STATE OF TEXAS
MEDICAID AND CHIP
MANAGED CARE
DENTAL RATE SETTING
FY2023

Prepared for:
Texas Health and Human Services Commission
Texas Dental HHS0002879A-8

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TABLE OF CONTENTS

I. Introduction 1

II. Overview of Rate Setting Methodology 4

III. Adjustment Factors 6

IV. Administrative Fees, Taxes and Risk Margin 9

V. Summary 10

VI. Actuarial Certification 11

VII. Attachments 12

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, 2022 through August 31, 2023 (FY2023) 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 FY2023 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 35 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 2023. These projections were prepared by HHS Forecasting staff.

- Financial Statistical Reports (FSR) for each participating dental plan for the period March 2012 through February 2022. The FSR contains detailed information regarding monthly

enrollment, revenue, incurred claims and administrative expenses, as reported by the dental 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 2018 through February 2022. 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 HHSC and the DHMOs regarding prior authorization changes to repetitive restorative dental service.

- Information provided by HHSC regarding the default enrollment process.

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 FY2023 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 FY2023 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. Due to the significant impact of the COVID-19 pandemic 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 2022 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 FY2023 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

The statewide community rates are developed by a weighted average of the projected FY2023 cost for each dental plan. The weights used in this formula are the projected FY2023 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 FY2023 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.

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 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 2022, the PHE has had a significant impact on average Medicaid and CHIP dental expenditures. Enrollment has increased by over 40% for Medicaid Dental and decreased by over 60% for CHIP Dental and average cost per member for all services has decreased from the pre-pandemic historical norms. During the early stages of the PHE, it was expected that these reductions were short-term and tied to the initial shock of the pandemic and the associated shutdowns; however, the reduction has continued into FY2021 and the first quarter of FY2022. While a return to the pre-pandemic norms is expected, we believe the return will be gradual and won’t occur until termination of the PHE. A rating adjustment was calculated in order to estimate the continued impact of the PHE on average program cost in FY2023. 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.

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 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 excels on meeting the measures. For CY2018, one DHMO paid a penalty less than 0.04 percent of capitation. For CY2019, 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 CY2020 and CY2021, HHSC received a waiver to suspend the Dental P4Q Program due to the PHE. As a result, we believe the P4Q program does not have a material impact on the premium rate development.

Attachment 7 provides 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 resulting PHE had on the FY2023 rate development was the significant reduction in average claims cost during FY2020 and FY2021. 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 impact of the cost reduction and expectations for FY2023 vary significantly by program. For the Dental programs, the most significant reductions occurred during the period March 2020 through August 2020; however, these reductions have continued into FY2021 and FY2022 and are now expected to continue until the termination of the PHE. During the last half of FY2021 and the first quarter of FY2022 the average cost per member per month and average trends by quarter continue to be lower than the historical "normal" levels and it is expected that the impact of the pandemic and the PHE on the Medicaid and CHIP Dental programs will continue into FY2023.

In addition to adjusting the base period used in the FY2023 rate development, we have also applied

a PHE-related cost adjustment as discussed in Attachment 5. In order to mitigate the risk to both HHSC and the DHMOs resulting from COVID-19, the following actions will be implemented for FY2023:

- HHSC made revisions to the experience rebate tiers effective September 1, 2020. 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 ranging from 3.6% to 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 resulting in an administrative expense rate that is more than double that for the other DHMO. In reviewing the administrative expense experience, the administrative cost per member for the DHMO outsourcing to a related party was assumed to be the same as that for the other DHMO. The table below summarizes the reported per capita administrative expense for the past three fiscal years for the dental programs.

	Average
FY19	1.71
FY20	1.79
FY21	1.83

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).

V. Summary

The chart below presents the resulting statewide FY2023 Medicaid and CHIP Dental Plan premium rates pmpm.

	<1	1-5	6-14	15-18	19-20
Medicaid Dental					
Dentaquest	12.88	31.21	32.81	33.19	23.87
MCNA	12.88	31.21	32.81	33.19	23.87
United	10.95	27.57	32.98	32.86	21.00
CHIP Dental					
Dentaquest	3.37	18.07	24.69	23.65	n/a
MCNA	3.37	18.07	24.69	23.65	n/a
United	5.43	16.10	23.77	22.82	n/a

Attachment 1 presents a description of the calculation of the FY2023 Medicaid and CHIP Dental Plan premium rates.

Attachment 8 presents the required rating index summarizing the applicable sections from the 2022-2023 Medicaid Managed Care Rate Development Guide.

VI. Actuarial Certification of FY2023 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, 2022 through August 31, 2023 (FY2023) 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;

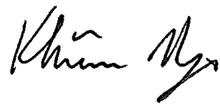
(b) The premium rates are appropriate for the populations and services covered under the managed care contract; and

(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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VII. Attachments

Attachment 1 – Summary of FY2023 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 2022-2023 Medicaid Managed Care Rate Development Guide

Attachment 1

Summary of FY2023 Medicaid and CHIP Dental Rating Analysis

Attachment 1 presents summary information regarding the FY2023 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 FY2023 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 FY2023 cost based on the above assumptions.

The FY2023 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 presents 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 primary cost driver behind the rate reduction is the continued impact of the PHE on enrollment and average cost. The PHE has resulted in large reductions in the average cost of dental services.

