STATE OF TEXAS
MEDICAID AND CHIP
MANAGED CARE
DENTAL RATE SETTING
FY2022

Prepared for:
Texas Health and Human Services Commission
Texas Dental HHS0002879A-6

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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, 2021 through August 31, 2022 (FY2022) 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 FY2022 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 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 30 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 since March 2012 and a projection of future enrollment through August 2022. These projections were prepared by HHS Forecasting staff.

- Financial Statistical Reports (FSR) for each participating health plan for the period March 2012 through February 2021. The FSR contains detailed information regarding monthly

enrollment, revenue, incurred claims and administrative expenses, as reported by the health plan. These reports were provided by HHSC.

- Claim lag reports by type of service and by age group for each dental plan for the period September 2017 through February 2021. These reports were provided by the dental plans and include monthly paid claims by month of service.

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

- DHMO's detailed encounter claims data for the FY2019 and FY2020 period provided by the EQRO.

- Information provided by HHSC regarding dental fee schedule reimbursement changes.

- Information provided by the DHMOs regarding prior authorization changes to repetitive restorative dental service.

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. We compared (i) the claim lag reports provided by the DHMOs, (ii) the claim amounts reported in the FSRs and (iii) the claim amounts in the encounter data files. The three data sources are compared to ensure consistent results such that the three are considered interchangeable in aggregate. Although interchangeable in total, each data source has a unique role in the analysis. FSR data provides high level summary information of claims data, expenses and administrative costs. In some cases, this information is available at the risk group level while for others it is only provided at an aggregated level. DHMO summary reports provide HHSC-specified data points at a more granular level such as claim lag data by type of service. The detail encounter data provides claim data at the most granular level including information for individual claims such as provider, procedure code, diagnostic information, etc. 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.

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.

In addition to the review for reasonableness performed by Rudd and Wisdom, HHSC employs the Institute for Child Health Policy (ICHP) as an External Quality Review Organization (EQRO). ICHP reviews the detail encounter data and provides certification of the data quality. Below is an excerpt from their data certification report:

Medicaid Dental Certification

Based on an administrative review, the EQRO considers the required data elements for all DHMOs in the Medicaid dental program 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.*

CHIP Dental Certification

Based on an administrative review, the EQRO considers the required data elements for all DHMOs in the CHIP dental program 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.*

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 high quality and we have no concerns over the availability or applicability to the FY2022 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.

II. Overview of the Rate Setting Methodology

The actuarial model used to derive the FY2022 Medicaid and CHIP Dental Plan premium rates relies primarily on health plan financial experience. The historical claims experience for the program was analyzed and estimates for the base period were developed. Due to the significant impact of COVID-19 and the public health emergency (PHE) we have made adjustments to the standard base periods used in prior rate setting. Beginning March 2020, all programs experienced significant declines in the average cost due to large scale shutdowns and deferral of services. As a result, we have determined that the data after February 2020 is not indicative of future cost patterns. The base period was defined as March 2019 through February 2020 which is the most recent twelve-month period which includes claims not impacted by COVID-19 and the PHE. Estimates of the base period included an evaluation of incurred but unpaid claims (IBNR). Given the extensive runout beyond the base period, the IBNR estimates are immaterial. The IBNR estimate is based on claims paid through February 2021 and represents the following percentage of claims by dental program:

- Medicaid Dental - 0.0%
- CHIP Dental - 0.0%

These estimates were then projected forward to FY2022 using assumed trend rates and other adjustment factors. These adjustment factors are described in more detail in Section III. 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

Attachment 1 to this report provides a description of the calculation of the FY2022 Medicaid and CHIP Dental Plan premium rates. Attachment 2 contains a summary of recent program incurred claims experience. Attachment 3 provides details regarding the calculation of the trend assumption. Attachment 4 presents the calculation of the rate adjustment factors. Attachment 5 presents the calculation of the continuing impact of the PHE on FY2022 cost. Attachment 6 presents information on the Pay-for-Quality Program. Attachment 7 provides the required index summarizing sections from the 2021-2022 Medicaid Managed Care Rate Development Guide.

III. 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 March 1, 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 0.30% for Medicaid Dental and 0.40% for CHIP Dental.

Attachment 3 – Exhibits A and B 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 FQHC's 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 rating adjustment was calculated by collecting the FQHC wrap payments paid by the DHMOs during the base period. Attachment 4 Exhibit A 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 2021, the PHE has had a significant impact on dental expenditures. Medicaid dental enrollment has grown by nearly 25% and average dental claims have dropped significantly. A rating adjustment was calculated in order to estimate the ongoing impact of the PHE on average program cost in FY2022 as enrollment continues to increase and we have yet to see an abatement in the reduced program costs. Attachment 5 provide details regarding the calculation of the PHE related cost adjustment for the Medicaid Dental program. Please note the PHE related adjustment was only applied to the Medicaid dental program where there was significant increase in enrollment.

