cost based on the above assumptions.

The FY2025 Medicaid and CHIP Dental premium rates were then defined as the statewide community rate with default enrollment acuity adjustment for all risk groups. Exhibits A-2 and B-2 of Attachment 1 present the derivation of the premium rates by dental plan and risk group for the Medicaid and CHIP dental programs. Additional information regarding the default enrollment acuity adjustment is included in Attachment 6.

The reasons for the rate changes shown in Exhibit A-1 for Medicaid Dental and Exhibit B-1 for CHIP Dental are numerous and vary from risk group to risk group. The overall premium rates increased by an average of 1.3% for Medicaid and 6.4% for CHIP which is primarily attributed to (a) the updating of the base period to FY2023 and (b) the PHE unwinding process which has resulted in increased average cost.

FY2025 Medicaid Dental Rating
Statewide

Attachment 1 - Exhibit A-1

| | <1 | | 1-5 | | 6-14 | | 15-18 | | 19-20 | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Amount | pmpm | Amount | pmpm | Amount | pmpm | Amount | pmpm | Amount | pmpm | Amount | pmpm |
| Experience Period FY2023 | | | | | | | | | | | | |
| Member Months | 2,123,994 | | 13,136,576 | | 21,830,548 | | 8,879,661 | | 3,484,099 | | 49,454,878 | |
| Incurred Claims | | | | | | | | | | | | |
| Diagnostic | 18,900,315 | 8.90 | 142,370,272 | 10.84 | 162,051,750 | 7.42 | 55,887,743 | 6.29 | 12,837,285 | 3.68 | 392,047,366 | 7.93 |
| Preventive | 51,948 | 0.02 | 44,476,979 | 3.39 | 167,869,722 | 7.69 | 50,350,433 | 5.67 | 9,860,847 | 2.83 | 272,609,930 | 5.51 |
| Restorative | 1,681 | 0.00 | 93,515,276 | 7.12 | 191,955,113 | 8.79 | 74,286,299 | 8.37 | 18,265,707 | 5.24 | 378,024,077 | 7.64 |
| Orthodontic | 0 | 0.00 | 6,047 | 0.00 | 430,805 | 0.02 | 274,657 | 0.03 | 61,968 | 0.02 | 773,476 | 0.02 |
| All Others | 99,311 | 0.05 | 26,938,972 | 2.05 | 47,532,173 | 2.18 | 45,569,483 | 5.13 | 14,193,907 | 4.07 | 134,333,846 | 2.72 |
| Total | 19,053,256 | 8.97 | 307,307,546 | 23.39 | 569,839,563 | 26.10 | 226,368,616 | 25.49 | 55,219,714 | 15.85 | 1,177,788,694 | 23.82 |
| Projected FY2025 | | | | | | | | | | | | |
| Member Months | 2,200,623 | | 10,366,842 | | 16,743,645 | | 5,697,558 | | 595,521 | | 35,604,189 | |
| Premium @ Current Rates | 25,403,965 | 11.54 | 293,313,516 | 28.29 | 519,759,850 | 31.04 | 175,775,069 | 30.85 | 12,463,828 | 20.93 | 1,026,716,228 | 28.84 |
| Annual Cost Trend Assumptions | 0.50 % | | 0.50 % | | 0.50 % | | 0.50 % | | 0.50 % | | | |
| Rating Adjustment Factors | | | | | | | | | | | | |
| Adjustment #1 - FQHC Wrap Adjustment | 0.9934 | | 0.9933 | | 0.9943 | | 0.9947 | | 0.9948 | | | |
| Adjustment #2 - PHE Adjustment | 1.0475 | | 1.0659 | | 1.0720 | | 1.1197 | | 1.1753 | | | |
| Adjustment #3 | 1.0000 | | 1.0000 | | 1.0000 | | 1.0000 | | 1.0000 | | | |
| Projected FY2025 Incurred Claims | 20,748,550 | 9.43 | 259,334,956 | 25.02 | 470,511,682 | 28.10 | 163,385,854 | 28.68 | 11,146,010 | 18.72 | 925,127,052 | 25.98 |
| Other Dental Expense/Capitation | 635,620 | 0.29 | 5,543,152 | 0.53 | 7,781,922 | 0.46 | 3,145,952 | 0.55 | 441,235 | 0.74 | 17,547,881 | 0.35 |
| Administrative Fee | 3,851,090 | 1.75 | 18,141,974 | 1.75 | 29,301,379 | 1.75 | 9,970,726 | 1.75 | 1,042,162 | 1.75 | 62,307,330 | 1.75 |
| Risk Margin | 392,040 | 1.50% | 4,391,659 | 1.50% | 7,875,747 | 1.50% | 2,738,535 | 1.50% | 196,020 | 1.50% | 15,594,000 | 1.50% |
| Premium Tax | 457,380 | 1.75% | 5,123,602 | 1.75% | 9,188,371 | 1.75% | 3,194,957 | 1.75% | 228,690 | 1.75% | 18,193,000 | 1.75% |
| Maintenance Tax | 51,348 | 0.02 | 241,893 | 0.02 | 390,685 | 0.02 | 132,943 | 0.02 | 13,895 | 0.02 | 830,764 | 0.02 |
| Projected Total Cost | 26,136,028 | 11.88 | 292,777,235 | 28.24 | 525,049,785 | 31.36 | 182,568,967 | 32.04 | 13,068,013 | 21.94 | 1,039,600,028 | 29.20 |
| Rate Change % | | 2.9% | | -0.2% | | 1.0% | | 3.9% | | 4.8% | | 1.3% |

