STATE OF TEXAS
MEDICAID AND CHIP
MANAGED CARE
DENTAL RATE SETTING
FY2024

Prepared for:
Texas Health and Human Services Commission
Texas Dental HHS0002879A-10

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TABLE OF CONTENTS

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, 2023 through August 31, 2024 (FY2024) 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 FY2024 Medicaid and CHIP Dental premium rates.

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

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

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

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

Rudd and Wisdom has provided actuarial services to the Texas Medicaid program for over 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 for the period March 2012 through March 2023 and a projection of future enrollment through August 2024. These projections were prepared by HHS Forecasting staff.

- Financial Statistical Reports (FSR) from the dental plan for FY2020, FY2021, FY2022 and the first six months of FY2023. The FSR contains detailed information regarding monthly

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

- Detailed DHMO encounter data for FY2022. The encounter data is a dataset that includes detail claim information for every claim incurred during FY2022 and paid through November 30, 2022. The dataset includes but is not limited to (1) individual member information – date of birth, risk group, dental plan; (2) provider information – type of provider, NPI, taxonomy code; (3) procedure information – procedure code, modifier, tooth number; and (4) payment information – paid amount, billed amount. This information is used to identify the providers and services which will receive or have received reimbursement changes in order to determine the cost impact of such changes.

- Claim lag reports by type of service and by age group for each dental plan for the period September 2019 through February 2023. These reports were provided by the dental plans and include monthly paid claims by month of service. These reports summarize the detail encounter data.

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

- Information provided by HHSC regarding the default enrollment process.

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

- Current (FY2023) dental premium rates.

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

II. Base Period Data

The actuarial model used to derive the FY2024 Medicaid and CHIP dental premium rates relies primarily on historical dental plan experience. The historical claims experience for the program was analyzed and estimates for the base period were developed. The base period was defined as FY2022 (September 1, 2021 through August 31, 2022). Estimates of the base period include an estimate of incurred but unpaid claims (IBNR). Given that there are six months of runout beyond the base period the IBNR are immaterial. The IBNR estimate is based on claims paid through February 2023 and represents the following percentage of claims by dental program:

- Medicaid Dental - ~0.04%
- CHIP Dental – ~0.03%

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

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

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

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

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

- Volume analysis based on service category

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

Below is an excerpt from their data certification report:

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

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

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

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

Based on the review of the data by the EQRO, HHSC and Rudd and Wisdom, we have concluded that all data sources are consistent, complete and accurate. It is our opinion that the data collected for the rate development is of high quality and we have no concerns over the availability or applicability to the FY2024 rate development. The accumulation of data sources noted above have been assigned full credibility. Given the history of managed care data available for the Medicaid and CHIP dental programs, the rate development is based exclusively on managed care data.

III. Overview of the Rate Setting Methodology

The actuarial model used to derive the FY2024 Medicaid and CHIP Dental plan premium rates relies primarily on dental plan financial experience. The historical claims experience for the program was analyzed and estimates for the base period were developed. The base period was defined as FY2022 (September 1, 2021 through August 31, 2022). Estimates of the base period included an evaluation of incurred but unpaid claims (IBNR). These estimates were then projected forward to FY2024 using assumed trend rates and other adjustment factors. These adjustment factors are described in more detail in Section IV. We added a reasonable provision for administrative expenses, taxes, and risk margin in order to project the total cost for the rating period. The results of this analysis were then combined for all dental plans in order to develop a set of statewide community rates that vary by dental program and the following age groups:

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

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

The statewide community rates are developed by a weighted average of the projected FY2024 cost for each dental plan. The weights used in this formula are the projected FY2024 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 FY2024 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 FY2024 premium rates by dental plan and risk group for the Medicaid and CHIP Dental programs.

IV. Adjustment Factors

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

Trend Factors

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

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

Federally Qualified Health Center (FQHC) Wrap Payment Removal

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

Public Health Emergency (PHE) Related Cost Adjustment

COVID-19 and the associated PHE have had an unprecedented impact on the historical enrollment and claims data beginning March 2020 and continuing through 2023. Average Medicaid dental enrollment during the FY2022 base period is about 40% larger than the enrollment prior to the PHE and average costs for all services have dropped significantly. During the FY2020 through FY2023 rating periods, HHSC addressed the additional risk associated with the PHE with multiple approaches including paying COVID-19 related expenditures on a non-risk basis, adjusting the base period used in rate development and revising the experience rebate structure.

With the expiration of the PHE on May 11, 2023 and the commencement of the PHE unwinding process, the Medicaid programs are expected to eventually return to enrollment and average cost

patterns that are in line with historical pre-PHE norms. In our opinion, the pre-PHE base period, March 2019 through February 2020, which was used for the FY2022 and FY2023 rate developments is outdated for use in developing FY2024 rates. As a result, the base period has been updated to FY2022, which aligns with managed care regulations. Given that this experience was during the middle of the PHE, it must be adjusted to reflect the expected impact of the PHE unwinding process. The unwinding process will take many months and the disenrollments are expected to be staggered throughout FY2024. Given the significant disenrollment in the Medicaid dental program, it is expected that the average cost during the FY2024 rating period will increase significantly towards pre-PHE levels. A rate adjustment was calculated in order to estimate the impact of the PHE unwinding process and the associated disenrollment on average cost in FY2024. Attachment 5 presents a summary of the derivation of this adjustment factor. The PHE-related cost adjustment is intended to adjust the base period for expected changes to the enrollment, acuity and average cost for each program.