Pay-for-Quality

The Pay-for-Quality (P4Q) Program creates incentives and disincentives for DHMOs based on their performance on certain quality measures. Dental plans that excel on meeting the measures are eligible for a bonus while dental plans that don't meet their measures are subject to a penalty.

The DHMO's 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 DHMO is penalized and the other DHMO excels on meeting the measures. For 2018, one DHMO paid a penalty less than 0.04 percent of capitation. For 2019, the other DHMO paid a penalty less than 0.1 percent of capitation. In both cases, the other DHMO did not perform well enough to receive a bonus. For 2020, HHSC received a waiver to suspend the Dental P4Q Program due to the COVID-19 pandemic. As a result, we do not believe the P4Q program has a material impact on the premium rate development.

Attachment 6 provides more details on the Dental P4Q Program.

COVID-19

In addition to the PHE-related cost adjustment discussed above, the most significant impact that COVID-19 and the PHE had on the FY2022 rate development was the significant reduction in claims during FY2020. As a result, the base period was altered such that all data beyond February 2020 was deemed to have no credibility and was excluded from the base period and all trend and adjustment factor calculations. The duration of the cost reduction and expectations for FY2022 vary significantly by program. For the Dental programs, the most significant reductions occurred during the period March 2020 through August 2020. The Medicaid dental program has experienced both increased enrollment and reduced average claims cost. This has continued into FY2021 with little sign of abatement. During the first half of FY2021, the average cost per member per month and average trends by quarter continue to be lower than the normal levels and it is expected that the impact of the pandemic and the PHE on the Medicaid dental program will continue into FY2022.

In addition to adjusting the base period used in the FY2022 rate development, we have also applied a PHE-related cost adjustment as discussed in Attachment 4 Exhibit B. In order to mitigate the risk to both HHSC and the DHMOs resulting from COVID-19, the following actions will be implemented for FY2022:

- HHSC and its actuaries will collect additional information from the participating DHMOs during the summer and fall of 2021 to determine if a retroactive adjustment is necessary to properly account for COVID-19 related impacts to program expenditures.

- HHSC made revisions to the experience rebate tiers effective FY2021. The revised structure will limit the opportunity for excessive profitability should the reduction in cost associated with the PHE extend longer than anticipated. The experience rebate tiers vary by DHMO with a max profit not to exceed 4.5% of premiums.

IV. 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 three 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.

One of the DHMOs outsourced a significant portion of their administrative function to a related party. We capped the portion of the administrative expense that is outsourced to a related party to $0.75 pmpm. The table below summarizes the reported per capita administrative expense for the past three fiscal years for the dental programs.

	Average
FY19	1.80
FY20	1.81
FY21 (thru Feb 21)	1.86

The administrative expense included in the capitation rates of $1.75 pmpm is line with the historical averages.

The premium rates also include an amount for premium tax (1.75% of premium), maintenance tax ($0.024 pmpm) and a risk margin (1.50% of premium).

The capitation rates included in this document do not include provision for the Affordable Care Act (ACA) Health Insurance Providers Fee, which is no longer applicable.

V. Summary

The chart below presents the resulting statewide FY2022 Medicaid and CHIP Dental Plan premium rates pmpm. Attachment 1 presents the derivation of the premium rates.

Program	Age <1	Age 1-5	Age 6-14	Age 15-18	Age 19-20
CHIP Dental	3.46	17.32	24.37	23.75	n/a
Medicaid Dental	12.46	31.15	33.06	33.62	23.03

Attachment 1 presents a description of the calculation of the FY2022 Medicaid and CHIP Dental Plan premium rates.

Attachment 7 presents the required rating index summarizing the applicable sections from the 2021-2022 Medicaid Managed Care Rate Development Guide.

VI. Actuarial Certification of FY2022 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, 2021 through August 31, 2022 (FY2022) 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;

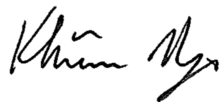
(b) The premium rates are appropriate for the populations and services covered under the managed care contract; and

(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 costs 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.



Khiem D. Ngo, F.S.A., M.A.A.A.

VII. Attachments

Attachment 1 - Summary of FY2022 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 - Dental Pay-for-Quality (P4Q) Program

Attachment 7 - Index for 2021-2022 Medicaid Managed Care Rate Development Guide

Attachment 1

Summary of FY2022 Medicaid and CHIP Dental Rating Analysis

Attachment 1 presents summary information regarding the FY2022 Medicaid and CHIP Dental Plan rate development. Exhibit A presents rate development for Medicaid Dental and Exhibit B presents rate development for CHIP Dental. The top of the exhibit shows summary base period enrollment, premium and claims experience. We projected the FY2022 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 III of this report.