	<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												
Diagnostic	21,537,410	10.40	121,139,700	12.43	133,431,867	8.42	40,566,310	7.53	1,963,719	4.19	318,639,006	9.51
Preventive	73,452	0.04	41,789,684	4.29	139,757,979	8.82	35,189,754	6.53	1,489,068	3.17	218,299,936	6.51
Restorative	7,734	0.00	91,766,146	9.41	171,832,026	10.85	58,402,191	10.85	3,920,419	8.36	325,928,516	9.72
Orthodontic	0	0.00	11,751	0.00	764,606	0.05	462,685	0.09	58,912	0.13	1,297,955	0.04
All Others	46,524	0.02	24,949,423	2.56	37,729,157	2.38	32,280,404	5.99	2,254,940	4.81	97,260,447	2.90
Total	21,665,119	10.46	279,656,704	28.69	483,515,635	30.52	166,901,344	30.99	9,687,058	20.65	961,425,860	28.69
Projected FY2023												
Member Months	2,481,632		11,679,028		19,028,079		6,459,268		565,423		40,213,430	
Premium @ Current Rates	30,921,133	12.46	363,801,724	31.15	629,068,304	33.06	217,160,575	33.62	13,021,703	23.03	1,253,973,440	31.18
Annual Cost Trend Assumptions	0.50 %		0.50 %		0.50 %		0.50 %		0.50 %			
Rating Adjustment Factors												
Adjustment #1 - FQHC Wrap Adjustment	0.9857		0.9937		0.9943		0.9943		0.9937			
Adjustment #2 - PHE Adjustment	0.9551		0.9599		0.9643		0.9589		0.9568			
Adjustment #3	1.0000		1.0000		1.0000		1.0000		1.0000			
Projected FY2023 Incurred Claims	24,872,436	10.02	325,194,706	27.84	566,646,006	29.78	194,229,398	30.07	11,296,657	19.98	1,122,239,203	27.91
Other Dental Expense/Capitation	40,207	0.02	1,716,187	0.15	3,756,094	0.20	1,555,468	0.24	572,469	1.01	7,640,426	0.23
Administrative Fee	4,342,856	1.75	20,438,299	1.75	33,299,139	1.75	11,303,718	1.75	989,491	1.75	70,373,503	1.75
Risk Margin	454,503	1.50%	5,389,635	1.50%	9,366,839	1.50%	3,213,096	1.50%	199,570	1.50%	18,623,643	1.50%
Premium Tax	530,254	1.75%	6,287,907	1.75%	10,927,978	1.75%	3,748,612	1.75%	232,832	1.75%	21,727,583	1.75%
Maintenance Tax	59,973	0.02	282,243	0.02	459,845	0.02	156,099	0.02	13,664	0.02	971,825	0.02
Projected Total Cost	30,300,229	12.21	359,308,977	30.77	624,455,902	32.82	214,206,391	33.16	13,304,684	23.53	1,241,576,182	30.87
Rate Change %		-2.0%		-1.2%		-0.7%		-1.4%		2.2%		-1.0%

	<1		1-5		6-14		15-18		Total	
	Amount	pmpm	Amount	pmpm	Amount	pmpm	Amount	pmpm	Amount	pmpm
Experience Period 3/19-2/20										
Member Months	2,800		1,053,300		2,460,245		846,173		4,362,518	
Incurred Claims										
Diagnostic	1,942	0.69	5,985,893	5.68	19,628,231	7.98	6,073,175	7.18	31,689,241	7.26
Preventive	1,915	0.68	4,949,333	4.70	17,899,216	7.28	5,166,939	6.11	28,017,404	6.42
Restorative	570	0.20	4,210,960	4.00	14,282,300	5.81	4,560,795	5.39	23,054,624	5.28
Orthodontic	0	0.00	0	0.00	26,446	0.01	25,981	0.03	52,428	0.01
All Others	0	0.00	662,936	0.63	1,672,128	0.68	2,071,832	2.45	4,406,896	1.01
Total	4,427	1.58	15,809,121	15.01	53,508,321	21.75	17,898,724	21.15	87,220,593	19.99
Projected FY2023										
Member Months	712		264,037		618,288		212,551		1,095,588	
Premium @ Current Rates	2,465	3.46	4,573,117	17.32	15,067,683	24.37	5,048,078	23.75	24,691,342	22.54
Annual Cost Trend Assumptions	1.30 %		1.30 %		1.30 %		1.30 %			
Rating Adjustment Factors										
Adjustment #1 - FQHC Wrap Adjustment	1.0000		0.9894		0.9938		0.9936			
Adjustment #2 - PHE Adjustment	1.0769		0.9868		0.9635		0.9463			
Adjustment #3	1.0000		1.0000		1.0000		1.0000			
Projected FY2023 Incurred Claims	1,269	1.78	4,048,257	15.33	13,471,987	21.79	4,422,759	20.81	21,944,273	20.03
Other Dental Expense/Capitation	15	0.02	41,771	0.16	150,160	0.24	45,778	0.22	237,723	0.05
Administrative Fee	1,247	1.75	462,064	1.75	1,082,004	1.75	371,964	1.75	1,917,279	1.75
Risk Margin	40	1.50%	70,674	1.50%	228,203	1.50%	75,126	1.50%	374,043	1.50%
Premium Tax	46	1.75%	82,453	1.75%	266,237	1.75%	87,647	1.75%	436,383	1.75%
Maintenance Tax	17	0.02	6,381	0.02	14,942	0.02	5,137	0.02	26,477	0.02
Projected Total Cost	2,634	3.70	4,711,600	17.84	15,213,533	24.61	5,008,411	23.56	24,936,177	22.76
Rate Change %		6.8%		3.0%		1.0%		-0.8%		1.0%