The PHE has had an opposite effect on the CHIP dental program enrollment. Average CHIP dental enrollment during the FY2022 base period was about 75% less than the enrollment prior to the PHE. The impact of the PHE unwinding process on the CHIP dental program was studied; however, an adjustment has not been applied due to the following reasons.

- In order to determine if the PHE had a material impact on the CHIP dental program, the number of members without a claim was determined by month for the pre-PHE period March 2019 through February 2020 and for the FY2022 base period. The percent of members without a claim for the two periods is presented in the table below.

Period	Min	Max	Avg
3/19-2/20	87.4%	90.5%	89.0%
FY2022	87.3%	91.3%	90.0%

  The CHIP dental program has a high percent of members without a claim. Even though enrollment during the base period is about 75% less than the enrollment prior to the PHE, the percent of members without a claim is similar between the pre-PHE period March 2019 through February 2020 and the FY2022 base period.

- Unlike the Medicaid dental program where we're able to estimate the disenrollment from the unwinding process, we're not able to determine how many of the members to be disenrolled from Medicaid will transition to CHIP and their acuity level compared to the base period experience.

As a result, no other adjustment was made other than updating the base period to reflect more recent experience. We are assuming that the members who will transition to CHIP from the unwinding process will have an average cost profile similar to those in the base period experience.

In order to mitigate the risk to both HHSC and the DHMOs resulting from the PHE, 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.

Default Enrollment Acuity Adjustment

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

V. Administrative Fees, Taxes and Risk Margin

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

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

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

	Administrative Expense PMPM				
	Actual		Average Annual ECI	Inflation Adjusted	
	Method 1	Method 2		Method 1	Method 2
FY2019	1.49	1.61	3.80%	1.79	2.05
FY2020	1.50	1.49	4.10%	1.76	2.11
FY2021	1.56	1.71	4.10%	1.76	2.08
FY2022	1.38	1.79	3.60%	1.48	1.78
Average	1.48	1.65		1.70	2.01

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

Based on this analysis the expected range of administrative costs for FY2024 was deemed to be $1.70-$2.00. The administrative expense included in the capitation rates of $1.75 pmpm is in line with the historical averages.

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

VI. Summary

The chart below presents the resulting statewide FY2024 Medicaid and CHIP Dental Plan premium rates pmpm.

	<1	1-5	6-14	15-18	19-20
Medicaid Dental					
Dentaquest	11.86	29.13	31.06	30.92	21.35
MCNA	11.86	29.13	31.06	30.92	21.35
United	10.76	25.23	30.87	30.17	18.65
CHIP Dental					
Dentaquest	2.63	19.00	23.09	20.98	n/a
MCNA	2.63	19.00	23.09	20.98	n/a
United	3.42	16.77	22.53	20.28	n/a

Attachment 1 presents a description of the calculation of the FY2024 Medicaid and CHIP Dental Plan premium rates.

Attachment 8 presents the required rating index summarizing the applicable sections from the 2023-2024 Medicaid Managed Care Rate Development Guide.

VII. Actuarial Certification of FY2024 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, 2023 through August 31, 2024 (FY2024) and to provide the actuarial certification required under Centers for Medicare and Medicaid Services (CMS) requirements 42 CFR 438.4.

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

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

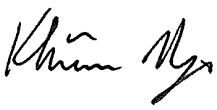
(b) The premium rates are appropriate for the populations and services covered under the managed care contract; and

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

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

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

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



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VIII. Attachments

Attachment 1 – Summary of FY2024 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 2023-2024 Medicaid Managed Care Rate Development Guide

Attachment 1

Summary of FY2024 Medicaid and CHIP Dental Rating Analysis

Attachment 1 presents summary information regarding the FY2024 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 FY2024 cost for the dental plans by estimating their base period average claims cost and then applying trend and other adjustment factors. These adjustment factors are described in more detail in Section IV of this report. The rating methodology includes an explicit provision for administrative expenses ($1.75 pmpm), risk margin (1.50% of gross premium), premium tax (1.75% of gross premiums) and maintenance tax ($.024 pmpm). The bottom of the exhibit presents the projected FY2024 cost based on the above assumptions.

The FY2024 Medicaid and CHIP Dental premium rates were then defined as the statewide community rate with default enrollment acuity adjustment for all risk groups. Exhibits A-2 and B-2 of Attachment 1 present the derivation of the premium rates by dental plan and risk group for the Medicaid and CHIP dental programs. Additional information regarding the default enrollment acuity adjustment is included in Attachment 6.

The primary cost drivers behind the rate reduction for Medicaid dental are (a) the updating of the base period to FY2022 and (b) the lingering impact of the PHE on enrollment and average cost as disenrollments are expected to be staggered throughout FY2024. The PHE has resulted in significant enrollment growth and large reductions in the average cost for all services which is expected to partially continue into FY2024 as the significant number of disenrollments will not be complete until the 3rd or 4th quarter of FY2024. The primary cost driver behind the rate reduction for CHIP dental is updating the base period to FY2022.