* Projected enrollment does not represent HHSC official caseload projections

FY2025 CHIP Dental Rating
Statewide



| | <1 | | 1-5 | | 6-14 | | 15-18 | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Amount | pmpm | Amount | pmpm | Amount | pmpm | Amount | pmpm | Amount | pmpm |
| Experience Period FY2023 | | | | | | | | | | |
| Member Months | 975 | | 71,401 | | 406,396 | | 165,103 | | 643,875 | |
| Incurred Claims | | | | | | | | | | |
| Diagnostic | 295 | 0.30 | 476,624 | 6.68 | 3,236,879 | 7.96 | 1,156,155 | 7.00 | 4,869,952 | 7.56 |
| Preventive | 241 | 0.25 | 322,129 | 4.51 | 2,976,842 | 7.32 | 962,628 | 5.83 | 4,261,841 | 6.62 |
| Restorative | 0 | 0.00 | 315,824 | 4.42 | 2,210,787 | 5.44 | 908,511 | 5.50 | 3,435,122 | 5.34 |
| Orthodontic | 0 | 0.00 | 0 | 0.00 | 5,456 | 0.01 | 4,803 | 0.03 | 10,259 | 0.02 |
| All Others | 0 | 0.00 | 52,859 | 0.74 | 245,834 | 0.60 | 261,023 | 1.58 | 559,716 | 0.87 |
| Total | 536 | 0.55 | 1,167,436 | 16.35 | 8,675,799 | 21.35 | 3,293,120 | 19.95 | 13,136,890 | 20.40 |
| Projected FY2025 | | | | | | | | | | |
| Member Months | 609 | | 824,757 | | 1,957,329 | | 666,709 | | 3,449,404 | |
| Premium @ Current Rates | 1,744 | 2.86 | 15,269,125 | 18.51 | 45,022,733 | 23.00 | 13,915,728 | 20.87 | 74,209,330 | 21.51 |
| Annual Cost Trend Assumptions | 1.30 % | | 1.30 % | | 1.30 % | | 1.30 % | | | |
| Rating Adjustment Factors | | | | | | | | | | |
| Adjustment #1 - FQHC Wrap Adjustment | 1.0000 | | 0.9976 | | 0.9989 | | 0.9989 | | | |
| Adjustment #2 - PHE Adjustment | 1.0000 | | 1.0000 | | 1.0000 | | 1.0000 | | | |
| Adjustment #3 | 1.0000 | | 1.0000 | | 1.0000 | | 1.0000 | | | |
| Projected FY2025 Incurred Claims | 344 | 0.56 | 13,805,467 | 16.74 | 42,830,206 | 21.88 | 13,630,818 | 20.44 | 70,266,834 | 20.37 |
| Other Dental Expense/Capitation | 0 | 0.00 | 2,215 | 0.00 | 18,261 | 0.01 | 6,585 | 0.01 | 27,061 | 0.04 |
| Administrative Fee | 1,066 | 1.75 | 1,443,325 | 1.75 | 3,425,326 | 1.75 | 1,166,741 | 1.75 | 6,036,457 | 1.75 |
| Risk Margin | 22 | 1.50% | 236,748 | 1.50% | 718,131 | 1.50% | 229,763 | 1.50% | 1,184,664 | 1.50% |
| Premium Tax | 26 | 1.75% | 276,206 | 1.75% | 837,820 | 1.75% | 268,057 | 1.75% | 1,382,108 | 1.75% |
| Maintenance Tax | 14 | 0.02 | 19,244 | 0.02 | 45,671 | 0.02 | 15,557 | 0.02 | 80,486 | 0.02 |
| Projected Total Cost | 1,471 | 2.42 | 15,783,205 | 19.14 | 47,875,415 | 24.46 | 15,317,519 | 22.97 | 78,977,611 | 22.90 |
| Rate Change % | | -15.7% | | 3.4% | | 6.3% | | 10.1% | | 6.4% |

* Projected enrollment does not represent HHSC official caseload projections

FY2025 Dental Rating
Medicaid Dental

| | <1 | 1-5 | 6-14 | 15-18 | 19-20 |
|---|---|---|---|---|---|
| FY2025 Statewide Community Rates | | | | | |
| Dentaquest | 11.88 | 28.24 | 31.36 | 32.04 | 21.94 |
| MCNA | 11.88 | 28.24 | 31.36 | 32.04 | 21.94 |
| United | 11.88 | 28.24 | 31.36 | 32.04 | 21.94 |
| | | | | | |
| Default Enrollment Acuity Adjustment | | | | | |
| Dentaquest | 1.00762 | 1.01508 | 1.00170 | 1.00229 | 1.00851 |
| MCNA | 1.00762 | 1.01508 | 1.00170 | 1.00229 | 1.00851 |
| United | 0.98110 | 0.94477 | 0.98352 | 0.97741 | 0.95390 |
| | | | | | |
| FY2025 Acuity Adjusted Rates | | | | | |
| Dentaquest | 11.97 | 28.67 | 31.41 | 32.12 | 22.13 |
| MCNA | 11.97 | 28.67 | 31.41 | 32.12 | 22.13 |
| United | 11.65 | 26.68 | 30.84 | 31.32 | 20.93 |

FY2025 Dental Rating
CHIP Dental

| | <1 | 1-5 | 6-14 | 15-18 |
|---|---|---|---|---|
| FY2025 Statewide Community Rates | | | | |
| Dentaquest | 2.42 | 19.14 | 24.46 | 22.97 |
| MCNA | 2.42 | 19.14 | 24.46 | 22.97 |
| United | 2.42 | 19.14 | 24.46 | 22.97 |
| | | | | |
| Default Enrollment Acuity Adjustment | | | | |
| Dentaquest | 1.00087 | 1.01115 | 1.00144 | 1.00177 |
| MCNA | 1.00087 | 1.01115 | 1.00144 | 1.00177 |
| United | 0.99795 | 0.96003 | 0.99226 | 0.99026 |
| | | | | |
| FY2025 Acuity Adjusted Rates | | | | |
| Dentaquest | 2.42 | 19.35 | 24.49 | 23.02 |
| MCNA | 2.42 | 19.35 | 24.49 | 23.02 |
| United | 2.41 | 18.37 | 24.27 | 22.75 |

***Attachment 2***

*Medicaid and CHIP Dental Incurred Claims Experience*

The attached exhibit presents a summary of the historical incurred claims experience used in the rate setting analysis for the Medicaid and CHIP Dental programs. For each month, the exhibit shows enrollment, claims incurred during the month and paid through February 2024 and estimated incurred claims.

Exhibits A and B present the claims experience applicable to the Medicaid and CHIP Dental programs.