The rating methodology includes an explicit provision for administrative expenses. The amount allocated for administrative expenses is $1.75 pmpm. Provisions are also included for risk margin (1.50% of gross premium), premium tax (1.75%) and maintenance tax ($.024 pmpm).

The bottom of the exhibit presents the projected FY2022 cost based on the above assumptions.

The primary cost driver behind the rate reduction is the continued impact of the PHE on enrollment and average cost. The PHE has resulted in significant enrollment growth and large reductions in the average cost of dental services. While it is expected that the impact of COVID-19 and the PHE will eventually fade, such a return to normal, it is not expected before December 31, 2021.

	<1		1-5		6-14		15-18		19-20		Total	
	Amount	pmpm	Amount	pmpm	Amount	pmpm	Amount	pmpm	Amount	pmpm	Amount	pmpm
Experience Period 3/19-2/20												
Member Months	2,070,851		9,748,943		15,842,110		5,384,919		469,096		33,515,919	
Incurred Claims												
Non Ortho - Diagnostic	21,464,772	10.37	121,022,739	12.41	133,263,109	8.41	40,571,347	7.53	1,953,968	4.17	318,275,934	9.50
Non Ortho - Preventive	71,700	0.03	41,786,558	4.29	139,746,208	8.82	35,180,072	6.53	1,480,051	3.16	218,264,589	6.51
Non Ortho - Restorative	7,498	0.00	91,755,473	9.41	171,869,337	10.85	58,485,159	10.86	3,882,949	8.28	326,000,417	9.73
Non Ortho - Other	44,079	0.02	24,933,678	2.56	37,691,479	2.38	32,326,731	6.00	2,241,227	4.78	97,237,193	2.90
Orthodontic	0	0.00	11,690	0.00	758,706	0.05	464,102	0.09	55,208	0.12	1,289,707	0.04
Other Dental Expense/Capitation	162,249	0.08	1,442,878	0.15	2,533,347	0.16	1,130,415	0.21	157,676	0.34	5,426,564	0.16
Total	21,750,298	10.50	280,953,016	28.82	485,862,186	30.67	168,157,826	31.23	9,771,079	20.83	966,494,405	28.84
Projected FY2022 Member Months	1,521,781		10,002,488		16,140,038		5,743,931		503,649		33,911,887	
Projected FY2022 Premium												
@ Current Rates	19,113,569	12.56	315,078,386	31.50	541,498,261	33.55	195,695,715	34.07	11,775,311	23.38	1,083,161,243	31.94
Annual Cost Trend Assumptions	0.30 %		0.30 %		0.30 %		0.30 %		0.30 %			
Adjustment Factors												
FQHC Wrap Adjustment	0.9879		0.9939		0.9946		0.9945		0.9939			
PHE/COVID Adjustment	0.9828		0.9828		0.9828		0.9828		0.9828			
Projected FY2022 Incurred Claims												
Non Orthodontia	15,518,575	10.20	282,224,727	28.22	484,214,899	30.00	174,959,584	30.46	10,099,249	20.05	967,017,034	28.52
Orthodontia	0	0.00	11,804	0.00	761,292	0.05	487,497	0.08	58,333	0.12	1,318,927	0.04
Other Dental Expense/Capitation	120,126	0.08	1,491,532	0.15	2,600,390	0.16	1,214,843	0.21	170,563	0.34	5,597,454	0.17
Total	15,638,701	10.28	283,728,063	28.37	487,576,581	30.21	176,661,924	30.76	10,328,144	20.51	973,933,414	28.72
Administrative Fee	2,663,117	1.75	17,504,355	1.75	28,245,066	1.75	10,051,879	1.75	881,386	1.75	59,345,801	1.75
Risk Margin	284,319	1.50%	4,674,018	1.50%	8,003,282	1.50%	2,896,940	1.50%	173,980	1.50%	16,032,539	1.50%
Premium Tax	331,706	1.75%	5,453,021	1.75%	9,337,162	1.75%	3,379,763	1.75%	202,977	1.75%	18,704,629	1.75%
Maintenance Tax	36,776	0.024	241,727	0.024	390,051	0.024	138,812	0.024	12,172	0.024	819,537	0.024
Projected Total Cost	18,954,619	12.46	311,601,183	31.15	533,552,143	33.06	193,129,317	33.62	11,598,658	23.03	1,068,835,920	31.52
Rate Change %		-0.8%		-1.1%		-1.5%		-1.3%		-1.5%		-1.3%