FY2024 Medicaid Dental Rating
Statewide

Attachment 1 - Exhibit A-1

	<1		1-5		6-14		15-18		19-20		Total	
	Amount	pmpm	Amount	pmpm	Amount	pmpm	Amount	pmpm	Amount	pmpm	Amount	pmpm
Experience Period FY2022												
Member Months	2,066,231		12,686,509		21,074,856		8,140,573		2,745,059		46,713,229	
Incurred Claims												
Diagnostic	17,619,362	8.53	135,699,223	10.70	153,657,456	7.29	50,659,670	6.22	10,490,536	3.82	368,126,247	7.88
Preventive	53,620	0.03	41,841,974	3.30	162,278,945	7.70	44,800,396	5.50	8,158,745	2.97	257,133,681	5.50
Restorative	2,820	0.00	90,262,578	7.11	187,296,658	8.89	68,487,601	8.41	14,463,646	5.27	360,513,303	7.72
Orthodontic	0	0.00	7,262	0.00	411,990	0.02	308,317	0.04	59,421	0.02	786,990	0.02
All Others	56,315	0.03	26,165,697	2.06	44,409,549	2.11	40,110,033	4.93	11,039,530	4.02	121,781,125	2.61
Total	17,732,117	8.58	293,976,734	23.17	548,054,598	26.01	204,366,017	25.10	44,211,879	16.11	1,108,341,345	23.73
Projected FY2024												
Member Months	2,127,132		11,099,834		18,792,866		6,891,048		652,712		39,563,593	
Premium @ Current Rates	26,240,798	12.34	338,642,726	30.51	616,856,240	32.82	228,505,702	33.16	15,390,804	23.58	1,225,636,270	30.98
Annual Cost Trend Assumptions	0.50 %		0.50 %		0.50 %		0.50 %		0.50 %			
Rating Adjustment Factors												
Adjustment #1 - FQHC Wrap Adjustment	0.9862		0.9936		0.9943		0.9947		0.9949			
Adjustment #2 - PHE Adjustment	1.0000		1.0805		1.0606		1.0864		1.0966			
Adjustment #3	1.0000		1.0000		1.0000		1.0000		1.0000			
Projected FY2024 Incurred Claims	18,183,862	8.55	278,908,785	25.13	520,537,113	27.70	188,828,584	27.40	11,584,216	17.75	1,018,042,562	25.73
Other Dental Expense/Capitation	1,805,268	0.85	6,186,874	0.56	10,511,290	0.56	4,648,931	0.67	567,211	0.87	23,719,575	0.51
Administrative Fee	3,722,481	1.75	19,424,710	1.75	32,887,515	1.75	12,059,334	1.75	1,142,247	1.75	69,236,287	1.75
Risk Margin	368,419	1.50%	4,725,405	1.50%	8,750,234	1.50%	3,189,200	1.50%	206,348	1.50%	17,239,605	1.50%
Premium Tax	429,822	1.75%	5,512,972	1.75%	10,208,606	1.75%	3,720,733	1.75%	240,739	1.75%	20,112,873	1.75%
Maintenance Tax	51,406	0.02	268,246	0.02	454,161	0.02	166,534	0.02	15,774	0.02	956,120	0.02
Projected Total Cost	24,561,259	11.55	315,026,993	28.38	583,348,919	31.04	212,613,316	30.85	13,756,536	21.08	1,149,307,022	29.05
Rate Change %		-6.4%		-7.0%		-5.4%		-7.0%		-10.6%		-6.2%

FY2024 CHIP Dental Rating
Statewide

	<1		1-5		6-14		15-18		Total	
	Amount	pmpm	Amount	pmpm	Amount	pmpm	Amount	pmpm	Amount	pmpm
Experience Period FY2022										
Member Months	890		169,302		721,834		290,024		1,182,050	
Incurred Claims										
Diagnostic	439	0.49	1,073,396	6.34	5,362,802	7.43	1,866,042	6.43	8,302,678	7.02
Preventive	339	0.38	750,182	4.43	4,939,769	6.84	1,541,205	5.31	7,231,495	6.12
Restorative	0	0.00	797,097	4.71	3,745,750	5.19	1,387,144	4.78	5,929,991	5.02
Orthodontic	0	0.00	0	0.00	5,921	0.01	5,258	0.02	11,179	0.01
All Others	0	0.00	126,823	0.75	438,996	0.61	442,520	1.53	1,008,340	0.85
Total	778	0.87	2,747,499	16.23	14,493,238	20.08	5,242,169	18.07	22,483,683	19.02
Projected FY2024										
Member Months	621		757,708		2,086,973		745,146		3,590,448	
Premium @ Current Rates	2,302	3.71	13,647,095	18.01	51,464,957	24.66	17,600,140	23.62	82,714,494	23.04
Annual Cost Trend Assumptions	1.30 %		1.30 %		1.30 %		1.30 %			
Rating Adjustment Factors										
Adjustment #1 - FQHC Wrap Adjustment	1.0000		0.9930		0.9964		0.9965			
Adjustment #2 - PHE Adjustment	1.0000		1.0000		1.0000		1.0000			
Adjustment #3	1.0000		1.0000		1.0000		1.0000			
Projected FY2024 Incurred Claims	557	0.90	12,529,600	16.54	42,843,279	20.53	13,772,029	18.48	69,145,465	19.26
Other Dental Expense/Capitation	0	0.00	6,858	0.01	39,056	0.02	13,977	0.02	59,891	0.05
Administrative Fee	1,087	1.75	1,325,989	1.75	3,652,203	1.75	1,304,006	1.75	6,283,284	1.75
Risk Margin	26	1.50%	215,206	1.50%	722,248	1.50%	234,233	1.50%	1,171,712	1.50%
Premium Tax	30	1.75%	251,073	1.75%	842,622	1.75%	273,272	1.75%	1,366,997	1.75%
Maintenance Tax	15	0.02	18,311	0.02	50,435	0.02	18,008	0.02	86,769	0.02
Projected Total Cost	1,714	2.76	14,347,037	18.93	48,149,843	23.07	15,615,524	20.96	78,114,118	21.76
Rate Change %		-25.5%		5.1%		-6.4%		-11.3%		-5.6%

