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State of Texas

Health and Human Services Commission

Medicaid Managed Care
STAR+Plus Program Rate Setting

State Fiscal Year 2009

Prepared By:

Deloitte Consulting LLP

Steven N. Wander, FSA, MAAA

William Eichman, FSA, MAAA

Chris Schmidt, FSA, MAAA

Khoa Do

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I. Introduction

The Texas Health and Human Services Commission (HHSC) retained Deloitte Consulting to help them develop the State Fiscal Year 2009 (SFY09: September 1, 2008 through August 31, 2009) capitation rates (rates) for managed care organizations (MCOs) participating in the Texas Medicaid STAR+Plus program. We have worked closely with HHSC to help them develop these rates. This report presents the rating methodology and assumptions used in this rate development, as well as our certification of these rates.

MCOs participating in STAR+Plus are paid a monthly capitation rate per member to provide long-term care and certain acute care services to enrolled members. The long-term care services that are provided by the MCOs include Primary Home Care (PHC), Day Activity and Health Services (DAHS), and Community-based Alternatives (CBA). Acute care services that are provided by the MCOs include physician, outpatient hospital, lab/radiology, as well as other services. Non-psychiatric hospital inpatient facility services and prescription drugs are provided by the State via FFS, as are Nursing Facility (NF) LTC services after four months of institutionalization.

Medicaid pays for the LTC for both eligibility categories. Medicaid also pays for the acute care of Medicaid-only eligibles, whereas Medicare pays for the acute care of persons eligible for both Medicare and Medicaid (Dual Eligible). Within each of these two eligibility categories there are three eligibility classes (a.k.a. risk groups). The following identifies these risk groups and describes the types of associated services:

- NF – for members that must be institutionalized and cannot, therefore, benefit from home and community-based care;
- CBA – for persons age 21 and older who would qualify for NF care but elect to stay in their home and receive services such as:
    - Personal Assistance Services
        - Assistance to the participant including assistance with the performance of the activities of daily living and household chores necessary to maintain the home in a clean, sanitary, and safe environment.
        - The level of assistance provided is determined by the participant's needs for assistance and the plans of care.
        - Personal assistance services may include the provision of nursing tasks delegated by an RN in accordance with state rules promulgated by the Texas Board of Nurse Examiners.
    - Adaptive Aids and Medical Supplies
        - Devices, controls, or medically necessary supplies which enable persons with functional impairments to perform activities of daily living or control the environment in which they live.
    - Adult Foster Care
        - A 24-hour living arrangement in an enrolled foster home for persons who, because of physical or mental limitations, are unable to continue residing in their own homes.
        - Services may include meal preparation, housekeeping, personal care, help with activities of daily living, supervision, and the provision of or arrangement of transportation.
    - Assisted Living/Residential Care Services
        - A 24-hour living arrangement in licensed personal care facilities in which personal care, home management, escort, social and recreational activities, twenty-four hour

supervision, supervision of, assistance with, and direct administration of medications, and the provision or arrangement of transportation are provided.
        - Under the CBA, personal care facilities may contract to provide services in three distinct types of living arrangements:
            - Assisted Living apartments.
            - Residential Care apartments, or
            - Residential Care non-apartment settings.
    - Emergency Response Services
        - An electronic monitoring system for use by functionally impaired individuals who live alone or are isolated in the community.
        - In an emergency, the participant can press a call button to signal for help.
        - The electronic monitoring system, which has a 24-hour, seven-day-a-week capability, helps insure that the appropriate persons or service agency respond to an alarm call from the participant.
    - Minor Home Modifications
        - Services that assess the need for, arrange for, and provide modifications and/or improvements to an individual's residence to enable them to reside in the community and to ensure safety, security and accessibility.
    - Nursing Services
        - Includes, but is not limited to, the assessment and evaluation of health problems and the direct delivery of nursing tasks, providing treatments and health care procedures ordered by a physician and/or required by standards of professional practice or state law, delegation of nursing tasks to unlicensed persons according to state rules promulgated by the Texas Board of Nurse Examiners, developing the health care plan, and teaching individuals about proper health maintenance.
    - Occupational Therapy
        - The full range of activities provided by an occupational therapist, or a licensed occupational therapy assistant under the direction of a licensed occupational therapist, within the scope of his state licensure.
    - Physical Therapy
        - The full range of activities provided by a physical therapist or a licensed physical therapy assistant, under the direction of a licensed physical therapist, within the scope of his state licensure.
    - Respite Care
        - Temporary relief to persons caring for functionally impaired adults in community settings other than AFC homes or AL/RC facilities.
        - Respite services are provided on an in-home basis and out-of-home basis and are limited to 30 days per IPC year.
        - Room and board is included in the waiver payment for out-of-home settings.
    - Speech and/or Language Pathology Therapy
        - The full range of activities provided by speech and language pathologists under the scope of their state licensure.
- Other Community Care (OCC) services – namely:
    - PHC (e.g. primary home care services, family care services, and community attendant services), as well as
    - DAHS
        - Adult day care including nursing services, physical rehabilitation services, nutrition/food service, and other supportive services (e.g. community interaction, cultural enrichment, educational or recreational activities, and other social activities).