CHIP Dental
Rating Period: FY2022 (9/1/2021 - 8/31/2022)
Statewide

	<1		1-5		6-14		15-18		19-20		Total	
	Amount	pmpm	Amount	pmpm	Amount	pmpm	Amount	pmpm	Amount	pmpm	Amount	pmpm
Experience Period 3/19-2/20												
Member Months	2,795		1,053,306		2,460,249		846,181				4,362,531	
Incurred Claims												
Non Ortho - Diagnostic	1,772	0.63	5,971,769	5.67	19,586,792	7.96	6,061,391	7.16			31,621,724	7.25
Non Ortho - Preventive	1,933	0.69	4,946,262	4.70	17,882,318	7.27	5,162,051	6.10			27,992,565	6.42
Non Ortho - Restorative	661	0.24	4,205,271	3.99	14,265,082	5.80	4,558,407	5.39			23,029,421	5.28
Non Ortho - Other	0	0.00	663,430	0.63	1,672,454	0.68	2,073,871	2.45			4,409,755	1.01
Orthodontic	0	0.00	0	0.00	26,522	0.01	25,299	0.03			51,821	0.01
Other Dental Expense/Capitation	-2	0.00	-3,928	0.00	-8,584	0.00	-2,926	0.00			-15,441	0.00
Total	4,365	1.56	15,782,804	14.98	53,424,584	21.72	17,878,092	21.13			87,089,845	19.96
Projected FY2022 Member Months	2,472		628,044		1,819,068		668,004				3,117,588	
Projected FY2022 Premium												
@ Current Rates	8,306	3.36	10,921,685	17.39	44,494,403	24.46	15,985,336	23.93			71,409,730	22.91
Annual Cost Trend Assumptions	0.40 %		0.40 %		0.40 %		0.40 %					
Adjustment Factors												
FQHC Wrap Adjustment	1.0000		0.9897		0.9941		0.9938					
PHE/COVID Adjustment	1.0000		1.0000		1.0000		1.0000					
Projected FY2022 Incurred Claims												
Non Orthodontia	3,901	1.58	9,409,891	14.98	39,650,070	21.80	14,148,631	21.18			63,212,492	20.28
Orthodontia	0	0.00	0	0.00	19,690	0.01	20,047	0.03			39,737	0.01
Other Dental Expense/Capitation	-2	0.00	-2,365	0.00	-6,411	0.00	-2,333	0.00			-11,111	0.00
Total	3,899	1.58	9,407,525	14.98	39,663,349	21.80	14,166,344	21.21			63,241,118	20.29
Administrative Fee	4,326	1.75	1,099,077	1.75	3,183,369	1.75	1,169,007	1.75			5,455,779	1.75
Risk Margin	128	1.50%	163,128	1.50%	664,972	1.50%	238,008	1.50%			1,066,236	1.50%
Premium Tax	150	1.75%	190,316	1.75%	775,800	1.75%	277,676	1.75%			1,243,942	1.75%
Maintenance Tax	60	0.024	15,178	0.024	43,961	0.024	16,143	0.024			75,342	0.024
Projected Total Cost	8,563	3.46	10,875,225	17.32	44,331,451	24.37	15,867,178	23.75			71,082,417	22.80
Rate Change %		3.1%		-0.4%		-0.4%		-0.7%				-0.5%

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 2021 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-17	2,937,144	82,152,094	1.000	82,152,094	27.97	
Oct-17	2,943,694	91,803,740	1.000	91,803,740	31.19	
Nov-17	2,974,571	86,488,420	1.000	86,488,420	29.08	
Dec-17	2,976,990	77,916,948	1.000	77,916,948	26.17	
Jan-18	2,944,452	92,133,434	1.000	92,133,434	31.29	
Feb-18	2,931,308	85,016,213	1.000	85,016,213	29.00	
Mar-18	2,918,340	97,301,045	1.000	97,301,045	33.34	
Apr-18	2,902,092	87,010,853	1.000	87,010,853	29.98	
May-18	2,901,837	85,147,321	1.000	85,147,321	29.34	
Jun-18	2,892,540	89,622,446	1.000	89,622,446	30.98	
Jul-18	2,879,944	92,957,200	1.000	92,957,200	32.28	
Aug-18	2,877,622	102,667,918	1.000	102,667,918	35.68	
Sep-18	2,870,548	77,402,827	1.000	77,402,827	26.96	0.964
Oct-18	2,866,016	92,044,957	1.000	92,044,957	32.12	1.030
Nov-18	2,877,675	81,870,200	1.000	81,870,200	28.45	0.978
Dec-18	2,877,012	71,040,711	1.000	71,040,711	24.69	0.943
Jan-19	2,855,064	92,687,550	1.000	92,687,550	32.46	1.038
Feb-19	2,846,418	78,914,768	1.000	78,914,768	27.72	0.956
Mar-19	2,838,049	85,680,201	1.000	85,680,201	30.19	0.905
Apr-19	2,799,601	81,950,990	1.000	81,950,990	29.27	0.976
May-19	2,791,351	76,076,052	1.000	76,076,052	27.25	0.929
Jun-19	2,783,060	78,560,516	1.000	78,560,516	28.23	0.911
Jul-19	2,773,062	88,651,328	1.000	88,651,328	31.97	0.990
Aug-19	2,793,401	92,459,968	1.000	92,459,968	33.10	0.928
Sep-19	2,794,602	73,912,112	1.000	73,912,112	26.45	0.981
Oct-19	2,797,306	85,531,085	1.000	85,531,085	30.58	0.952
Nov-19	2,798,808	72,810,570	1.000	72,810,570	26.01	0.914
Dec-19	2,795,978	67,426,364	1.000	67,426,364	24.12	0.977
Jan-20	2,784,482	83,035,029	1.000	83,035,481	29.82	0.919
Feb-20	2,766,219	74,972,611	1.000	74,973,173	27.10	0.978
Mar-20	2,773,188	47,913,685	1.000	47,914,463	17.28	0.572
Apr-20	2,871,819	2,640,094	1.000	2,640,222	0.92	0.031
May-20	2,960,648	45,215,495	1.000	45,220,580	15.27	0.560
Jun-20	3,038,435	75,416,611	1.000	75,431,975	24.83	0.879
Jul-20	3,115,178	76,341,114	1.000	76,370,118	24.52	0.767
Aug-20	3,164,766	82,587,709	0.999	82,638,352	26.11	0.789
Sep-20	3,219,687	83,146,622	0.998	83,278,987	25.87	0.978
Oct-20	3,269,715	79,075,983	0.997	79,308,959	24.26	0.793
Nov-20	3,312,836	69,638,523	0.991	70,257,973	21.21	0.815
Dec-20	3,373,268	77,484,282	0.974	79,563,033	23.59	0.978
CY2018	34,739,386			1,054,215,125	30.35	
CY2019	33,666,700			974,661,504	28.95	0.954
CY2020	36,650,240			800,633,315	21.85	0.755
3/18-2/19	34,565,108			1,048,667,795	30.34	
3/19-2/20	33,515,919			961,067,840	28.67	0.945