FY2024 Dental Rating
Medicaid Dental

	<1	1-5	6-14	15-18	19-20
FY2024 Statewide Community Rates					
Dentaquest	11.55	28.38	31.04	30.85	21.08
MCNA	11.55	28.38	31.04	30.85	21.08
United	11.55	28.38	31.04	30.85	21.08
Default Enrollment Acuity Adjustment					
Dentaquest	1.02679	1.02651	1.00049	1.00224	1.01295
MCNA	1.02679	1.02651	1.00049	1.00224	1.01295
United	0.93170	0.88889	0.99451	0.97777	0.88486
FY2024 Acuity Adjusted Rates					
Dentaquest	11.86	29.13	31.06	30.92	21.35
MCNA	11.86	29.13	31.06	30.92	21.35
United	10.76	25.23	30.87	30.17	18.65

FY2024 Dental Rating
CHIP Dental

	<1	1-5	6-14	15-18
FY2024 Statewide Community Rates				
Dentaquest	2.76	18.93	23.07	20.96
MCNA	2.76	18.93	23.07	20.96
United	2.76	18.93	23.07	20.96
Default Enrollment Acuity Adjustment				
Dentaquest	0.95336	1.00353	1.00079	1.00122
MCNA	0.95336	1.00353	1.00079	1.00122
United	1.23856	0.88549	0.97638	0.96766
FY2024 Acuity Adjusted Rates				
Dentaquest	2.63	19.00	23.09	20.98
MCNA	2.63	19.00	23.09	20.98
United	3.42	16.77	22.53	20.28

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 2023 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-19	2,794,602	73,295,841	1.000	73,295,841	26.23	
Oct-19	2,797,306	84,819,995	1.000	84,819,995	30.32	
Nov-19	2,798,808	72,200,458	1.000	72,200,458	25.80	
Dec-19	2,795,978	66,954,583	1.000	66,954,583	23.95	
Jan-20	2,784,482	82,407,046	1.000	82,407,046	29.60	
Feb-20	2,766,219	74,453,591	1.000	74,453,591	26.92	
Mar-20	2,773,188	47,544,992	1.000	47,544,992	17.14	
Apr-20	2,871,819	2,619,436	1.000	2,619,436	0.91	
May-20	2,960,648	44,836,556	1.000	44,836,556	15.14	
Jun-20	3,038,497	74,807,112	1.000	74,807,112	24.62	
Jul-20	3,115,343	76,023,920	1.000	76,023,920	24.40	
Aug-20	3,163,737	83,257,639	1.000	83,257,639	26.32	
Sep-20	3,217,425	84,196,078	1.000	84,196,078	26.17	0.998
Oct-20	3,270,214	80,328,494	1.000	80,328,494	24.56	0.810
Nov-20	3,313,831	71,003,484	1.000	71,003,484	21.43	0.831
Dec-20	3,370,408	80,178,285	1.000	80,178,285	23.79	0.993
Jan-21	3,435,761	82,120,440	1.000	82,120,440	23.90	0.808
Feb-21	3,482,963	66,751,205	1.000	66,751,205	19.17	0.712
Mar-21	3,518,032	101,529,334	1.000	101,529,334	28.86	1.683
Apr-21	3,551,374	86,081,837	1.000	86,081,837	24.24	26.574
May-21	3,587,316	76,353,822	1.000	76,353,822	21.28	1.405
Jun-21	3,618,126	90,845,918	1.000	90,845,918	25.11	1.020
Jul-21	3,656,310	92,218,665	1.000	92,218,665	25.22	1.034
Aug-21	3,685,272	92,406,445	1.000	92,406,445	25.07	0.953
Sep-21	3,720,173	86,467,044	1.000	86,467,044	23.24	0.888
Oct-21	3,749,185	89,908,301	1.000	89,908,301	23.98	0.976
Nov-21	3,786,747	84,844,313	1.000	84,844,313	22.41	1.046
Dec-21	3,823,512	84,118,103	1.000	84,118,103	22.00	0.925
Jan-22	3,850,226	86,151,782	1.000	86,165,234	22.38	0.936
Feb-22	3,884,739	85,081,972	1.000	85,100,328	21.91	1.143
Mar-22	3,912,164	108,960,559	1.000	108,988,997	27.86	0.965
Apr-22	3,946,423	94,807,090	1.000	94,839,962	24.03	0.991
May-22	3,969,620	84,751,515	1.000	84,791,574	21.36	1.004
Jun-22	3,999,034	100,660,492	0.999	100,721,957	25.19	1.003
Jul-22	4,023,171	95,296,828	0.999	95,388,624	23.71	0.940
Aug-22	4,048,235	106,850,637	0.999	107,006,907	26.43	1.054
FY2020	34,660,627			783,221,170	22.60	
FY2021	41,707,032			1,004,014,007	24.07	1.065
FY2022	46,713,229			1,108,341,345	23.73	0.986