FY2023 Dental Rating
Medicaid Dental

	<1	1-5	6-14	15-18	19-20
FY2023 Statewide Community Rates					
Dentaquest	12.21	30.77	32.82	33.16	23.53
MCNA	12.21	30.77	32.82	33.16	23.53
United	12.21	30.77	32.82	33.16	23.53
Default Enrollment Acuity Adjustment					
Dentaquest	1.0546	1.0144	0.9997	1.0007	1.0146
MCNA	1.0546	1.0144	0.9997	1.0007	1.0146
United	0.8964	0.8960	1.0050	0.9909	0.8924
FY2023 Acuity Adjusted Rates					
Dentaquest	12.88	31.21	32.81	33.19	23.87
MCNA	12.88	31.21	32.81	33.19	23.87
United	10.95	27.57	32.98	32.86	21.00

FY2023 Dental Rating
CHIP Dental

	<1	1-5	6-14	15-18
FY2023 Statewide Community Rates				
Dentaquest	3.70	17.84	24.61	23.56
MCNA	3.70	17.84	24.61	23.56
United	3.70	17.84	24.61	23.56
Default Enrollment Acuity Adjustment				
Dentaquest	0.9119	1.0124	1.0036	1.0036
MCNA	0.9119	1.0124	1.0036	1.0036
United	1.4697	0.9025	0.9661	0.9686
FY2023 Acuity Adjusted Rates				
Dentaquest	3.37	18.07	24.69	23.65
MCNA	3.37	18.07	24.69	23.65
United	5.43	16.10	23.77	22.82

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 2022 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-18	2,870,548	77,413,823	1.000	77,413,823	26.97	
Oct-18	2,866,016	92,057,878	1.000	92,057,878	32.12	
Nov-18	2,877,675	81,879,964	1.000	81,879,964	28.45	
Dec-18	2,877,012	71,046,919	1.000	71,046,919	24.69	
Jan-19	2,855,064	92,689,262	1.000	92,689,262	32.46	
Feb-19	2,846,418	78,920,026	1.000	78,920,026	27.73	
Mar-19	2,838,049	85,691,754	1.000	85,691,754	30.19	
Apr-19	2,799,601	81,964,899	1.000	81,964,899	29.28	
May-19	2,791,351	76,084,037	1.000	76,084,037	27.26	
Jun-19	2,783,060	78,579,067	1.000	78,579,067	28.23	
Jul-19	2,773,062	88,666,018	1.000	88,666,018	31.97	
Aug-19	2,793,401	92,473,964	1.000	92,473,964	33.10	
Sep-19	2,794,602	73,919,382	1.000	73,919,382	26.45	0.981
Oct-19	2,797,306	85,543,995	1.000	85,543,995	30.58	0.952
Nov-19	2,798,808	72,822,095	1.000	72,822,095	26.02	0.914
Dec-19	2,795,978	67,533,070	1.000	67,533,070	24.15	0.978
Jan-20	2,784,482	83,099,900	1.000	83,099,900	29.84	0.919
Feb-20	2,766,219	75,047,681	1.000	75,047,681	27.13	0.979
Mar-20	2,773,188	47,938,385	1.000	47,938,385	17.29	0.573
Apr-20	2,871,819	2,641,863	1.000	2,641,863	0.92	0.031
May-20	2,960,648	45,225,824	1.000	45,225,824	15.28	0.560
Jun-20	3,038,497	75,451,534	1.000	75,451,534	24.83	0.879
Jul-20	3,115,343	76,679,990	1.000	76,679,990	24.61	0.770
Aug-20	3,163,737	83,968,088	1.000	83,968,088	26.54	0.802
Sep-20	3,217,425	84,910,802	1.000	84,910,802	26.39	0.998
Oct-20	3,270,214	81,009,335	1.000	81,009,335	24.77	0.810
Nov-20	3,313,831	71,607,416	1.000	71,607,416	21.61	0.830
Dec-20	3,370,408	80,862,109	1.000	80,862,109	23.99	0.993
Jan-21	3,435,761	82,811,047	1.000	82,807,229	24.10	0.808
Feb-21	3,482,963	67,313,416	1.000	67,310,134	19.33	0.712
Mar-21	3,518,032	102,391,592	1.000	102,387,851	29.10	1.684
Apr-21	3,551,374	86,804,291	1.000	86,805,448	24.44	26.570
May-21	3,587,316	76,962,822	1.000	76,975,597	21.46	1.405
Jun-21	3,618,126	91,549,482	1.000	91,577,496	25.31	1.019
Jul-21	3,656,310	92,893,113	0.999	92,945,877	25.42	1.033
Aug-21	3,685,615	93,074,752	0.999	93,183,756	25.28	0.953
Sep-21	3,720,523	86,954,763	0.997	87,178,935	23.43	0.888
Oct-21	3,749,607	90,278,466	0.995	90,693,779	24.19	0.976
Nov-21	3,787,254	84,859,972	0.990	85,694,961	22.63	1.047
Dec-21	3,824,185	82,966,423	0.974	85,183,872	22.28	0.928
CY2019	33,666,700			974,887,566	28.96	
CY2020	36,645,811			808,442,929	22.06	0.762
CY2021	43,617,066			1,042,744,935	23.91	1.084
3/19-2/20	33,515,919			961,425,860	28.69	