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-17	405,597	7,224,440	1.000	7,224,440	17.81	
Oct-17	413,939	8,303,804	1.000	8,303,804	20.06	
Nov-17	418,820	8,103,973	1.000	8,103,973	19.35	
Dec-17	422,491	7,839,961	1.000	7,839,961	18.56	
Jan-18	420,271	8,663,910	1.000	8,663,910	20.62	
Feb-18	419,897	7,997,180	1.000	7,997,180	19.05	
Mar-18	420,456	9,936,929	1.000	9,936,929	23.63	
Apr-18	412,845	8,038,318	1.000	8,038,318	19.47	
May-18	408,583	7,594,586	1.000	7,594,586	18.59	
Jun-18	397,745	8,843,142	1.000	8,843,142	22.23	
Jul-18	393,224	9,139,410	1.000	9,139,410	23.24	
Aug-18	392,267	9,536,844	1.000	9,536,844	24.31	
Sep-18	390,474	6,841,173	1.000	6,841,173	17.52	0.984
Oct-18	384,593	7,867,162	1.000	7,867,162	20.46	1.020
Nov-18	384,186	7,395,479	1.000	7,395,479	19.25	0.995
Dec-18	384,856	6,688,061	1.000	6,688,061	17.38	0.936
Jan-19	382,627	8,380,439	1.000	8,380,439	21.90	1.062
Feb-19	380,338	7,122,251	1.000	7,122,251	18.73	0.983
Mar-19	377,490	8,568,129	1.000	8,568,129	22.70	0.960
Apr-19	375,330	7,536,276	1.000	7,536,276	20.08	1.031
May-19	374,381	6,821,016	1.000	6,821,016	18.22	0.980
Jun-19	369,289	7,683,983	1.000	7,683,983	20.81	0.936
Jul-19	364,475	8,414,608	1.000	8,414,608	23.09	0.993
Aug-19	362,584	8,399,034	1.000	8,399,034	23.16	0.953
Sep-19	361,818	6,185,641	1.000	6,185,641	17.10	0.976
Oct-19	360,475	7,199,818	1.000	7,199,818	19.97	0.976
Nov-19	358,542	6,570,092	1.000	6,570,092	18.32	0.952
Dec-19	355,351	5,970,663	1.000	5,970,663	16.80	0.967
Jan-20	352,888	7,130,076	1.000	7,130,039	20.20	0.922
Feb-20	349,908	6,625,880	1.000	6,625,986	18.94	1.011
Mar-20	342,617	4,580,382	1.000	4,580,579	13.37	0.589
Apr-20	331,147	203,982	1.000	204,021	0.62	0.031
May-20	325,245	3,708,462	1.000	3,709,124	11.40	0.626
Jun-20	320,985	6,177,223	1.000	6,179,348	19.25	0.925
Jul-20	317,594	6,093,396	1.000	6,096,125	19.19	0.831
Aug-20	314,297	6,188,301	1.000	6,190,901	19.70	0.850
Sep-20	307,576	5,595,370	0.998	5,609,210	18.24	1.067
Oct-20	299,191	5,146,335	0.996	5,167,339	17.27	0.865
Nov-20	294,159	4,416,677	0.990	4,462,024	15.17	0.828
Dec-20	266,413	4,606,100	0.975	4,723,467	17.73	1.055
CY2018	4,809,397			98,542,195	20.49	
CY2019	4,422,700			88,851,950	20.09	0.981
CY2020	3,822,020			60,678,163	15.88	0.790
3/18-2/19	4,732,194			97,383,795	20.58	
3/19-2/20	4,362,531			87,105,285	19.97	0.970