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-19	361,818	6,215,551	1.000	6,215,551	17.18	
Oct-19	360,475	7,235,302	1.000	7,235,302	20.07	
Nov-19	358,542	6,605,160	1.000	6,605,160	18.42	
Dec-19	355,347	6,013,321	1.000	6,013,321	16.92	
Jan-20	352,883	7,184,533	1.000	7,184,533	20.36	
Feb-20	349,904	6,664,020	1.000	6,664,020	19.05	
Mar-20	342,613	4,599,997	1.000	4,599,997	13.43	
Apr-20	331,143	202,106	1.000	202,106	0.61	
May-20	325,234	3,725,613	1.000	3,725,613	11.46	
Jun-20	320,980	6,208,965	1.000	6,208,965	19.34	
Jul-20	317,585	6,127,884	1.000	6,127,884	19.30	
Aug-20	314,285	6,229,793	1.000	6,229,793	19.82	
Sep-20	307,568	5,633,901	1.000	5,633,901	18.32	1.066
Oct-20	299,176	5,193,691	1.000	5,193,691	17.36	0.865
Nov-20	294,139	4,472,408	1.000	4,472,408	15.21	0.825
Dec-20	266,142	4,728,956	1.000	4,728,956	17.77	1.050
Jan-21	250,033	4,298,420	1.000	4,298,420	17.19	0.844
Feb-21	238,037	3,286,477	1.000	3,286,477	13.81	0.725
Mar-21	216,404	4,931,883	1.000	4,931,883	22.79	1.697
Apr-21	209,354	3,760,896	1.000	3,760,896	17.96	29.434
May-21	205,077	3,194,619	1.000	3,194,619	15.58	1.360
Jun-21	200,132	4,013,148	1.000	4,013,148	20.05	1.037
Jul-21	192,061	3,825,604	1.000	3,825,604	19.92	1.032
Aug-21	184,860	3,366,621	1.000	3,366,621	18.21	0.919
Sep-21	175,033	2,855,809	1.000	2,855,809	16.32	0.891
Oct-21	163,310	2,857,361	1.000	2,857,361	17.50	1.008
Nov-21	122,373	2,119,028	1.000	2,119,028	17.32	1.139
Dec-21	100,620	1,938,236	1.000	1,938,236	19.26	1.084
Jan-22	88,678	1,684,092	1.000	1,684,345	18.99	1.105
Feb-22	88,986	1,650,146	1.000	1,650,319	18.55	1.343
Mar-22	80,410	1,980,515	1.000	1,980,859	24.63	1.081
Apr-22	78,472	1,563,642	1.000	1,564,060	19.93	1.110
May-22	74,753	1,250,199	1.000	1,250,687	16.73	1.074
Jun-22	73,076	1,674,040	0.999	1,675,107	22.92	1.143
Jul-22	69,632	1,473,124	0.999	1,474,706	21.18	1.063
Aug-22	66,707	1,430,864	0.998	1,433,168	21.48	1.180
FY2020	4,090,809			67,012,245	16.38	
FY2021	2,862,983			50,706,624	17.71	1.081
FY2022	1,182,050			22,483,683	19.02	1.074

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 2023. 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 FY2024 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 as for the period 3/19-2/20.

CHIP Dental FY2024 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 as for the period 3/19-2/20.

Attachment 4

FQHC Wrap Payment Removal

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

FY2024 Dental Rating Attachment 4
FQHC Wrap Payment Rate Adjustment
Experience Period - September 1, 2021 through August 31, 2022 (FY2022)

	<1	1-5	6-14	15-18	19-20	Total
FQHC Wrap Reimbursement						
Medicaid	(241,071)	(1,922,205)	(3,127,899)	(1,077,074)	(227,350)	(6,595,599)
CHIP	-	(18,896)	(52,522)	(18,469)		(89,888)
Experience Period Incurred Claims (September 1, 2021 through August 31, 2022)						
Medicaid	17,506,186	301,032,729	548,380,549	204,526,298	44,532,895	1,115,978,658
CHIP	641	2,692,283	14,452,824	5,219,871		22,365,620
Rating Adjustment Factor						
Medicaid	0.9862	0.9936	0.9943	0.9947	0.9949	
CHIP	1.0000	0.9930	0.9964	0.9965		

Attachment 5

PHE Related Cost Adjustment – Medicaid Dental

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

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

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

Current Medicaid members are spread throughout these cohorts based on known eligibility information and type program/type of assistance but are not specific to Medicaid program. Each cohort contains members from any Medicaid program and the disenrollments and renewals are staggered throughout the twelve-month period with the majority occurring in the first six months. Based on the planned PHE unwinding process and detailed information regarding the specific Medicaid members within each cohort and their expected redetermination dates, HHS Forecasting has developed projected caseload forecasts for the Medicaid dental program by month, DHMO and risk group through the end of FY2024.

Given that the FY2022 base period was heavily impacted by the PHE and the expected disenrollments that will occur during FY2024, it is necessary to calculate an adjustment factor to properly estimate the impact of the PHE unwind process. The PHE impact was not uniform across all Medicaid programs and the adjustment factors calculated are specific to the populations being rated based on historical program-specific experience.