- Transportation to/from approved therapies.

Enrollment in an MCO is required for most Medicaid eligibles. This includes Supplemental Security Income (SSI) eligibles age 21 years and over, CBA clients, and, clients entering a NF. SSI eligibles under age 21 years may chose to enroll in an MCO on a voluntary basis.

Since institutionalized members are ultimately disenrolled from the STAR+Plus managed care program, only four risk groups are ultimately developed. They are:

- Medicaid-only OCC (Acute Care and Long-term Care - PHC, DAHS, and NF);
- Medicaid-only CBA (Acute Care and Long-term Care - CBA);
- Dual Eligible OCC (Long-term Care only - PHC, DAHS, and NF); and
- Dual Eligible CBA (Long-term Care only - CBA).

II. Overview of the Rate Setting Methodology

The actuarial approach used to develop the SFY09 STAR+Plus managed care capitation rates incorporates the following components:

- Base period claims costs
- Trend in health care costs
- Programmatic changes
- Anticipated managed care savings
- Provision for administrative expense, risk and contingency margin

The risk groups (or rating populations) used in the analysis are as follows:

- Medicaid-only – OCC
- Medicaid-only – CBA
- Dual Eligible – OCC
- Dual Eligible – CBA

For each of the risk groups, rates were separately determined for acute care services and long-term care services. The summarized acute care service categories used in the analysis include the following:

- Inpatient Hospital Psychiatric Services
- Outpatient Hospital
- Primary Care Physician
- Specialist Physician
- Non-Physician Professional Services
- Other Professional Services
- Behavioral Health Services
- Home Health Services
- Emergency Room Services
- Ambulance Services
- Lab, X-ray and Radiology Services
- Medical Supplies
- EPSDT Medical Services
- Hearing Services

The long-term care services used in the analysis include the following:

- Personal Assistance Services (PAS)
- Respite Care
- Skilled Nursing
- Personal Emergency Response Systems
- Consumer Directed – PAS
- Adult Foster Care
- Assisted Living/Residential Care

- Minor Home Modifications
- Adaptive Aids/Medical Supplies
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Home Delivered Meals
- Transition Assistance Services

Services specifically excluded from the analysis include:

- Prescription Drugs
- Dental and Orthodontia Services

Base Period Claims Costs

The actuarial methodology used to develop the SFY09 STAR+Plus MCO capitation rates relies on State FFS and a combination of MCO encounter and financial experience. The managed care program has existed in the Harris County SDA since 2000. As of February 1, 2007, the State expanded the STAR+Plus managed care program to include the following SDAs:

- Bexar – Contiguous Counties
- Harris – Contiguous Counties
- Nueces – Contiguous Counties
- Travis – Contiguous Counties

Since meaningful FFS claims experience for Harris County is no longer available, historical claims experience for each MCO was analyzed to develop the base period claim cost estimates for this area. For SFY09 rates a 50/50 blend of MCO encounter and financial experience was used. The MCO encounter data reflects experience for SFY06 and SFY07. MCO financial data includes experience for the twelve month period ending February 29, 2008. In addition to direct claims experience (e.g. claims paid on a FFS basis) MCO financial experience reflects expenditures such as capitation payments, reinsurance costs and administrative expenses.

As the four expansion service areas accumulate credible actual experience, the data used for establishing the base period will ultimately mirror that used for Harris County. Until such time, we intend to use a blending of MCO encounter and financial data, as well as historical FFS data for these service areas. For the SFY09 rates we have used a blending of 60/30/10 for MCO financial data, State FFS data, and MCO encounter data, respectively. Each of these items will be discussed further:

- MCO financial data includes experience for the twelve month period ending February 29, 2008.
  - We chose this time period because it represents twelve months of experience under managed care.
  - Although the program began February 1, 2007, the first month of membership reflects a "ramp-up" period. Enrollment by MCO reaches a consistent level by March 1, 2007, which is why we elected to start with this month.
  - Using twelve months of data mitigates the need for seasonality adjustments to the data, which are sometimes necessary when less than a full year are used.
- State FFS data includes the twenty-four month period ending January 31, 2007 for acute care services and SFY06 for LTC services.