Medicaid Dental Plan
Estimated Claims Experience
All Age Groups
Total - All Services

| Month | Members | Inc & Pd Claims | Compl Factor | Est. Inc. Claims | Est. Inc. pmpm | Trend Factor |
|---|---|---|---|---|---|---|
| Sep-20 | 3,217,425 | 84,459,186 | 1.000 | 84,459,186 | 26.25 | |
| Oct-20 | 3,270,214 | 80,574,751 | 1.000 | 80,574,751 | 24.64 | |
| Nov-20 | 3,313,831 | 71,224,488 | 1.000 | 71,224,488 | 21.49 | |
| Dec-20 | 3,370,408 | 80,431,972 | 1.000 | 80,431,972 | 23.86 | |
| Jan-21 | 3,435,761 | 82,371,743 | 1.000 | 82,371,743 | 23.97 | |
| Feb-21 | 3,482,963 | 66,958,140 | 1.000 | 66,958,140 | 19.22 | |
| Mar-21 | 3,518,032 | 101,848,750 | 1.000 | 101,848,750 | 28.95 | |
| Apr-21 | 3,551,374 | 86,349,190 | 1.000 | 86,349,190 | 24.31 | |
| May-21 | 3,587,316 | 76,588,452 | 1.000 | 76,588,452 | 21.35 | |
| Jun-21 | 3,618,126 | 91,129,748 | 1.000 | 91,129,748 | 25.19 | |
| Jul-21 | 3,656,310 | 92,501,817 | 1.000 | 92,501,817 | 25.30 | |
| Aug-21 | 3,685,272 | 92,682,880 | 1.000 | 92,682,880 | 25.15 | |
| Sep-21 | 3,720,173 | 86,727,653 | 1.000 | 86,727,653 | 23.31 | 0.888 |
| Oct-21 | 3,749,185 | 90,175,667 | 1.000 | 90,175,667 | 24.05 | 0.976 |
| Nov-21 | 3,786,747 | 85,099,271 | 1.000 | 85,099,271 | 22.47 | 1.046 |
| Dec-21 | 3,823,512 | 84,379,026 | 1.000 | 84,379,026 | 22.07 | 0.925 |
| Jan-22 | 3,850,226 | 86,418,145 | 1.000 | 86,418,145 | 22.44 | 0.936 |
| Feb-22 | 3,884,739 | 85,353,975 | 1.000 | 85,353,975 | 21.97 | 1.143 |
| Mar-22 | 3,912,164 | 109,383,348 | 1.000 | 109,383,348 | 27.96 | 0.966 |
| Apr-22 | 3,946,423 | 95,197,683 | 1.000 | 95,197,683 | 24.12 | 0.992 |
| May-22 | 3,969,620 | 85,133,219 | 1.000 | 85,133,219 | 21.45 | 1.005 |
| Jun-22 | 3,999,034 | 101,182,831 | 1.000 | 101,182,831 | 25.30 | 1.005 |
| Jul-22 | 4,023,171 | 95,952,136 | 1.000 | 95,952,136 | 23.85 | 0.943 |
| Aug-22 | 4,041,395 | 107,598,393 | 1.000 | 107,598,393 | 26.62 | 1.059 |
| Sep-22 | 4,069,262 | 94,409,699 | 1.000 | 94,409,699 | 23.20 | 0.995 |
| Oct-22 | 4,091,564 | 97,291,363 | 1.000 | 97,291,363 | 23.78 | 0.989 |
| Nov-22 | 4,159,730 | 90,318,111 | 1.000 | 90,318,111 | 21.71 | 0.966 |
| Dec-22 | 4,180,382 | 89,120,119 | 1.000 | 89,120,119 | 21.32 | 0.966 |
| Jan-23 | 4,196,897 | 101,311,350 | 1.000 | 101,310,807 | 24.14 | 1.075 |
| Feb-23 | 4,215,769 | 94,453,386 | 1.000 | 94,455,535 | 22.41 | 1.020 |
| Mar-23 | 4,234,886 | 114,818,988 | 1.000 | 114,829,943 | 27.12 | 0.970 |
| Apr-23 | 4,257,435 | 95,030,577 | 1.000 | 95,049,060 | 22.33 | 0.926 |
| May-23 | 4,269,126 | 96,781,385 | 1.000 | 96,816,125 | 22.68 | 1.057 |
| Jun-23 | 3,985,748 | 100,567,334 | 0.999 | 100,625,812 | 25.25 | 0.998 |
| Jul-23 | 3,941,749 | 96,827,415 | 0.999 | 96,917,999 | 24.59 | 1.031 |
| Aug-23 | 3,852,330 | 106,491,397 | 0.999 | 106,644,122 | 27.68 | 1.040 |
| FY2021 | 41,707,032 | | | 1,007,121,115 | 24.15 | |
| FY2022 | 46,706,389 | | | 1,112,601,346 | 23.82 | 0.986 |
| FY2023 | 49,454,878 | | | 1,177,788,694 | 23.82 | 1.000 |