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-18	390,474	6,846,819	1.000	6,846,819	17.53	
Oct-18	413,939	7,873,639	1.000	7,873,639	19.02	
Nov-18	418,820	7,401,416	1.000	7,401,416	17.67	
Dec-18	422,491	6,693,410	1.000	6,693,410	15.84	
Jan-19	420,271	8,386,020	1.000	8,386,020	19.95	
Feb-19	419,897	7,127,576	1.000	7,127,576	16.97	
Mar-19	420,456	8,574,930	1.000	8,574,930	20.39	
Apr-19	412,845	7,541,791	1.000	7,541,791	18.27	
May-19	408,583	6,826,410	1.000	6,826,410	16.71	
Jun-19	397,745	7,689,777	1.000	7,689,777	19.33	
Jul-19	393,224	8,421,174	1.000	8,421,174	21.42	
Aug-19	392,267	8,408,060	1.000	8,408,060	21.43	
Sep-19	390,474	6,192,063	1.000	6,192,063	15.86	0.904
Oct-19	384,593	7,207,699	1.000	7,207,699	18.74	0.985
Nov-19	384,186	6,579,809	1.000	6,579,809	17.13	0.969
Dec-19	384,856	5,988,846	1.000	5,988,846	15.56	0.982
Jan-20	382,627	7,152,537	1.000	7,152,537	18.69	0.937
Feb-20	380,338	6,637,497	1.000	6,637,497	17.45	1.028
Mar-20	377,490	4,583,207	1.000	4,583,207	12.14	0.595
Apr-20	375,330	201,374	1.000	201,374	0.54	0.029
May-20	374,381	3,712,018	1.000	3,712,018	9.92	0.593
Jun-20	369,289	6,186,257	1.000	6,186,257	16.75	0.866
Jul-20	364,475	6,104,727	1.000	6,104,727	16.75	0.782
Aug-20	362,584	6,206,312	1.000	6,206,312	17.12	0.799
Sep-20	361,818	5,612,688	1.000	5,612,688	15.51	0.978
Oct-20	360,475	5,173,981	1.000	5,173,981	14.35	0.766
Nov-20	358,542	4,455,423	1.000	4,455,423	12.43	0.726
Dec-20	355,351	4,710,558	1.000	4,710,558	13.26	0.852
Jan-21	352,888	4,281,794	1.000	4,282,340	12.14	0.649
Feb-21	349,908	3,274,136	1.000	3,274,429	9.36	0.536
Mar-21	342,617	4,911,141	1.000	4,911,522	14.34	1.181
Apr-21	331,147	3,744,613	1.000	3,745,013	11.31	21.079
May-21	325,245	3,182,098	1.000	3,182,709	9.79	0.987
Jun-21	320,985	3,995,907	1.000	3,997,188	12.45	0.743
Jul-21	317,594	3,806,441	0.999	3,808,471	11.99	0.716
Aug-21	314,297	3,346,708	0.999	3,350,254	10.66	0.623
Sep-21	307,576	2,834,287	0.998	2,840,117	9.23	0.595
Oct-21	299,191	2,837,223	0.996	2,848,109	9.52	0.663
Nov-21	294,159	2,090,785	0.991	2,108,949	7.17	0.577
Dec-21	266,413	1,888,692	0.974	1,938,611	7.28	0.549
CY2019	4,809,397			88,944,154	18.49	
CY2020	4,422,700			60,736,579	13.73	0.743
CY2021	3,822,020			40,287,711	10.54	0.768
3/19-2/20	4,732,194			87,220,593	18.43	

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 2022. 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 FY2023 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) Remove impact of reimbursement and policy changes from trend analysis.
(2) Adjusted unit cost to normalize difference in service mix.
Assume same service mix distribution same as for period 3/19-2/20.

CHIP Dental FY2023 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) Remove impact of reimbursement and policy changes from trend analysis.
(2) Adjusted unit cost to normalize difference in service mix.
Assume same service mix distribution same as for 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.

FY2023 Dental Rating

Attachment 4

FQHC Wrap Payment Rate Adjustment

Experience Period - March 2019 through February 2020

	<1	1-5	6-14	15-18	19-20	Total
FQHC Wrap Reimbursement						
Medicaid	(310,110)	(1,757,638)	(2,746,565)	(959,340)	(61,289)	(5,834,943)
CHIP	-	(167,074)	(330,039)	(114,779)		(611,891)
Incurred Claims						
Medicaid	21,665,119	279,656,704	483,515,635	166,901,344	9,687,058	961,425,860
CHIP	4,427	15,809,121	53,508,321	17,898,724		87,220,593
Rating Adjustment Factor						
Medicaid	0.9857	0.9937	0.9943	0.9943	0.9937	
CHIP	1.0000	0.9894	0.9938	0.9936		

Attachment 5

PHE Related Cost Adjustment

The COVID-19 pandemic and the resulting Public Health Emergency (PHE) have had a significant impact on the Medicaid and CHIP Dental programs. Beginning in March 2020 and continuing into 2022, the PHE has had a significant impact on average Medicaid and CHIP dental expenditures. Enrollment has increased by over 40% for Medicaid Dental and decreased by over 60% for CHIP Dental and average cost per member for all services has decreased from the pre-pandemic historical norms. During the early stages of the PHE, it was expected that these reductions were short-term and tied to the initial shock of the pandemic and the associated shutdowns; however, the reduction has continued into FY2021 and the first quarter of FY2022. While a return to the pre-pandemic norms is expected, we believe the return will be gradual and won't occur until the termination of the PHE.