    - Acute Care
        - We chose this time period because it includes data up to the date the expansion occurred.
        - Data for this two year period were consistent in aggregate, resulting in increased credibility.
        - Over this two year period we noted that certain service categories experienced wider variation in costs PMPM than were expected. When averaged over the two year period, the results were more reasonable at the service category level.
    - LTC
        - We chose the one year SFY06 time period because it represents the most recent FFS LTC data available at the time of rate development.
- The MCO encounter data for these four service areas reflects experience for the final seven months of SFY07.
    - Because of the reporting requirements, validated encounter experience was not available after August 31, 2007.
    - As noted previously, the program began February 1, 2007. Thus, encounter experience represents only seven months.
    - Because of this, we elected to apply only 10% credibility to this data source.

Ultimately, the Harris County/Contiguous experience was combined to reflect a single region.

In helping HHSC develop these rates, we have relied on the following data sources as provided by HHSC, the participating MCOs, and the agency's External Quality Review Organization (EQRO):

Managed Care Program Information

- Monthly enrollment by risk group for each MCO in Harris County. This includes historical enrollment since September 2004 and a projection of future enrollment through August 2009. These projections were prepared by HHSC System Forecasting staff.
- Encounter data reports by risk group and service category for each MCO with claims incurred for the period September 2005 through August 2007 and paid between September 2005 and November 2007. These reports include monthly paid claims by month of service.
- Financial Statistical Reports (FSR) for each participating MCO for September 1, 2006 through February 29, 2008. The FSRs contain detailed information reported by the MCOs including monthly enrollment, revenue, incurred claims, and administrative expenses.
- MCO encounter claim assessment provided by the agency's EQRO vendor for each participating MCO for services incurred September 1, 2005 through August 31, 2007 and reported through November 30, 2007.
- Additional MCO reported data including: sub-capitation payments, acute care lag data, LTC lag data, claims exceeding $100,000 annually, claims experience under reinsurance contracts, direct service expenses, and third party reimbursements.

State Fee-For-Service Data

Not all FFS claims and member months are applicable to HMO rate setting. Further, coverage limits and parameters of the FFS program differ from that required for HMO coverage for some services. Adjustments to the FFS claims and exposures to account for these items were made. Specifics regarding the adjustments are described in this document.

- Monthly eligibility and claims experience for the Medicaid FFS program.

- Claim lag data representing monthly paid claims by month of service, which were used to establish completion factors to project incurred claims.
- Retroactive eligibility periods for each Medicaid FFS client. We removed these member months and the corresponding claims from the base data used to develop the capitation rates.
- We used STAR+Plus eligibility criteria to identify the Medicaid FFS clients eligible for the STAR+Plus program. Only the member months and claims for these eligibles were included in our analysis.

Other Information

- Current (SFY08) capitation rates by risk group and service category for each MCO.
- Information regarding recent changes in covered services and provider reimbursement under the Medicaid program.

Although the above data was reviewed for reasonableness, Deloitte Consulting did not audit the data.

Trend in Health Care Costs

Having the base data using the respective data sources (e.g. FFS, encounter and financial data), we applied trends to project the corresponding claim costs for SFY09. Trend factors were agreed upon by Texas and the MCO's. We independently measured the trend underlying the various data sources provided to us. We utilized a rolling twelve-month linear regression methodology for our analysis. In our opinion the results of our review indicate that these trend factors are not unreasonable. These factors are described in more detail in Section III.

Programmatic Changes

The claim cost rates thus obtained for SFY09 were then adjusted for the following items:

- The Legislature had previously required a 1.1% cost reduction across-the-board for LTC services. Thus, the LTC rates had been reduced by 1.1% to reflect this mandate. That 1.1% reduction was reinstated for SFY06. The LTC rates for SFY09 reflect this reinstatement.
- The claim cost rates have been increased to reflect the cost of other services. These other services include capitation payments, care coordination, reinsurance premiums, and cost settlements.
- Recent legislative changes to provider reimbursement have been incorporated as well. These represent adjustments for:
  - Restoration of rates for prior rate reductions for professional services
  - State Teaching Rate Increase
  - PT/OT/ST Rate Increase
  - Physician Drugs Rate Decrease
  - Ambulance Rate Increase
  - LTC Attendant Care Rate Increase
  - LTC Provider Rate Increase
  - LTC Minimum Wage Increase
  - Mental Health Facility Rate Increase
  - Obstetrical Sonogram Rate Increase
  - Nursing Facility Rate Increase
  - NF Provider Rate Increase
  - Cap to Qualify for CBA
  - Frew Unit Cost < 21