CHIP Dental Plan
Estimated Claims Experience
All Age Groups
Total - All Services

| Month | Members | Inc & Pd Claims | Compl Factor | Est. Inc. Claims | Est. Inc. pmpm | Trend Factor |
|---|---|---|---|---|---|---|
| Sep-20 | 307,568 | 5,605,868 | 1.000 | 5,605,868 | 18.23 | |
| Oct-20 | 299,176 | 5,167,918 | 1.000 | 5,167,918 | 17.27 | |
| Nov-20 | 294,139 | 4,450,177 | 1.000 | 4,450,177 | 15.13 | |
| Dec-20 | 266,142 | 4,705,419 | 1.000 | 4,705,419 | 17.68 | |
| Jan-21 | 250,033 | 4,277,068 | 1.000 | 4,277,068 | 17.11 | |
| Feb-21 | 238,037 | 3,270,115 | 1.000 | 3,270,115 | 13.74 | |
| Mar-21 | 216,404 | 4,907,422 | 1.000 | 4,907,422 | 22.68 | |
| Apr-21 | 209,350 | 3,742,457 | 1.000 | 3,742,457 | 17.88 | |
| May-21 | 205,069 | 3,178,688 | 1.000 | 3,178,688 | 15.50 | |
| Jun-21 | 200,123 | 3,995,218 | 1.000 | 3,995,218 | 19.96 | |
| Jul-21 | 192,055 | 3,806,680 | 1.000 | 3,806,680 | 19.82 | |
| Aug-21 | 184,853 | 3,349,593 | 1.000 | 3,349,593 | 18.12 | |
| Sep-21 | 175,022 | 2,841,467 | 1.000 | 2,841,467 | 16.23 | 0.891 |
| Oct-21 | 163,301 | 2,843,083 | 1.000 | 2,843,083 | 17.41 | 1.008 |
| Nov-21 | 122,363 | 2,109,233 | 1.000 | 2,109,233 | 17.24 | 1.139 |
| Dec-21 | 100,606 | 1,929,190 | 1.000 | 1,929,190 | 19.18 | 1.085 |
| Jan-22 | 88,661 | 1,675,826 | 1.000 | 1,675,826 | 18.90 | 1.105 |
| Feb-22 | 88,962 | 1,641,918 | 1.000 | 1,641,918 | 18.46 | 1.343 |
| Mar-22 | 80,380 | 1,970,374 | 1.000 | 1,970,374 | 24.51 | 1.081 |
| Apr-22 | 78,440 | 1,558,319 | 1.000 | 1,558,319 | 19.87 | 1.111 |
| May-22 | 74,714 | 1,245,008 | 1.000 | 1,245,008 | 16.66 | 1.075 |
| Jun-22 | 73,035 | 1,669,190 | 1.000 | 1,669,190 | 22.85 | 1.145 |
| Jul-22 | 69,579 | 1,473,028 | 1.000 | 1,473,028 | 21.17 | 1.068 |
| Aug-22 | 66,654 | 1,429,639 | 1.000 | 1,429,639 | 21.45 | 1.184 |
| Sep-22 | 64,808 | 1,179,380 | 1.000 | 1,179,380 | 18.20 | 1.121 |
| Oct-22 | 63,017 | 1,269,385 | 1.000 | 1,269,385 | 20.14 | 1.157 |
| Nov-22 | 58,674 | 1,076,119 | 1.000 | 1,076,119 | 18.34 | 1.064 |
| Dec-22 | 53,832 | 1,058,267 | 1.000 | 1,058,267 | 19.66 | 1.025 |
| Jan-23 | 50,986 | 1,039,877 | 1.000 | 1,039,891 | 20.40 | 1.079 |
| Feb-23 | 48,942 | 938,348 | 1.000 | 938,397 | 19.17 | 1.039 |
| Mar-23 | 41,377 | 1,033,742 | 1.000 | 1,033,813 | 24.99 | 1.019 |
| Apr-23 | 40,357 | 823,188 | 1.000 | 823,316 | 20.40 | 1.027 |
| May-23 | 39,424 | 756,753 | 1.000 | 757,093 | 19.20 | 1.152 |
| Jun-23 | 46,020 | 963,113 | 0.999 | 964,261 | 20.95 | 0.917 |
| Jul-23 | 59,636 | 1,366,060 | 0.998 | 1,368,320 | 22.94 | 1.084 |
| Aug-23 | 76,802 | 1,625,108 | 0.998 | 1,628,649 | 21.21 | 0.989 |
| FY2021 | 2,862,949 | | | 50,456,623 | 17.62 | |
| FY2022 | 1,181,717 | | | 22,386,275 | 18.94 | 1.075 |
| FY2023 | 643,875 | | | 13,136,890 | 20.40 | 1.077 |

***Attachment 3***

*Trend Analysis*

The rating methodology uses assumed trend factors to adjust the base period claims cost to the rating period. The cost trend factors used in this analysis are a combination of utilization and inflation components. The projected trend rate assumptions were developed by the actuary based on an analysis of recent experience. A single trend assumption by dental program was used for all age groups in order to reduce fluctuation from year to year and to increase credibility.

The trend analysis included a review of dental plan claims experience through February 2024. Orthodontia claim experience was excluded from the Medicaid Dental trend analysis in order to not skew results due to Medicaid policy changes that resulted in large reductions to orthodontia claims experience. All historical trends were calculated as the average cost per member per calendar year and compared to the prior year. The experience trends for all time periods were adjusted to remove the impact of various provider reimbursement changes and other revisions that have impacted the cost of the program. Effective in February 2019 and March 2019, the dental plans made prior authorization changes to restorative dental services which required providers to submit additional documentation for previously provided repetitive restoration (same tooth, same dental service) for the same provider or location. As a result, utilization for restorative service reduced significantly. In order to account for the change in mix of services, the trend analysis was determined assuming the service mix distribution for all time period is the same as for the period March 2019 through February 2020. Dental experience after February 2020 has been excluded from the trend analysis due to the significant reduction in cost caused by the COVID-19 pandemic and the corresponding PHE declaration.

The annual trend assumption was selected based on the weighted average of the trends equal to 20% of the experience trend rate for the 12-month period ending February 2018, 30% of the experience trend rate for the 12-month period ending February 2019 and 50% of the experience trend rate for the 12-month period ending February 2020. The annual trend assumption used in the rating analysis for all dental services was 0.50% for Medicaid Dental and 1.30% for CHIP Dental.

Exhibits A and B provide details regarding the calculation of the trend assumptions applicable to the Medicaid and CHIP Dental programs.

Medicaid Dental FY2025 Rating
Trend Analysis

| Trend Period | Utilization | Unit Cost | Total PMPM |
|---|---|---|---|
| **Medicaid Dental** | | | |
| 3/17-2/18 | 1.2% | -0.9% | 0.3% |
| 3/18-2/19 | 1.1% | -0.2% | 0.9% |
| 3/19-2/20 | -0.4% | 0.8% | 0.3% |
| Selected | 0.4% | 0.2% | **0.50%** |

Notes:
(1) Removed impact of reimbursement and policy changes from trend analysis
(2) Adjusted unit cost to normalize difference in service mix.
Assumed same service mix distribution as for the period 3/19-2/20.