In order to estimate the continued impact of the PHE on the FY2023 average costs, we have studied the actual, quarterly average cost and compared to expected per-capita cost absent the PHE. Based on historical claims and enrollment information prior to the PHE, we have estimated incurred claims during each quarter beginning March 2020 through November 2021. The expected (absent the PHE) quarterly average cost was developed based on the trend assumptions described in Attachment 3. Actual average claims were then compared to the expected average claims to determine the actual to expected ratio which is assumed to be representative of the impact of the PHE on program costs during each observed quarter.

The PHE-related cost impact has been defined as the average of the actual to expected ratio during the period March 2021 through August 2021, the last two quarters of FY2021. This period was selected as representative of the ongoing impact on future cost of the PHE because it represents a relatively stable period which was not overly influenced by a spike in COVID-19 infections and hospitalizations.

Currently, the PHE is assumed to end October 13, 2022, at which time it is expected that the PHE impact on eligibility and average cost will begin to unwind. As a result, we have assumed that the PHE-related cost impact described above will impact the first quarter of FY2023. Much uncertainty remains as to how the unwinding process will impact each program and we believe using one quarter of the PHE-related cost impact allows for the potential for pent-up demand, elimination of temporary behavior change which has reduced recent expenditures, benefit rush as members lose eligibility and the eventual return to a more historically normal cost pattern.

Exhibits A and B provide details regarding the calculation of the PHE-related cost adjustment factor for the Medicaid and CHIP Dental programs.

FY2023 Medicaid Dental Rating
PHE Related Cost Adjustment
Statewide Experience

	Actual Claims (1)	VBP Impact (2)	Actual + VBP (3)	Assumed Trend (4)	Expected Claims PMPM (5)	Actual to Expected Ratio
Under Age 1						
9/18-11/18	10.07	0.00	10.07		10.07	1.000
12/18-2/19	9.51	0.00	9.51		9.51	1.000
3/19-5/19	10.88	0.00	10.88		10.88	1.000
6/19-8/19	11.25	0.00	11.25		11.25	1.000
9/19-11/19	9.92	0.00	9.92		9.92	1.000
12/19-2/20	9.73	0.00	9.73		9.73	1.000
3/20-5/20	3.99	0.00	3.99	0.5%	10.93	0.365
6/20-8/20	7.90	0.03	7.93	0.5%	11.31	0.702
9/20-11/20	8.74	0.13	8.86	0.5%	9.97	0.889
12/20-2/21	7.62	0.11	7.74	0.5%	9.78	0.791
3/21-5/21	8.87	0.12	8.99	0.5%	10.98	0.818
6/21-8/21	9.22	0.13	9.35	0.5%	11.36	0.823
9/21-11/21	8.19	0.13	8.33	0.5%	10.02	0.831
					Estimated PHE Impact (6)	0.821
					Adjustment Factor (7)	**-4.49%**
Ages 1 -5						
9/18-11/18	28.70	0.00	28.70		28.70	1.000
12/18-2/19	27.23	0.00	27.23		27.23	1.000
3/19-5/19	29.53	0.00	29.53		29.53	1.000
6/19-8/19	30.14	0.00	30.14		30.14	1.000
9/19-11/19	27.87	0.00	27.87		27.87	1.000
12/19-2/20	27.06	0.00	27.06		27.06	1.000
3/20-5/20	11.19	0.00	11.19	0.5%	29.68	0.377
6/20-8/20	23.88	0.09	23.96	0.5%	30.29	0.791
9/20-11/20	23.95	0.31	24.26	0.5%	28.01	0.866
12/20-2/21	22.25	0.30	22.55	0.5%	27.19	0.829
3/21-5/21	25.30	0.37	25.67	0.5%	29.83	0.861
6/21-8/21	24.55	0.38	24.93	0.5%	30.44	0.819
9/21-11/21	23.11	0.34	23.45	0.5%	28.15	0.833
					Estimated PHE Impact (6)	0.840
					Adjustment Factor (7)	**-4.01%**
Ages 6 -14						
9/18-11/18	31.26	0.00	31.26		31.26	1.000
12/18-2/19	30.41	0.00	30.41		30.41	1.000
3/19-5/19	30.47	0.00	30.47		30.47	1.000
6/19-8/19	33.46	0.00	33.46		33.46	1.000
9/19-11/19	29.42	0.00	29.42		29.42	1.000
12/19-2/20	28.63	0.00	28.63		28.63	1.000
3/20-5/20	11.68	0.00	11.68	0.5%	30.62	0.381
6/20-8/20	27.81	0.13	27.94	0.5%	33.63	0.831
9/20-11/20	25.79	0.48	26.27	0.5%	29.57	0.888
12/20-2/21	24.07	0.46	24.53	0.5%	28.77	0.853
3/21-5/21	26.63	0.54	27.17	0.5%	30.78	0.883
6/21-8/21	27.51	0.59	28.10	0.5%	33.80	0.831
9/21-11/21	25.53	0.54	26.07	0.5%	29.72	0.877
					Estimated PHE Impact (6)	0.857
					Adjustment Factor (7)	**-3.57%**