In order to estimate the impact of the PHE unwind on the FY2024 Medicaid dental program average costs, we have analyzed the base period claims using two methods: (1) Cohort Methodology and (2) Non-Utilizer Distribution Methodology. Each method is a reasonable approach to measuring the PHE impact, which is inherently complicated since the task is to compare a period of known overstated enrollment and understated average cost with a rating period in which a theoretical disenrollment process will occur. Given the unknown factors associated with the PHE unwind process, we have averaged the results of the two reasonable methodologies, each assigned equal weighting, in order to minimize the reliance on a single data point in analyzing the

expected PHE-related cost impact. Items A and B below further describe the details of the two methodologies.

A. Cohort Methodology

HHSC provided a list of Medicaid IDs for members in Cohorts 1, 2 and 3. The cohorts are grouped based on various circumstances including how likely they are to be ineligible for coverage. Cohort 1 includes individuals most likely to be ineligible for coverage such as members who age out of the program. Cohort 2 includes individuals likely to transfer to another HHSC program such as pregnant women transitioning to the Healthy Texas Women Program. Cohort 3 includes the remaining population that could potentially be ineligible for coverage, but also includes individuals who could potentially remain eligible based on redetermination. Everyone who is not included in Cohorts 1, 2 and 3 is assumed to remain eligible under the program.

The base period average cost per member per month was determined for members within each cohort. The PHE adjustment was determined by comparing (1) the projected FY2022 average cost excluding members who are continuously enrolled due to the PHE to (2) the actual FY2022 average cost. Members who are expected to be ineligible (i.e., continuously enrolled due to PHE) and disenrolled from the program were identified starting with Cohort 1, then Cohort 2, etc. such that the number of members expected to remain in the program by risk group is less than or equal to the number of members enrolled prior to the PHE for the period March 2019 through February 2020. The adjustment factor was defined as the adjusted FY2022 average cost excluding members expected to be disenrolled divided by the actual FY2022 average cost including all members.

B. Non-Utilizer Distribution Methodology

An analysis of the distribution of average monthly claims cost by member and by size during the PHE demonstrates material changes since being relatively stable prior to the PHE. Most notably, the percentage of members with $0 claims during a given month has increased significantly. In our opinion; this change is most closely tied to the large enrollment growth associated with the continuous eligibility requirements. We have further observed that the distribution of claimants utilizing services, i.e., claimants with greater than $0 in a given month, has not changed significantly during the PHE. Based on this analysis, we conclude that the distribution of non-utilizers is one of the primary causes of average cost differences during the PHE and the FY2022 base period.

The increase in the percentage of non-utilizers is largest in those programs and risk groups with the most enrollment growth. Consequently, those programs and risk groups are likely to be those most heavily impacted by the PHE unwind process.

The base period average cost was adjusted by applying the distribution of non-utilizers during the twelve-month period immediately preceding the PHE to the average cost per utilizer observed during the FY2022 base period. For example,

- FY2022 actual average cost = $100
- FY2022 percentage of non-utilizers – 55%
- FY2022 average cost per utilizer – $100 divided by (1-.55) = $222.22
- 3/2019-2/2020 percentage of non-utilizers – 30%
- FY2022 adjusted average cost - $222.22 multiplied by (1-.30) = $155.56
- PHE adjustment factor = $155.56 divided by $100 = 1.5556

The derivation of the Cohort Method and Non-Utilizer Distribution Method adjustment factors are included in Exhibit A.

The two methodologies are then weighted 50/50 in order to estimate the full impact of the PHE-related cost impact on the FY2022 base period. The PHE adjustment factors calculated for each methodology are limited to no less than 1.0 since it is not expected that the PHE unwind would have a negative impact on average cost.

The methodologies described above assume that all impacted members will unwind and be disenrolled prior to the rating period. In other words, the calculated adjustment factors represent the full impact of the PHE. Given that the PHE unwind process will occur throughout FY2024, a weighting factor must be applied to the calculated adjustment in order to properly account for the partial impact expected during FY2024. The weighting factor has been calculated by analyzing the percentage of cumulative disenrollments expected each month during the rating period and developing a weighted average based on monthly enrollment. Risk groups that are not expected to have a reduction in enrollment are assigned a weight of 0% since the PHE unwind is not expected to impact these groups. Exhibit B provides the derivation of the weighting factor and the application to the full adjustment factor calculated in Exhibit A.

The PHE has had an opposite effect on the CHIP dental program enrollment. Average CHIP dental enrollment during the FY2022 base period was about 75% less than the enrollment prior to the PHE. The impact of the PHE unwinding process on the CHIP dental program was studied; however, an adjustment has not been applied due to the following reasons.

- In order to determine if the PHE had a material impact on the CHIP dental program, the number of members without a claim was determined by month for the pre-PHE period March 2019 through February 2020 and for the FY2022 base period. The percent of members without a claim for the two periods is presented in the table below.

Period	Min	Max	Avg
3/19-2/20	87.4%	90.5%	89.0%
FY2022	87.3%	91.3%	90.0%

The CHIP dental program has a high percent of members without a claim. Even though enrollment during the base period is about 75% less than the enrollment prior to the PHE, the percent of members without a claim is similar between the pre-PHE period March 2019 through February 2020 and the FY2022 base period.