CHIP Dental FY2025 Rating
Trend Analysis

| Trend Period | Utilization | Unit Cost | Total PMPM |
|---|---|---|---|
| **CHIP Dental** | | | |
| 3/17-2/18 | 1.6% | -0.8% | 0.8% |
| 3/18-2/19 | 1.6% | 0.5% | 2.2% |
| 3/19-2/20 | 1.2% | -0.2% | 1.0% |
| Selected | 1.4% | -0.1% | **1.30%** |

Notes:
(1) Removed impact of reimbursement and policy changes from trend analysis
(2) Adjusted unit cost to normalize difference in service mix.
Assumed same service mix distribution as for the period 3/19-2/20.

***Attachment 4***

*FQHC Wrap Payment Removal*

Effective March 1, 2018, DHMOs were no longer required to reimburse FQHCs the full encounter rate. The DHMOs are expected to reimburse FQHCs at a rate that is comparable to the reimbursement of all other non-FQHC providers providing similar services. Subsequently, the FQHC will be reimbursed up to their full encounter rate through the FQHC wrap payments outside of the capitation rate. The base period data includes the full reimbursement rate paid to the FQHCs. As a result, this adjustment is necessary to remove the FQHC wrap payment portion from the base period data. The rating adjustment was calculated by collecting the FQHC wrap payments paid by the DHMOs during the base period. Attachment 4 provides details regarding the calculation of the FQHC wrap payment adjustment factor for the Medicaid and CHIP Dental programs.

FY2025 Dental Rating Attachment 4
FQHC Wrap Payment Rate Adjustment
Experience Period - September 1, 2022 through August 31, 2023 (FY2023)

| | <1 | 1-5 | 6-14 | 15-18 | 19-20 | Total |
|---|---|---|---|---|---|---|
| FQHC Wrap Reimbursement | | | | | | |
| Medicaid | (125,056) | (2,062,823) | (3,263,618) | (1,210,133) | (286,880) | (6,948,510) |
| CHIP | - | (2,745) | (9,835) | (3,682) | | (16,262) |
| | | | | | | |
| Experience Period Incurred Clalims (September 1, 2022 through August 31, 2023) | | | | | | |
| Medicaid | 19,053,256 | 307,307,546 | 569,839,563 | 226,368,616 | 55,219,714 | 1,177,788,694 |
| CHIP | 536 | 1,167,436 | 8,675,799 | 3,293,120 | | 13,136,890 |
| | | | | | | |
| Rating Adjustment Factor | | | | | | |
| Medicaid | 0.9934 | 0.9933 | 0.9943 | 0.9947 | 0.9948 | |
| CHIP | 1.0000 | 0.9976 | 0.9989 | 0.9989 | | |

***Attachment 5***

*PHE Related Cost Adjustment*

The COVID-19 pandemic and the resulting Public Health Emergency (PHE) had a significant impact on the Medicaid dental program. Beginning March 2020, enrollment grew by about 40% while the average cost for all services declined significantly. The enrollment growth is due to the continuous enrollment provision during the PHE included in the Families First Coronavirus Response Act (FFCRA), while the cost reductions are due to many factors including mandatory shutdowns, mask mandates, social distancing, other environmental factors as well as inherent differences in cost between historically eligible members and the continuously enrolled members eligible under the PHE.

With the expiration of the PHE on May 11, 2023, HHSC has begun the PHE unwind process, which is expected to span a twelve-month period. HHSC will begin disenrollments on June 1, 2023 and has prioritized members into three cohorts:

- Cohort 1 - Individuals likely to be ineligible
- Cohort 2 - Individuals likely to transfer to another HHSC program
- Cohort 3 - Individuals likely to remain eligible

Current Medicaid members are spread throughout these cohorts based on known eligibility information and type program/type of assistance but are not specific to Medicaid program. Each cohort contains members from any Medicaid program and the disenrollments and renewals are staggered throughout the twelve-month period with the majority occurring in the first six months. Based on the planned PHE unwinding process and detailed information regarding the specific Medicaid members within each cohort and their expected redetermination dates, HHS Forecasting has developed projected caseload forecasts for the Medicaid dental program by month, DHMO and risk group through the end of FY2025.

Given that the FY2023 base period was impacted by the PHE and the expected disenrollments that will occur prior to FY2025, it is necessary to calculate an adjustment factor to properly estimate the impact of the PHE unwind process. The PHE impact was not uniform across all Medicaid programs and the adjustment factors calculated are specific to the populations being rated based on historical program-specific experience.

<u>Medicaid Dental Adjustment</u>

In order to estimate the impact of the PHE unwind on the FY2025 dental average costs, we have analyzed the base period claims along with enrollment and disenrollment information through February 2024. Base period enrollment was divided into two categories: (1) members who were continuously enrolled in the program as a result of the PHE and (2) members who remained enrolled in the Medicaid dental program. Continuously enrolled members were defined as individuals enrolled in the Medicaid Dental program as of May 2023 and disenrolled as of February 2024. The PHE adjustment was determined by comparing (1) the FY2023 base period PMPM average cost to (2) the FY2023 average cost excluding the members who were

continuously enrolled as a result of the PHE. This adjustment adjusts the FY2023 base period to eliminate those members that have been disenrolled from the program as a result of the PHE unwinding process. The attached exhibit presents a summary of the derivation of the adjustment factors.

The methodology described above assumes that all impacted members will unwind and be disenrolled prior to the FY2025 rating period. In other words, the calculated adjustment factors represent the full impact of the PHE.

CHIP Dental Adjustment

In order to estimate the impact of the PHE unwind on the FY2025 dental average costs, we have analyzed the base period claims along with enrollment and disenrollment information through February 2024. The PHE unwinding process resulted in members being disenrolled from Medicaid dental and transferring to CHIP dental for qualified members. Members that transferred from Medicaid to CHIP dental from the unwinding process were defined as individuals enrolled in the Medicaid dental program during the FY2023 base period and enrolled in CHIP dental as of February 2024. The PHE adjustment was determined by comparing (1) the FY2023 base period PMPM average cost to (2) the FY2023 average cost including members who transferred from Medicaid to CHIP dental. The FY2023 base period average cost is similar to the average cost for members who transferred from Medicaid to CHIP dental program. As a result, the PHE Adjustment was assumed to be 1.0 for the CHIP dental program.