FY2023 Medicaid Dental Rating
PHE Related Cost Adjustment
Statewide Experience

	Actual Claims (1)	VBP Impact (2)	Actual + VBP (3)	Assumed Trend (4)	Expected Claims PMPM (5)	Actual to Expected Ratio
Ages 15 -18						
9/18-11/18	31.62	0.00	31.62		31.62	1.000
12/18-2/19	31.55	0.00	31.55		31.55	1.000
3/19-5/19	30.67	0.00	30.67		30.67	1.000
6/19-8/19	34.36	0.00	34.36		34.36	1.000
9/19-11/19	29.47	0.00	29.47		29.47	1.000
12/19-2/20	29.30	0.00	29.30		29.30	1.000
3/20-5/20	12.43	0.00	12.43	0.5%	30.83	0.403
6/20-8/20	28.06	0.18	28.24	0.5%	34.53	0.818
9/20-11/20	26.50	0.65	27.15	0.5%	29.62	0.917
12/20-2/21	24.23	0.62	24.85	0.5%	29.45	0.844
3/21-5/21	26.24	0.66	26.90	0.5%	30.98	0.868
6/21-8/21	27.09	0.76	27.86	0.5%	34.70	0.803
9/21-11/21	24.43	0.67	25.09	0.5%	29.77	0.843
					Estimated PHE Impact (6)	0.836
					Adjustment Factor (7)	**-4.11%**
Ages 19 -20						
9/18-11/18	22.16	0.00	22.16		22.16	1.000
12/18-2/19	20.83	0.00	20.83		20.83	1.000
3/19-5/19	21.72	0.00	21.72		21.72	1.000
6/19-8/19	21.24	0.00	21.24		21.24	1.000
9/19-11/19	19.83	0.00	19.83		19.83	1.000
12/19-2/20	19.67	0.00	19.67		19.67	1.000
3/20-5/20	7.61	0.00	7.61	0.5%	21.83	0.349
6/20-8/20	16.32	0.13	16.44	0.5%	21.34	0.770
9/20-11/20	16.90	0.45	17.35	0.5%	19.93	0.871
12/20-2/21	15.36	0.43	15.79	0.5%	19.77	0.799
3/21-5/21	17.30	0.47	17.77	0.5%	21.94	0.810
6/21-8/21	17.58	0.53	18.11	0.5%	21.45	0.844
9/21-11/21	15.65	0.47	16.12	0.5%	20.03	0.805
					Estimated PHE Impact (6)	0.827
					Adjustment Factor (7)	**-4.32%**

Footnotes:
(1) Observed claims pmpm by quarter.
(2) Impact of Dentaquest value based purchasing program. Claims cost for certain provider were reduced by 50%.
Claims cost were grossed up assuming VBP was not implemented.
(3) Expected claims pmpm absent of VBP.
(4) Long term average expected trend.
(5) Expected claims absent COVID.
(6) Average ratio during 3/2021-8/2021.
(7) Assume PHE continues to 10/13/2022 and PHE plus unwinding impacts first quarter of FY2022.
Adjustment factor equals (6) minus 1 multiplied by 25%.

FY2023 CHIP Dental Rating
PHE Related Cost Adjustment
Statewide Experience

	Actual Claims (1)	VBP Impact (2)	Actual + VBP (3)	Assumed Trend (4)	Expected Claims PMPM (5)	Actual to Expected Ratio
Under Age 1						
9/18-11/18	1.46	0.00	1.46		1.46	1.000
12/18-2/19	1.01	0.00	1.01		1.01	1.000
3/19-5/19	0.85	0.00	0.85		0.85	1.000
6/19-8/19	1.39	0.00	1.39		1.39	1.000
9/19-11/19	1.81	0.00	1.81		1.81	1.000
12/19-2/20	2.17	0.00	2.17		2.17	1.000
3/20-5/20	0.17	0.00	0.17	1.3%	0.86	0.200
6/20-8/20	1.08	0.00	1.08	1.3%	1.41	0.768
9/20-11/20	1.05	0.00	1.05	1.3%	1.84	0.571
12/20-2/21	1.49	0.00	1.49	1.3%	2.20	0.678
3/21-5/21	1.09	0.00	1.09	1.3%	0.88	1.250
6/21-8/21	1.94	0.00	1.94	1.3%	1.42	1.364
9/21-11/21	0.79	0.00	0.79	1.3%	1.86	0.426
					Estimated PHE Impact (6)	1.307
					Adjustment Factor (7)	**7.69%**
Ages 1 -5						
9/18-11/18	14.39	0.00	14.39		14.39	1.000
12/18-2/19	14.23	0.00	14.23		14.23	1.000
3/19-5/19	15.98	0.00	15.98		15.98	1.000
6/19-8/19	15.85	0.00	15.85		15.85	1.000
9/19-11/19	14.05	0.00	14.05		14.05	1.000
12/19-2/20	14.00	0.00	14.00		14.00	1.000
3/20-5/20	6.60	0.00	6.60	1.3%	16.19	0.407
6/20-8/20	14.49	0.00	14.49	1.3%	16.06	0.902
9/20-11/20	12.77	0.00	12.77	1.3%	14.24	0.897
12/20-2/21	12.46	0.00	12.46	1.3%	14.18	0.879
3/21-5/21	15.47	0.00	15.47	1.3%	16.40	0.943
6/21-8/21	15.47	0.00	15.47	1.3%	16.27	0.951
9/21-11/21	13.97	0.00	13.97	1.3%	14.42	0.969
					Estimated PHE Impact (6)	0.947
					Adjustment Factor (7)	**-1.32%**
Ages 6 -14						
9/18-11/18	20.83	0.00	20.83		20.83	1.000
12/18-2/19	20.96	0.00	20.96		20.96	1.000
3/19-5/19	22.00	0.00	22.00		22.00	1.000
6/19-8/19	24.32	0.00	24.32		24.32	1.000
9/19-11/19	20.21	0.00	20.21		20.21	1.000
12/19-2/20	20.29	0.00	20.29		20.29	1.000
3/20-5/20	9.03	0.00	9.03	1.3%	22.29	0.405
6/20-8/20	20.77	0.00	20.77	1.3%	24.63	0.843
9/20-11/20	18.20	0.00	18.20	1.3%	20.48	0.889
12/20-2/21	17.40	0.00	17.40	1.3%	20.56	0.846
3/21-5/21	19.91	0.00	19.91	1.3%	22.58	0.882
6/21-8/21	20.62	0.00	20.62	1.3%	24.95	0.826
9/21-11/21	17.98	0.00	17.98	1.3%	20.74	0.867
					Estimated PHE Impact (6)	0.854
					Adjustment Factor (7)	**-3.65%**