- Frew Unit Cost >= 21
- Frew Utilization < 21
- Statewide Rebasing of Hospital I/P Psychiatric Costs

Anticipated Managed Care Savings

Managed care adjustments account for variations in the health care delivery patterns between managed care and FFS. Typically, MCOs strive to facilitate the use of lower cost services in place of higher cost services, such as inpatient facilities. When FFS data is used as the base data, it is appropriate to adjust these historical results to reflect anticipated savings from managed care.

Provision for Administrative Expense, Risk and Contingency Margin

Exhibit C displays the detail involved in the adjustments for the costs of other services and exclusions. SFY09 capitation rates include a fixed $50.00 PMPM provisions for administrative expense, risk and contingency margin. This margin consists of:

- A fixed $50.00, which is intended to account for:
  - Premium tax of 1.75% of the capitation rate,
  - Provision for risk margin representing approximately 1.4% across all rate cells, and
  - A load for administrative (or non-benefit) expenses of approximately 7.4% across all rate cells.

III. Adjustment Factors

This section contains a description of the adjustment factors used in the SFY09 STAR+Plus rate setting process. We have classified each adjustment based on the point in the rate setting process where the adjustment has been applied; namely, an adjustment to the base data, trend, programmatic changes, managed care adjustment, or administrative adjustment.

Base Data Adjustments

IBNP Adjustments

In order to account for any claims that may still be outstanding in the FFS data we used Incurred But Not Paid (IBNP) adjustments to complete the data. For Harris County, the IBNP adjustments are based on information received from Texas. For all other service areas, we calculated completion factors for acute care services using standard actuarial techniques and the LTC IBNP adjustments are based on information received from Texas. The following tables show the IBNP adjustments for FFS claims, encounter claims, and financial data.

Type of Service	FFS Adjustment
AC IP Hosp	1.0002
AC OP Hosp	1.0003
AC Phys/Other	1.0010
LTC	1.0006

Type of Service	Encounter Adjustment				
	Bexar	Nueces	Travis	Harris County	Harris Contiguous
AC IP Hosp	1.0446	1.0298	1.0586	1.0133	1.0306
AC OP Hosp	1.0446	1.0298	1.0586	1.0133	1.0306
AC Phys/Other	1.0595	1.0312	1.0809	1.0142	1.0512
LTC	1.0409	1.0241	1.0466	1.0105	1.0420

Type of Service	Financial Adjustment			
	Bexar	Nueces	Travis	Harris County and Contiguous
AC IP Hosp	1.2105	1.1301	1.3661	1.2695
AC OP Hosp	1.2105	1.1301	1.3661	1.2695
AC Phys/Other	1.2105	1.1301	1.3661	1.2695
LTC	1.2291	1.1408	1.1739	1.1869

Large Claim Adjustments

In order to smooth any potential volatility as a result of an abnormal distribution of catastrophic claims in the experience period medical claims greater than $100,000 were reviewed. The number of members with these claims was prevalent mostly within the Medicaid Only OCC risk group. An analysis was performed to redistribute claims in excess of $100,000 evenly based on membership. As a result of this analysis, the following table highlights the adjustment factors applied to each service area.

Service Area	FFS Adjustment	Encounter Adjustment
Bexar Service Area	0.993	1.010
Nueces Service Area	1.017	1.007
Travis Service Area	0.995	1.014
Harris County		1.002
Harris Contiguous	0.999	0.960

Attendant Care / Enhanced Payments

The legislature required that the State make available enhanced payments to providers that utilize attendants. The FFS data included the enhanced payments, however the MCOs within the STAR+Plus program received these payments off line. We applied the following factors to the rates.

Risk Group	Adjustment Factor
Medicaid Only OCC	1.059
Medicaid Only CBA	1.002
Dual Eligible OCC	1.025
Dual Eligible CBA	1.002

Nursing Facility Rate Increase

State changes the way nursing home are reimbursed for SFY09. This leads to a 5.8% rate increase for nursing facility. We have increased the LTC portion of the rates for all service areas by .26% to reflect this change.