FY2025 Dental Rating
PHE Related Cost Adjustment
Statewide Experience

| | Age <1 | Age 1-5 | Age 6-14 | Age 15-18 | Age 19-20 |
|---|---|---|---|---|---|
| **Medicaid Dental - FY2023 Average PMPM (1)** | | | | | |
| Excluding Continuously Enrolled PHE Members (2) | 8.70 | 24.97 | 27.96 | 28.58 | 19.29 |
| Total | 8.31 | 23.43 | 26.08 | 25.52 | 16.41 |
| PHE Adjustment Factor (3) | 1.0475 | 1.0659 | 1.072 | 1.1197 | 1.1753 |

Notes:
(1) Based on FY2023 encounter data. Does not include IBNR runout.
(2) FY23 experience excluding experience for members enrolled in May 2023 (prior to PHE unwinding) and disenrolled in February 2024 (after PHE unwinding).
Includes 1% margin for pent-up demand, increased utilization and membership churn.
(3) Excluding Continuously Enrolled PHE Members PMPM divided by Total PMPM.

***Attachment 6***

*Default Enrollment Acuity Adjustment*

Effective September 1, 2020, a new DHMO was added to the dental programs for a total of three DHMOs each operating statewide. In order to increase enrollment for the new plan, all default enrollments without prior history were assigned to the new DHMO until a minimum threshold was met. Default members average cost is significantly less than that for non-default members. The purpose of default enrollment acuity adjustment is to recognize the anticipated cost differential between multiple dental plans by analyzing the average cost per member of their respective memberships. The default enrollment acuity adjustment was applied in a budget neutral manner.

The default enrollment acuity adjustment was defined as the difference in average cost per member between the new DHMO and the existing DHMOs by program and risk group for the base period September 1, 2022 through August 31, 2023. Effective May 2022, the new DHMO met the minimum enrollment threshold and preferential treatment of default enrollment ended. However, there is still much uncertainty to the cost characteristic of each dental plan in FY2025, specifically the impact to each DHMO once the PHE unwinding process begins. As a result, we have applied a 25% credibility factor to the default enrollment acuity adjustment.

Exhibits A and B provide details regarding the calculation of the default enrollment acuity adjustment factor for the Medicaid and CHIP Dental programs.

FY2025 Medicaid Dental Rating
Default Enrollment Acuity Analysis
September 1, 2022 through August 31, 2023

| | <1 | 1-5 | 6-14 | 15-18 | 19-20 | Total |
|---|---|---|---|---|---|---|
| **Member Months** | | | | | | |
| MCNA+DQ | 1,508,385 | 10,828,157 | 20,036,138 | 8,117,042 | 3,157,049 | 43,646,771 |
| United | 615,609 | 2,308,419 | 1,794,410 | 762,619 | 327,050 | 5,808,107 |
| Total | 2,123,994 | 13,136,576 | 21,830,548 | 8,879,661 | 3,484,099 | 49,454,878 |
| **Incurred Claims** | | | | | | |
| MCNA+DQ | 13,951,284 | 268,694,679 | 526,618,409 | 208,834,482 | 51,667,152 | 1,069,766,006 |
| United | 5,107,794 | 41,971,075 | 43,754,081 | 17,684,531 | 4,210,393 | 112,727,873 |
| Total | 19,059,077 | 310,665,754 | 570,372,489 | 226,519,013 | 55,877,546 | 1,182,493,879 |
| **PMPM** | | | | | | |
| MCNA+DQ | 9.25 | 24.81 | 26.28 | 25.73 | 16.37 | 24.51 |
| United | 8.30 | 18.18 | 24.38 | 23.19 | 12.87 | 19.41 |
| Total | 8.97 | 23.65 | 26.13 | 25.51 | 16.04 | 23.91 |
| **Acuity Adjustment - Full** | | | | | | |
| MCNA+DQ | 1.03075 | 1.04928 | 1.00598 | 1.00855 | 1.02044 | 1.02505 |
| United | 0.92466 | 0.76882 | 0.93326 | 0.90903 | 0.80272 | 0.81172 |
| Total | 1.00000 | 1.00000 | 1.00000 | 1.00000 | 1.00000 | 1.00000 |
| **Acuity Adjustment - 25%** | | | | | | |
| MCNA+DQ | 1.00769 | 1.01232 | 1.00149 | 1.00214 | 1.00511 | 1.00626 |
| United | 0.98116 | 0.94220 | 0.98332 | 0.97726 | 0.95068 | 0.95293 |
| Total | 1.00000 | 1.00000 | 1.00000 | 1.00000 | 1.00000 | 1.00000 |
| **Budget Neutral Factor** | | | | | | |
| MCNA+DQ | 0.99993 | 1.00273 | 1.00021 | 1.00015 | 1.00338 | |
| United | 0.99993 | 1.00273 | 1.00021 | 1.00015 | 1.00338 | |
| Total | 0.99993 | 1.00273 | 1.00021 | 1.00015 | 1.00338 | |

| **Acuity Adjustment - 25% Budget Neutral** | | | | | |
|---|---|---|---|---|---|
| MCNA | 1.00762 | 1.01508 | 1.00170 | 1.00229 | 1.00851 |
| Dentaquest | 1.00762 | 1.01508 | 1.00170 | 1.00229 | 1.00851 |
| United | 0.98110 | 0.94477 | 0.98352 | 0.97741 | 0.95390 |