FY2023 CHIP Dental Rating
PHE Related Cost Adjustment
Statewide Experience

	Actual Claims (1)	VBP Impact (2)	Actual + VBP (3)	Assumed Trend (4)	Expected Claims PMPM (5)	Actual to Expected Ratio
Ages 15 -18						
9/18-11/18	19.76	0.00	19.76		19.76	1.000
12/18-2/19	20.93	0.00	20.93		20.93	1.000
3/19-5/19	20.96	0.00	20.96		20.96	1.000
6/19-8/19	24.75	0.00	24.75		24.75	1.000
9/19-11/19	18.92	0.00	18.92		18.92	1.000
12/19-2/20	19.77	0.00	19.77		19.77	1.000
3/20-5/20	9.26	0.00	9.26	1.3%	21.24	0.436
6/20-8/20	20.99	0.00	20.99	1.3%	25.07	0.837
9/20-11/20	17.55	0.00	17.55	1.3%	19.17	0.916
12/20-2/21	16.51	0.00	16.51	1.3%	20.03	0.825
3/21-5/21	18.13	0.00	18.13	1.3%	21.51	0.843
6/21-8/21	18.47	0.00	18.47	1.3%	25.40	0.727
9/21-11/21	15.85	0.00	15.85	1.3%	19.42	0.816
					Estimated PHE Impact (6)	0.785
					Adjustment Factor (7)	**-5.37%**

Footnotes:
(1) Observed claims pmpm by quarter.
(2) Impact of Dentaquest value based purchasing program. Claims cost for certain provider were reduced by 50%.
Claims cost were grossed up assuming VBP was not implemented.
(3) Expected claims pmpm absent of VBP.
(4) Long term average expected trend.
(5) Expected claims absent COVID.
(6) Average ratio during 3/2021-8/2021.
(7) Assume PHE continues to 10/13/2022 and PHE plus unwinding impacts first quarter of FY2022.
Adjustment factor equals (6) minus 1 multiplied by 25%.

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 period July 1, 2021 through December 31, 2021. This period was selected because it was almost a year after the new DHMO entered the program and experience had begun to stabilize. 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 FY2023, specifically the impact to each DHMO once the PHE unwinding process begins. As a result, we have applied a 50% 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.

FY2023 Medicaid Dental Rating
Default Enrollment Acuity Analysis
July 1, 2021 through December 31, 2021

	<1	1-5	6-14	15-18	19-20	Total
Member Months - July 2021- December 2021						
MCNA+DQ	617,285	5,778,524	9,724,973	3,651,660	1,073,701	20,846,143
United	387,324	415,360	491,515	209,219	73,933	1,577,352
Total	1,004,609	6,193,884	10,216,488	3,860,879	1,147,634	22,423,494
Incurred Claims - - July 2021- December 2021						
MCNA+DQ	5,813,293	136,718,107	252,779,993	92,045,404	17,747,458	505,104,254
United	2,613,240	7,551,496	12,913,516	5,170,518	929,902	29,178,671
Total	8,426,533	144,269,602	265,693,508	97,215,922	18,677,360	534,282,925
PMPM						
MCNA+DQ	9.42	23.66	25.99	25.21	16.53	24.23
United	6.75	18.18	26.27	24.71	12.58	18.50
Total	8.39	23.29	26.01	25.18	16.27	23.83
Acuity Adjustment - Full						
MCNA+DQ	1.12275	1.01577	0.99948	1.00106	1.01564	1.01692
United	0.80436	0.78054	1.01025	0.98148	0.77283	0.77637
Total	1.00000	1.00000	1.00000	1.00000	1.00000	1.00000
Acuity Adjustment - 50%						
MCNA+DQ	1.06138	1.00789	0.99974	1.00053	1.00782	1.00846
United	0.90218	0.89027	1.00512	0.99074	0.88642	0.88819
Total	1.00000	1.00000	1.00000	1.00000	1.00000	1.00000
Budget Neutral Factor						
MCNA+DQ	0.99362	1.00646	0.99991	1.00017	1.00676	
United	0.99362	1.00646	0.99991	1.00017	1.00676	
Total	0.99362	1.00646	0.99991	1.00017	1.00676	