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 2021. 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. 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 0.30% for Medicaid Dental and 0.40% 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 FY2022 Rating
Statewide Non-Orthodontia Service Experience
Trend Analysis

	<1	1-5	6-14	15-18	19-20	Total
Member Months						
3/15-2/16	2,277,350	10,398,101	16,728,622	5,156,039	495,523	35,055,635
3/16-2/17	2,290,759	10,437,086	16,857,955	5,303,304	492,736	35,381,840
3/17-2/18	2,224,521	10,438,182	16,766,594	5,442,657	494,617	35,366,571
3/18-2/19	2,137,065	10,148,413	16,348,969	5,446,298	484,363	34,565,108
3/19-2/20	2,070,851	9,748,943	15,842,110	5,384,919	469,096	33,515,919
Paid Amount - Adjusted for Reminbursement and Policy Changes (1)						
3/15-2/16	21,274,200	306,092,146	524,425,792	156,621,023	10,815,873	1,019,229,035
3/16-2/17	22,874,568	297,500,307	521,249,416	161,070,624	10,708,356	1,013,403,271
3/17-2/18	22,963,859	291,937,627	515,262,048	167,052,457	10,632,448	1,007,848,439
3/18-2/19	22,353,462	288,867,213	500,848,617	169,111,861	10,161,434	991,342,586
3/19-2/20	21,848,835	280,771,327	485,663,083	167,789,897	9,729,263	965,802,405
PMPM						
3/15-2/16	9.34	29.44	31.35	30.38	21.83	29.07
3/16-2/17	9.99	28.50	30.92	30.37	21.73	28.64
3/17-2/18	10.32	27.97	30.73	30.69	21.50	28.50
3/18-2/19	10.46	28.46	30.63	31.05	20.98	28.68
3/19-2/20	10.55	28.80	30.66	31.16	20.74	28.82
Statewide Trend						
3/15-2/16						
3/16-2/17						-1.5%
3/17-2/18						-0.5%
3/18-2/19						0.6%
3/19-2/20						0.5%
Selected - Wt. Avg (2)						**0.30%**

(1) Notes
Reimbursement Fee Schedule change effective 9/1/2018
Restorative PA Change effective 2/1/2019 for Dentaquest and 3/9/2019 for MCNA Dentaquest
Capitation arrangement effective 9/1/2018
(2) Weighted average trends using 20%, 30% and 50% for the past three years, respectively.

CHIP Dental FY2022 Rating
Statewide Experience
Trend Analysis

	<1	1-5	6-14	15-18	Total
Member Months					
3/15-2/16	2,083	932,834	2,348,271	829,133	4,112,321
3/16-2/17	2,075	1,033,206	2,575,943	908,831	4,520,055
3/17-2/18	2,593	1,146,640	2,754,641	982,979	4,886,853
3/18-2/19	2,576	1,129,506	2,653,374	946,738	4,732,194
3/19-2/20	2,795	1,053,306	2,460,249	846,181	4,362,531
Paid Amount - Adjusted for Reminbursement and Policy Changes (1)					
3/15-2/16	2,508	13,588,748	50,664,359	16,271,482	80,527,096
3/16-2/17	2,116	14,994,404	55,865,737	18,375,760	89,238,016
3/17-2/18	2,541	16,566,933	59,763,965	20,143,253	96,476,693
3/18-2/19	3,050	16,746,712	57,361,654	20,029,494	94,140,910
3/19-2/20	4,381	15,782,485	53,419,132	17,867,074	87,073,072
PMPM					
3/15-2/16	1.20	14.57	21.58	19.62	19.58
3/16-2/17	1.02	14.51	21.69	20.22	19.74
3/17-2/18	0.98	14.45	21.70	20.49	19.74
3/18-2/19	1.18	14.83	21.62	21.16	19.89
3/19-2/20	1.57	14.98	21.71	21.11	19.96
Statewide Trend					
3/15-2/16					
3/16-2/17					0.8%
3/17-2/18					0.0%
3/18-2/19					0.8%
3/19-2/20					0.3%
Selected - Wt. Avg (2)					**0.40%**

(1) Notes
Reimbursement Fee Schedule change effective 9/1/2018
Restorative PA Change effective 2/1/2019 for Dentaquest and 3/9/2019 for MCNA

(2) Weighted average trends using 20%, 30% and 50% for the past three years, respectively.