- Unlike the Medicaid dental program where we're able to estimate the disenrollment from the unwinding process, we're not able to determine how many of the members to be disenrolled from Medicaid will transition to CHIP and their acuity level compared to the base period experience.

As a result, no other adjustment was made other than updating the base period to reflect more recent experience. We are assuming that the members who will transition to CHIP from the unwinding process will have an average cost profile similar to those in the base period experience.

FY2024 Dental Rating
PHE Related Cost Adjustment
Medicaid Dental
Statewide Experience

	Age <1	Age 1-5	Age 6-14	Age 15-18	Age 19-20
Cohort Method					
FY2022 PMPM Actual (1)	8.01	23.81	26.49	25.83	17.18
FY2022 PMPM Projected (2)	8.01	24.53	26.99	26.79	15.94
PHE Adjustment Factor (3)	1.0000	1.0305	1.0189	1.0371	0.9275
Claim Distribution Non-Utilizer Distribution Method					
Percent of Members With No Claims					
Pre-COVID 3/19-2/20	93%	87%	88%	90%	93%
FY2022	94%	89%	89%	91%	94%
FY2022 PMPM Exclude Members with No Claims	141.31	215.44	247.92	291.84	301.06
PMPM - FY2022 (Actual) (1)	8.01	23.81	26.49	25.83	17.18
PMPM - FY2022 (Projected based on 3/19-2/20 Distribution) (4)	9.76	27.75	29.83	30.25	20.70
PHE Adjustment Factor (3)	1.2178	1.1658	1.126	1.171	1.2047
Average of Cohort and Claims Distribution Method (6)	1.1089	1.0982	1.0725	1.1041	1.1024
Weight (7)	0.0%	82.0%	83.7%	83.0%	94.4%
FY2024 Rate Adjustment Factors	1.0000	1.0805	1.0606	1.0864	1.0966

Notes:
(1) Equals FY2022 health plan fee-for-service claims PMPM for all services (from Encounter database).
(2) Projected FY2022 PMPM excluding continuous enrolled PHE members.
(3) Projected FY2022 PMPM divided by Actual FY2022 PMPM
(4) FY2022 PMPM excluding members with no claims * 3/19-2/20 percent of members with no claims.
(5) Projected FY2022 PMPM based on pre-COVID distribution divided by Actual FY2022 PMPM.
(6) Average of Cohort and Claims Distribution Method. Minimun value of 1.0 for each method.
(7) Attachment 5 - Exhibit B

FY2024 Dental Rating
PHE Related Cost Adjustment
Medicaid Dental
Statewide Experience

Weights	Under Age 1	Ages 1-5	Ages 6-14	Ages 15-18	Ages 19-20
Total Disenrollment (1)	5,518	(233,338)	(463,673)	(243,517)	(301,033)
% of Total Disenrollment (2)					
Sep-23	100.0%	57.9%	57.7%	59.5%	79.0%
Oct-23	89.8%	61.7%	62.1%	63.4%	87.4%
Nov-23	84.1%	67.9%	68.9%	69.7%	95.9%
Dec-23	100.0%	71.8%	76.6%	73.6%	99.0%
Jan-24	94.2%	78.1%	82.2%	79.9%	99.2%
Feb-24	76.8%	84.5%	87.8%	86.2%	99.5%
Mar-24	90.2%	91.0%	93.3%	92.4%	99.8%
Apr-24	74.3%	92.0%	94.2%	93.3%	99.8%
May-24	80.7%	93.0%	94.9%	94.1%	99.8%
Jun-24	84.6%	94.1%	95.6%	95.0%	99.8%
Jul-24	94.7%	97.3%	97.8%	97.5%	99.9%
Aug-24	100.0%	100.0%	100.0%	100.0%	100.0%
Weighted Impact (3)	0.0%	82.0%	83.7%	83.0%	94.4%

(1) Change in enrollment from May 2023 to August 2024.
(2) Cumulative percentage of disenrollments occurring by month.
(3) Annual weighted impact based on enrollment by month.

Attachment 6

Default Enrollment Acuity Adjustment

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

The default enrollment acuity adjustment was defined as the difference in average cost per member between the new DHMO and the existing DHMOs by program and risk group for the base period September 1, 2021 through August 31, 2022. 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 FY2024, 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.

FY2024 Medicaid Dental Rating
Default Enrollment Acuity Analysis
September 1, 2021 through August 31, 2022

	<1	1-5	6-14	15-18	19-20	Total
Member Months						
MCNA+DQ	1,311,820	11,370,098	19,813,164	7,604,712	2,548,009	42,647,803
United	754,411	1,316,412	1,261,693	535,861	197,050	4,065,426
Total	2,066,231	12,686,509	21,074,856	8,140,573	2,745,059	46,713,229
Incurred Claims						
MCNA+DQ	11,909,398	277,535,791	516,099,840	191,749,479	42,107,914	1,039,402,422
United	5,621,783	23,635,350	32,471,889	12,852,900	2,440,252	77,022,174
Total	17,531,181	301,171,141	548,571,729	204,602,379	44,548,166	1,116,424,596
PMPM						
MCNA+DQ	9.08	24.41	26.05	25.21	16.53	24.37
United	7.45	17.95	25.74	23.99	12.38	18.95
Total	8.48	23.74	26.03	25.13	16.23	23.90
Acuity Adjustment - Full						
MCNA+DQ	1.07000	1.02821	1.00072	1.00322	1.01832	1.01976
United	0.87828	0.75631	0.98875	0.95432	0.76310	0.79272
Total	1.00000	1.00000	1.00000	1.00000	1.00000	1.00000
Acuity Adjustment - 50%						
MCNA+DQ	1.03500	1.01411	1.00036	1.00161	1.00916	1.00988
United	0.93914	0.87815	0.99437	0.97716	0.88155	0.89636
Total	1.00000	1.00000	1.00000	1.00000	1.00000	1.00000
Budget Neutral Factor						
MCNA+DQ	0.99207	1.01223	1.00013	1.00063	1.00376	
United	0.99207	1.01223	1.00013	1.00063	1.00376	
Total	0.99207	1.01223	1.00013	1.00063	1.00376	