Acuity Adjustment - 50% Budget Neutral					
MCNA	1.05461	1.01440	0.99965	1.00070	1.01463
Dentaquest	1.05461	1.01440	0.99965	1.00070	1.01463
United	0.89643	0.89603	1.00503	0.99091	0.89241

FY2023 CHIP Dental Rating
Default Enrollment Acuity Analysis
July 1, 2021 through December 31, 2021

	<1	1-5	6-14	15-18	Total
Member Months - July 2021- December 2021					
MCNA+DQ	455	141,470	527,232	212,834	881,991
United	62	10,464	34,956	15,615	61,097
Total	517	151,934	562,188	228,449	943,088
Incurred Claims - - July 2021- December 2021					
MCNA+DQ	239	2,101,935	10,123,972	3,655,579	15,881,725
United	76	121,960	621,191	249,566	992,793
Total	315	2,223,895	10,745,163	3,905,146	16,874,518
PMPM					
MCNA+DQ	0.53	14.86	19.20	17.18	18.01
United	1.22	11.66	17.77	15.98	16.25
Total	0.61	14.64	19.11	17.09	17.89
Acuity Adjustment - Full					
MCNA+DQ	0.86333	1.01507	1.00466	1.00477	1.00636
United	2.00299	0.79627	0.92976	0.93497	0.90815
Total	1.00000	1.00000	1.00000	1.00000	1.00000
Acuity Adjustment - 50%					
MCNA+DQ	0.93166	1.00753	1.00233	1.00239	1.00318
United	1.50149	0.89813	0.96488	0.96748	0.95408
Total	1.00000	1.00000	1.00000	1.00000	1.00000
Budget Neutral Factor					
MCNA+DQ	0.97882	1.00483	1.00128	1.00118	
United	0.97882	1.00483	1.00128	1.00118	
Total	0.97882	1.00483	1.00128	1.00118	

Acuity Adjustment - 50% Budget Neutral				
MCNA	0.91193	1.01241	1.00362	1.00357
Dentaquest	0.91193	1.01241	1.00362	1.00357
United	1.46969	0.90248	0.96612	0.96863

Attachment 7

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 do not meet their measures are subject to a penalty. 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 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)	
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: • at least one sealant • 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: • at least one sealant • 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 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 2022 the reference year is calendar year 2020.

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 2022, 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 CY2018, one DHMO paid a penalty less than 0.04 percent of capitation. For CY2019, 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 CY2020 and CY2021, HHSC received a waiver to suspend the Dental P4Q Program due to the PHE. As a result, we believe the P4Q program does not have a material impact on the premium rate development.

Attachment 8

FY2023 Medicaid Rate Certification Index

The index below includes the pages of this report that correspond to the applicable sections of the 2022-2023 Medicaid Managed Care Rate Development Guide, dated April 2022.

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, 2022 through August 31, 2023 (FY2023).

iii. (a) The certification letter is on page 11 of the report.

(b) The final capitation rates are shown on page 10 of the report.

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

(ii) See page 1 of the report.

(iii) See pages 4 through 5 of the report.

(iv) See Attachment 6 pages 31 through 33 of the report.

(v) See Attachment 7 page 34 through 35 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 8 and Attachment 5 pages 26 through 30 for discussion on how COVID-19 and the PHE have been accounted for in the FY2023 rate development.

xiii. Acknowledged.

B. Appropriate Documentation

i. The actuary is certifying capitation rates. See page 11 of the report.

ii. Acknowledged.

iii. Acknowledged.

iv. Not applicable.

v. Acknowledged.

vi. Acknowledged. See page 11 of the report.

vii. Not applicable.

viii. a) See Attachment 1 pages 13 through 17 of the report.

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

c) FY2022 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 2021 to study the impact of COVID and the PHE.

(b) See pages 6 through 8 and Attachment 5 pages 26 through 30 of the report.

(c) Not applicable.

(d) See pages 6 through 8 and Attachment 5 pages 26 through 30 of the report. In addition, the experience rebate provisions have been tightened to limit the possibility of excessive profits in FY2023. 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.

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 pages 6 through 8 of the report.

(e) See page 1 of the report. In addition, value added 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 10 and Attachment 1 pages 13 through 17 of the report.

ii. (a) See Attachment 1 pages 13 through 17 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 21 through 23 of the report.

(b) See Attachment 3 pages 21 through 23 of the report.

(c) See Attachment 3 pages 21 through 23 of the report.

(d) See Attachment 3 pages 21 through 23 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 FY2023 premium rate.

(c) All enrollment data during retroactive enrollment periods are included in the base period data used to develop the FY2023 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 24 through 25 of the report.

viii. See pages 24 through 25 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 34 through 35 of the report.

B. Withhold Arrangements

i. Rate Development Standards

Acknowledged.

ii. Appropriate Documentation

(a) See Attachment 7 page 34 through 35 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 9 of the report.

ii. See page 9 of the report.

iii. See page 9 of the report.

6. Risk Adjustment and Acuity Adjustments

A. Rate Development Standards

Acknowledged.

B. Appropriate Documentation

Acknowledged.

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

Not applicable.

Section III. New Adult Group Capitation Rates

Not applicable.