FY2025 CHIP Dental Rating
Default Enrollment Acuity Analysis
September 1, 2022 through August 31, 2023

| | <1 | 1-5 | 6-14 | 15-18 | Total |
|---|---|---|---|---|---|
| **Member Months** | | | | | |
| MCNA+DQ | 653 | 55,827 | 342,634 | 139,697 | 538,811 |
| United | 322 | 15,574 | 63,762 | 25,406 | 105,064 |
| Total | 975 | 71,401 | 406,396 | 165,103 | 643,875 |
| **Incurred Claims** | | | | | |
| MCNA+DQ | 357 | 953,514 | 7,356,733 | 2,806,127 | 11,116,731 |
| United | 174 | 213,928 | 1,319,076 | 487,009 | 2,020,187 |
| Total | 530 | 1,167,443 | 8,675,810 | 3,293,135 | 13,136,918 |
| **PMPM** | | | | | |
| MCNA+DQ | 0.55 | 17.08 | 21.47 | 20.09 | 20.63 |
| United | 0.54 | 13.74 | 20.69 | 19.17 | 19.23 |
| Total | 0.54 | 16.35 | 21.35 | 19.95 | 20.40 |
| **Acuity Adjustment - Full** | | | | | |
| MCNA+DQ | 1.00386 | 1.04460 | 1.00576 | 1.00708 | 1.01123 |
| United | 0.99218 | 0.84011 | 0.96905 | 0.96105 | 0.94242 |
| Total | 1.00000 | 1.00000 | 1.00000 | 1.00000 | 1.00000 |
| **Acuity Adjustment - 25%** | | | | | |
| MCNA+DQ | 1.00096 | 1.01115 | 1.00144 | 1.00177 | 1.00281 |
| United | 0.99804 | 0.96003 | 0.99226 | 0.99026 | 0.98561 |
| Total | 1.00000 | 1.00000 | 1.00000 | 1.00000 | 1.00000 |
| **Budget Neutral Factor** | | | | | |
| MCNA+DQ | 0.99990 | 1.00000 | 1.00000 | 1.00000 | |
| United | 0.99990 | 1.00000 | 1.00000 | 1.00000 | |
| Total | 0.99990 | 1.00000 | 1.00000 | 1.00000 | |

| **Acuity Adjustment - 25% Budget Neutral** | | | | |
|---|---|---|---|---|
| MCNA | 1.00087 | 1.01115 | 1.00144 | 1.00177 |
| Dentaquest | 1.00087 | 1.01115 | 1.00144 | 1.00177 |
| United | 0.99795 | 0.96003 | 0.99226 | 0.99026 |

***Attachment 7***

*Dental Pay for Quality Program*

The Pay-for-Quality (P4Q) Program creates incentives and disincentives for Dental Maintenance Organizations (DMOs) based on their performance on certain quality measures. Dental plans that excel on their performance measures are eligible for rewards while health plans that do not improve their measures are subject to a recoupment. HHSC received a waiver to suspend the Dental P4Q Program due to the public health emergency (PHE) for the CY2020 and CY2021 measurement period.

**Dental P4Q Measures**

The dental P4Q measures beginning in calendar year 2022 include the following:

| P4Q Measure | Description | Medicaid Age | CHIP Age |
|---|---|---|---|
| DQA Oral Evaluation | Percentage of enrolled children:<br>•who received a comprehensive or periodic oral evaluation within the reporting year | 0-20 years | 0-18 years |
| DQA Topical Fluoride | Percentage of enrolled children:<br>•received at least 2 topical fluoride applications within the reporting year as a dental or oral health service | 1-20 years | 1-18 years |
| DQA Sealant Receipt on Permanent 1st Molars, One Sealant and All Four Sealants | Percentage of enrolled children, who have ever received sealants on permanent first molar teeth:<br>• at least one sealant<br>• all four first molars sealed by the 10th birthdate | Turned age 10 during Measurement Year | |
| DQA Sealant Receipt on Permanent 2nd Molars, One Sealant and All Four Sealants | Percentage of enrolled children, who have ever received sealants on permanent second molar teeth:<br>• at least one sealant<br>• all four second molars sealed by the 15th birthdate | Turned age 15 during Measurement Year | |

To further encourage improvement, HHSC introduced bonus pool measures beginning in calendar year 2022:

| Measure | Description | Medicaid Age | CHIP Age |
|---|---|---|---|
| DQA<br>Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children | Number of emergency department (ED) visits for caries-related reasons per 100,000 Member months for children | 0-20 years | 0-18 years |
| DQA<br>Care Continuity, Dental Services | Percentage of all children enrolled in two consecutive years who received a comprehensive or periodic oral evaluation in both years | 1-20 years | 1-18 years |

**Methodology for Payment and Recoupment**

Beginning in calendar year 2018, 1.5% of each DMO's capitation is at-risk. If a DMO's performance decreases beyond a certain threshold amount on the dental P4Q measures, HHSC will recoup up to 1.5% of the original baseline capitation. Performance will be based on changes from rates two years prior, which will be referred to as the reference year. Beginning with Measurement Year 2022, Measurement Year performance will be compared to the prior Measurement Year. This means Measurement Year 2022 will be compared to Measurement Year 2021.

If a DMO's performance is maintained or improves on all measures, the DMO's capitation will not be at risk for recoupment. If one DMO's performance decreases such that its capitation is subject to recoupment, the funds recouped will be available as an additional distribution payment to other DMOs. A DMO would only be eligible to receive an additional disbursement if its performance improves beyond the upper threshold of the neutral zone.

Beginning with calendar year 2022, funds remaining after these recoupments and distributions will be made available to DMOs that perform above set thresholds on the bonus pool measures.

The DMOs will only be penalized if utilization for the P4Q measure decreases more than the threshold amount for a two-year period, and funds will only be available for bonuses if one or more DMO is penalized and the other DMO excels on meeting the measures. For CY2018, one DMO paid a penalty less than 0.04 percent of capitation. For CY2019, the other DMO paid a penalty less than 0.1 percent of capitation. In both cases, the other DMO did not perform well enough to receive a bonus. For CY2020 and CY2021, HHSC received a waiver to suspend the Dental P4Q Program due to the PHE. MY2022 results are anticipated to be publicly available in August 2024.

***Attachment 8***

*FY2025 Medicaid Rate Certification Index*

The index below includes the pages of this report that correspond to the applicable sections of the 2024-2025 Medicaid Managed Care Rate Development Guide, dated January 2024.

## Section I. Medicaid Managed Care Rates

### 1. General Information

A. Rate Development Standards

i. Rate ranges are not being utilized in this rate development.

ii. Rates are for the period September 1, 2024 through August 31, 2025 (FY2025).

iii. (a) The certification letter is on page 10 of the report.

(b) The final capitation rates are shown on page 9 of the report.

(c) (i) See pages 1 through 2 of the report.

(ii) See page 1 of the report.

(iii) See page 5 of the report.

(iv) There have been no changes to program eligibility.

(v) See Attachment 7 page 31 through 32 of the report.