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 rating adjustment was calculated by collecting the FQHC wrap payments paid by the DHMOs during the base period. Exhibit A provides details regarding the calculation of the FQHC wrap payment adjustment factor for the Medicaid and CHIP dental program.

FY2022 Dental Rating — Attachment 4

FQHC Wrap Payment Rate Adjustment

Experience Period - March 1, 2019 through February 28, 2020

	<1	1-5	6-14	15-18	19-20	Total
FQHC Wrap Reimbursement						
Medicaid	(261,548)	(1,700,619)	(2,586,021)	(914,396)	(58,776)	(5,521,360)
CHIP	-	(161,877)	(313,410)	(111,267)		(586,553)
Incurred Claims						
Medicaid	21,634,552	279,310,078	483,042,563	166,678,631	9,588,124	960,253,948
CHIP	4,381	15,782,485	53,419,132	17,867,074		87,073,072
Rating Adjustment Factor						
Medicaid	0.9879	0.9939	0.9946	0.9945	0.9939	
CHIP	1.0000	0.9897	0.9941	0.9938		

Attachment 5

PHE Related Cost Adjustment

COVID-19 and the resulting Public Health Emergency (PHE) has had a significant impact on the Dental programs. Medicaid enrollment has grown by over 25% while the average cost for all services declined at unprecedented levels. The enrollment growth is directly connected to the declaration of the PHE while the cost reductions are due to many factors including but not limited to; mandatory shutdowns, mask mandates, social distancing and countless other environmental factors.

In order to estimate the ongoing impact of the PHE on FY2022 average costs, we have studied the quarterly dental trends. Through this analysis it is evident that the largest reductions occurred in the period immediately following the PHE declaration (March 2020-May 2020) but that the reductions have continued into the summer of 2020 and the first half of FY2021. Unlike some of the other Medicaid managed care programs in Texas, the average cost for the Medicaid dental program does not appear to be returning to normal levels. This leads us to believe that the impact on program costs will continue as long as the PHE is in effect.

The PHE-related cost adjustment was calculated by comparing the actual trends during the 1st quarter of FY2021 to the assumed historical trend levels. The difference in these two trends was assumed to be the PHE-related cost impact. We then assumed the PHE and the associated cost impact will continue until December 31, 2021. In order to recognize the potential for pent-up demand and changes in environmental factors such as elimination of mask mandates, children returning to school and reduction in social distancing we have applied a credibility factor of 37.5% to the calculated PHE-related cost adjustment. The attached exhibit presents a summary of the observed trends during the 1st quarter of FY2021, the historical average trend assumptions, the estimated PHE impact and the associated adjustment factors.

Please note the PHE-related adjustment was only applied to the Medicaid dental program where there was a significant increase in enrollment.

FY2022 Dental Rating
Medicaid Dental
PHE Related Cost Adjustment
Statewide Experience

Attachment 5

	All Risk Groups
9/2020-11/2020 Trend - Actual (1)	-13.53%
9/2020-11/2020 Trend - Assumed (2)	0.31%
Estimated PHE Impact (3)	-13.80%
PHE Adjustment % (4)	-4.60%
Credibility Factor (5)	0.375
Adj. PHE Adjustment % (6)	-1.72%
Adj. PHE Adjustment Factor (7)	0.9828

Footnotes:
(1) Observed trend through Q1 of FY2021 adjusted for reimbursement differences.
(2) Assumed trend from FY2021 rate development.
(3) Actual trend divided by Assumed trend = [1+(1)]/[1+ (2)]-1
(4) Assume PHE continues to 12/31/2021 = Estimated PHE Impact * 4/12
(5) Selected by Actuary.
(6) = (4) * (5)
(7) = 1+ (6)

Attachment 6

Pay for Quality Program

The Pay-for-Quality (P4Q) Program creates incentives and disincentives for DHMOs based on their performance on certain quality measures. Dental plans that excel on meeting the measures are eligible for a bonus while health plans that don't meet their measures are subject to a penalty. HHSC received a waiver to suspend the Dental P4Q Program due to the COVID-19 pandemic for the CY2020 measurement period.

Dental P4Q Measures

The dental P4Q measures beginning in calendar year 2019 includes the following:

P4Q Measure	Description	Medicaid Age	CHIP Age
DQA Oral Evaluation	Percentage of enrolled children: •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: •at "elevated" risk for cavities (i.e. "moderate" or "high") and •received at least 2 topical fluoride applications within the reporting year	1-20 years	1-18 years
DQA Dental Sealant	Percentage of enrolled children: •at "elevated" risk for cavities (i.e. "moderate" or "high") and •received a sealant on a permanent tooth within the reporting year	6-9 years (1st perm. molar); 10-14 years (2nd perm. molar)	

In an attempt to further encourage improvement, HHSC introduced bonus pool measures including the following beginning in calendar year 2021:

Measure	Description	Medicaid Age	CHIP Age
DQA 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 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 DHMO's capitation is at-risk. If a DHMO'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. For example, for measurement year 2018 the reference year is calendar year 2016.