Acuity Adjustment - 50% Budget Neutral					
MCNA	1.02679	1.02651	1.00049	1.00224	1.01295
Dentaquest	1.02679	1.02651	1.00049	1.00224	1.01295
United	0.93170	0.88889	0.99451	0.97777	0.88486

FY2024 CHIP Dental Rating
Default Enrollment Acuity Analysis
September 1, 2021 through August 31, 2022

	<1	1-5	6-14	15-18	Total
Member Months					
MCNA+DQ	740	150,272	653,517	261,163	1,065,692
United	150	19,030	68,317	28,861	116,358
Total	890	169,302	721,834	290,024	1,182,050
Incurred Claims					
MCNA+DQ	482	2,454,338	13,149,400	4,733,378	20,337,598
United	159	238,643	1,307,685	488,128	2,034,615
Total	642	2,692,981	14,457,085	5,221,506	22,372,214
PMPM					
MCNA+DQ	0.65	16.33	20.12	18.12	19.08
United	1.06	12.54	19.14	16.91	17.49
Total	0.72	15.91	20.03	18.00	18.93
Acuity Adjustment - Full					
MCNA+DQ	0.90400	1.02680	1.00463	1.00669	1.00831
United	1.47358	0.78839	0.95572	0.93942	0.92387
Total	1.00000	1.00000	1.00000	1.00000	1.00000
Acuity Adjustment - 50%					
MCNA+DQ	0.95200	1.01340	1.00231	1.00335	1.00416
United	1.23679	0.89419	0.97786	0.96971	0.96194
Total	1.00000	1.00000	1.00000	1.00000	1.00000
Budget Neutral Factor					
MCNA+DQ	1.00143	0.99027	0.99848	0.99788	
United	1.00143	0.99027	0.99848	0.99788	
Total	1.00143	0.99027	0.99848	0.99788	

Acuity Adjustment - 50% Budget Neutral				
MCNA	0.95336	1.00353	1.00079	1.00122
Dentaquest	0.95336	1.00353	1.00079	1.00122
United	1.23856	0.88549	0.97638	0.96766

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 include 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: •received at least 2 topical fluoride applications within the reporting year as a dental or oral health service	1-20 years	1-18 years
DQA Sealant Receipt on Permanent 1st Molars, One Sealant and All Four Sealants	Percentage of enrolled children, who have ever received sealants on permanent first molar teeth: • 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

FY2024 Medicaid Rate Certification Index

The index below includes the pages of this report that correspond to the applicable sections of the 2023-2024 Medicaid Managed Care Rate Development Guide, dated May 2023.

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, 2023 through August 31, 2024 (FY2024).

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 2 of the report.

(ii) See page 1 of the report.

(iii) See page 5 of the report.

(iv) See Attachment 6 pages 32 through 34 of the report.

(v) See Attachment 7 page 35 through 36 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 31 for discussion on how the COVID-19 PHE ending and related unwinding process have been accounted for in the FY2024 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) FY2023 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 2022 to study the impact of COVID and the PHE.

(b) See pages 6 through 8 and Attachment 5 pages 26 through 31 of the report.

(c) Not applicable.

(d) See pages 6 through 8 and Attachment 5 pages 26 through 31 of the report. In addition, the experience rebate provisions have been tightened to limit the possibility of excessive profits in FY2024. 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 4 of the report.

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

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

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

(d) Not applicable.

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

(b) See page 3 the report.

(c) No errors found in the data.

(d) See pages 6 through 8 of the report.

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

3. Projected Benefit Costs and Trends

A. Rate Development Standards

i. Acknowledged.

ii. Acknowledged.

iii. Not applicable.

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

v. Not applicable.

B. Appropriate Documentation

i. See page 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 FY2024 premium rate.

(c) All enrollment data during retroactive enrollment periods are included in the base period data used to develop the FY2024 premium rate.

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

vii. See pages 6 through 8 of the report.

viii. See pages 6 through 8 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 35 through 36 of the report.

B. Withhold Arrangements

i. Rate Development Standards

Acknowledged.

ii. Appropriate Documentation

(a) See Attachment 7 page 35 through 36 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

A. Rate Development Standards

Acknowledged.

B. Appropriate Documentation

Acknowledged.

7. Acuity Adjustment

A. Rate Development Standards

Acknowledged.

B. Appropriate Documentation

i. See Attachment 6 page 32 through 34 of the report.

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

Not applicable.

Section III. New Adult Group Capitation Rates

Not applicable.