(vi) Not applicable.

iv. Acknowledged.

v. Acknowledged.

vi. Acknowledged.

vii. Acknowledged.

viii. Not applicable.

ix. Not applicable.

x. Acknowledged.

xi. Acknowledged.

xii. See pages 6 through 7 and Attachment 5 pages 25 through 27 for discussion on how the COVID-19 PHE ending and related unwinding process have been accounted for in the FY2025 rate development.

xiii. Acknowledged.

B. Appropriate Documentation

i. The actuary is certifying capitation rates. See page 10 of the report.

ii. Acknowledged.

iii. Acknowledged. See page 9 of the report.

iv. Acknowledged.

v. Not applicable.

vi. Acknowledged.

vii. Acknowledged. See page 10 of the report.

viii. Not applicable.

ix. a) See Attachment 1 pages 12 through 16 of the report.

b) Not applicable. All rating adjustment factors have been included in the report.

c) FY2024 rates were not adjusted by a *de minimis* amount using the authority in 42 C.F.R 438.7(c)(3).

x. Not applicable. There are no known amendments at this time.

xi. (a) Texas Medicaid Managed Care data has been studied for all programs, risk groups and service delivery areas through February 2024 to study the impact of COVID and the PHE.

(b) See pages 6 through 7 and Attachment 5 pages 25 through 27 of the report.

(c) Not applicable.

(d) See pages 6 through 7 and Attachment 5 pages 25 through 27 of the report. In addition, the experience rebate provisions have been tightened to limit the possibility of excessive profits in FY2025. The experience rebate tiers vary by DHMO with a max profit ranging from 3.6% to 4.5% of premiums.

**2. Data**

A. Rate Development Standards

i. (a) Acknowledged.

(b) Acknowledged.

(c) Acknowledged.

(d) Not applicable. Data from the three most recent, completed years has been utilized.

B. Appropriate Documentation

i. (a) See pages 1 through 4 of the report.

ii. (a) See pages 1 through 4 of the report.

(b) See pages 1 through 4 of the report.

(c) See pages 1 through 4 of the report.

(d) Not applicable.

iii. (a) Base period data is fully credible.

(b) See page 3 of the report.

(c) No errors found in the data.

(d) See pages 6 through 7 of the report.

(e) See pages 1 through 4 of the report.

**3. Projected Benefit Costs and Trends**

A. Rate Development Standards

i. Acknowledged.

ii. Acknowledged.

iii. Not applicable.

iv. Not applicable. IMD regulation does not impact dental programs.

v. Not applicable.

B. Appropriate Documentation

i. See page 9 and Attachment 1 pages 12 through 16 of the report.

ii. (a) See Attachment 1 pages 12 through 16 of the report.

(b) There have been no significant changes in the development of the benefit cost since the last certification.

(c) All recoupments and recoveries resulting from overpayments to providers have been netted out of the claim payments used in the rate development. DHMOs are required to adjust encounter data to remove all overpayments and correct the submitted information. Any provider recoveries not adjusted for in the submitted encounter data are excluded from the base period as a negative add-on payment.

iii. (a) See Attachment 3 pages 20 through 22 of the report.

(b) See Attachment 3 pages 20 through 22 of the report.

(c) See Attachment 3 pages 20 through 22 of the report.

(d) See Attachment 3 pages 20 through 22 of the report.

(e) Not applicable.

iv. Not applicable.

v. Not applicable.

vi. (a) Restorative enrollment can occur when an individual is deemed to have been Medicaid or CHIP eligible during a prior period. If the individual was eligible for and enrolled in Medicaid or CHIP managed care during the prior period, then the individual is retrospectively enrolled in the same managed care plan as their prior enrollment segment. The managed care plan is then retrospectively responsible for all Medicaid expenses incurred during this retrospective period and is also paid a retrospective premium for this time period.

(b) All claims paid during retroactive enrollment periods are included in the base period data used to develop the FY2025 premium rate.

(c) All enrollment data during retroactive enrollment periods are included in the base period data used to develop the FY2025 premium rate.

(d) No adjustments are necessary to account for retroactive enrollment periods because the enrollment criteria have not changed from the base period to the rating period. All retroactive enrollment and claims information has been included in the base period data, the trend calculations and all other adjustment factors.

vii. See pages 6 through 7 of the report.

viii. See pages 6 through 7 of the report.

**4. Special Contract Provisions Related to Payment**

A. Incentive Arrangements

i. Rate Development Standards

Acknowledged.

ii. Appropriate Documentation

(a) See Attachment 7 page 31 through 32 of the report.

B. Withhold Arrangements

i. Rate Development Standards

Acknowledged.

ii. Appropriate Documentation

(a) See Attachment 7 page 31 through 32 of the report.

C. Risk-Sharing Arrangements

i. Rate Development Standards

Acknowledged.

ii. Appropriate Documentation

HHSC includes an experience rebate provision in its Uniform Managed Care Contract which requires the DHMOs to return a portion of net income before taxes if greater than the specified percentages. The net income is measured by the financial statistical reports (FSRs) submitted by the DHMOs and audited by an external auditor. Net income is aggregated across all programs and service delivery areas. The experience rebate tiers vary by DHMO with a max profit ranging from 3.6% to 4.5% of premiums.

D. State Directed Payments

i. Rate Development Standards

Acknowledged.

ii. Appropriate Documentation

(a) Not applicable.

E. Pass-Through Payments

i. Rate Development Standards

Acknowledged.

ii. Appropriate Documentation

(a) Not applicable.

**5. Projected Non-Benefit Costs**

A. Rate Development Standards

i. Acknowledged.

ii. Acknowledged.

B. Appropriate Documentation

i. See page 8 of the report.

ii. See page 8 of the report.

iii. See page 8 of the report.

**6. Risk Adjustment**

A. Rate Development Standards

Acknowledged.

B. Appropriate Documentation

Acknowledged.

**7. Acuity Adjustment**

A. Rate Development Standards

Acknowledged.

B. Appropriate Documentation

i. See Attachment 6 page 28 through 30 of the report.

## Section II. Medicaid Managed Care Rates with Long-Term Services and Support

Not applicable.

## Section III. New Adult Group Capitation Rates

Not applicable.