If a DHMO's performance is maintained or improves on all measures, the DHMO's capitation will not be at risk for recoupment. If one DHMO's performance decreases such that its capitation is subject to recoupment, the funds recouped will be available as an additional distribution payment to other DHMOs. A DHMO 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 2021, funds remaining after these recoupments and distributions will be made available to DHMOs that perform above set thresholds on the bonus pool measures.

The DHMOs 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 DHMO is penalized and the other DHMO excel on meeting the measures. For 2018, one DHMO paid a penalty less than 0.04 percent of capitation. For 2019, the other DHMO paid a penalty less than 0.1 percent of capitation. In both cases, the other DHMO did not perform well enough to receive a bonus. For 2020, HHSC received a waiver to suspend the Dental P4Q Program due to the COVID-19 pandemic. As a result, we do not believe the P4Q program has a material impact on the premium rate development.

Attachment 7

FY2022 Medicaid Rate Certification Index

The index below includes the pages of this report that correspond to the applicable sections of the 2021-2022 Medicaid Managed Care Rate Development Guide, dated June 2021.

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, 2021 through August 31, 2022 (FY2022).

iii. (a) The certification letter is on page 9 of the report.

(b) The final capitation rates are shown on page 8 of the report.

(c) (i) See pages 1 through 3 of the report.

(ii) See page 1 of the report.

(iii) See page 4 of the report.

(iv) Not applicable. There have been no changes since the prior certification.

(v) See Attachment 6 page 24 through 25 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 5, 6, 22 and 23 for discussion on how COVID-19 and the PHE have been accounted for in the FY2022 rate development.

xiii. Acknowledged.

B. Appropriate Documentation

i. The actuary is certifying capitation rates. See page 9 of the report.

ii. Acknowledged.

iii. Acknowledged.

iv. Not applicable.

v. Acknowledged.

vi. Acknowledged. See page 9 of the report.

vii. Not applicable.

viii. a) See Attachment 1 pages 11 through 13 of the report.

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

c) FY2021 rates were not adjusted by a *de minimis* amount using the authority in 42 C.F.R 438.7(c)(3).

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

x. (a) Texas Medicaid Managed Care data has been studied for all programs, risk groups and service delivery areas through December 2020 to study the impact of COVID and the PHE.

(b) See pages 5, 6, 22 and 23 of the report.

(c) See pages 5, 6, 22 and 23 of the report. Unlike the prior rating period we are making a prospective adjustment to the FY2022 capitation rates. In addition, the experience rebate provisions have been tightened to limit the possibility of excessive profits in FY2022.

2. Data

A. Rate Development Standards

i. (a) Acknowledged.

(b) Acknowledged.

(c) Acknowledged.

(d) Not applicable.

B. Appropriate Documentation

i. (a) See pages 1 through 3 of the report.

ii. (a) See pages 1 through 3 of the report.

(b) See pages 1 through 3 of the report.

(c) See pages 1 through 3 of the report.

(d) Not applicable.

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

(b) See page 4 the report.

(c) No errors found in the data.

(d) See page 5 through 6 of the report.

(e) See page 1 of the report. In addition, value added services and non-capitated services have been excluded from the analysis.

3. Projected Benefit Costs and Trends

A. Rate Development Standards

i. Acknowledged.

ii. Acknowledged.

iii. Acknowledged.

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

B. Appropriate Documentation

i. See page 8 and Attachment 1 pages 11 through 13 of the report.

ii. (a) See Attachment 1 pages 11 through 13 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 pages 17 through 19 of the report.

(b) See pages 17 through 19 of the report.

(c) See pages 17 through 19 of the report.

(d) See pages 17 through 19 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 FY2022 premium rate.

(c) All enrollment data during retroactive enrollment periods are included in the base period data used to develop the FY2022 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 20 through 21 of the report.

viii. See pages 20 through 21 of the report.

4. Special Contract Provisions Related to Payment

A. Incentive Arrangements

i. Rate Development Standards

Acknowledged.

ii. Appropriate Documentation

(a) See Attachment 6 page 24 through 25 of the report.

B. Withhold Arrangements

i. Rate Development Standards

Acknowledged.

ii. Appropriate Documentation

(a) See Attachment 6 page 24 through 25 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 provisions vary by DHMO with a max profit not to exceed 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 7 of the report.

ii. See page 7 of the report.

iii. See page 7 of the report.

6. Risk Adjustment and Acuity Adjustments

A. Rate Development Standards

Acknowledged.

B. Appropriate Documentation

Not applicable.

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

Not applicable.

Section III. New Adult Group Capitation Rates

Not applicable.