CBA Area Factors

For the Medicaid Only CBA and Dual Eligible CBA risk groups, the FFS data was not credible at a service area level. In order to account for this, area factors were developed using all CBA data. The "manual rate" assumed was the aggregate FFS PMPM for the appropriate risk group (Medicaid Only CBA or Dual Eligible CBA) across all service areas. The area factor was then applied with 50% credibility. The following table outlines the final factor used to adjust CBA data for Medicaid Only and Dual Eligible members.

Risk Group	Adjustment Factor
Medicaid Only OCC	1.007
Medicaid Only CBA	0.949
Dual Eligible OCC	1.064
Dual Eligible CBA	0.968

Long Term Care PMPM Adjustments

Care coordination and functional assessment are considered long term care service costs under STAR+Plus. We have added these PMPM costs to our base data for rate calculation.

Risk Group	LTC Care Coordination[1]	LTC Functional Assessment[2]
Medicaid Only OCC	$18.27	$3.11
Medicaid Only CBA	$18.42	$79.37
Dual Eligible OCC	$17.94	$3.11
Dual Eligible CBA	$18.00	$79.37

[1] Applied to FFS data only

[2] Applied to FFS, financial and encounter data

Trend

Enrollment Trend Rates

HHSC developed projections of member months for SFY08 and SFY09, which serve as the basis for estimating total program costs and average program increases from year-to-year. The Medicaid Only trend rate shown below was derived from the expected disabled and blind caseloads developed by HHSC. The Dual Eligible trend rate shown below was also developed by HHSC based on expected aged and Medicare related caseloads. The trending period corresponds to enrollment that will be effective for the period September 1, 2008 through August 31, 2009.

Eligibility Category	SFY08	SFY09	Trend
Medicaid Only	878,428	927,602	5.60%
Dual Eligible	968,796	981,554	1.32%

Medical Trend Factors

The rating methodology uses assumed trend factors to adjust the base period claims cost to the projection period. The factors used in this analysis reflect a combination of utilization and unit cost trend components. The trends used to project claim costs to SFY09 were calculated using FFS data and the expected impact of future budget allocations. These expected trends have been discussed with Texas personnel.

Type of Service	Trend
Acute Inpatient Hospital	2.20%
Acute Outpatient Hospital	5.25%
Acute Physician and Other	5.25%
LTC	5.25%

The trends reflect per member per month cost changes including changes due to utilization, mix of services, and unit cost changes. We also considered the fact that budget allocation increases must also address expected increases in enrollment. The trending period varies based on the center point of the base period, but corresponds to rates that will be effective for the period September 1, 2008 through August 31, 2009.

Programmatic Changes

First Four Months of CBA

When the eligibility status of a STAR+Plus member changes from OCC to CBA, there is a four month lag until the CBA capitation payments begin. We reviewed the fee-for service (FFS) data for members with a change in eligibility status from OCC to CBA, and we calculated adjustments to move their costs for the first four months of CBA eligibility (remove from CBA; add to OCC). We applied the following factors to the non-Harris County rates.

Risk Group	Acute Care Non-Inpatient	LTC
Medicaid Only OCC	1.002	1.018
Medicaid Only CBA	0.975	1.000
Dual Eligible OCC	1.002	1.018
Dual Eligible CBA	0.975	1.000

Inpatient Psychiatric Providers

All inpatient facility costs are excluded from the rates, with the exception of inpatient psychiatric providers. Services for inpatient psychiatric providers are included in the calculation of the rates, however, and include a 22% managed care savings adjustment in the expansion areas for the base data representing FFS claims. Since financial and encounter data already reflect managed care savings, no adjustment is necessary for these two data sources.

Managed Care Savings Assumptions

The following shows the managed care savings assumptions used in the rate setting. We based the savings on market conditions to represent targets for a well-managed HMO. These adjustments were only applied to FFS data, since MCO encounter and financial data already reflect managed care savings.

	AC - IP		AC OP Hosp		AC Phys/Other							
Risk Group	Non-Pschy	Pschy	ER	Non-ER	Phy PCP	Phy Spec	Non-Phy	Amb	Home Hlth	Behav Hlth	Other Other	LTC LTC
Non-Harris Medicaid Only OCC	22.0%	22.0%	15.0%	15.0%	0.0%	0.0%	15.0%	15.0%	15.0%	15.0%	15.0%	10.0%
Non-Harris Medicaid Only CBA	22.0%	22.0%	15.0%	15.0%	0.0%	0.0%	15.0%	15.0%	15.0%	15.0%	15.0%	10.0%
Non-Harris Dual Eligible OCC	22.0%	22.0%	15.0%	15.0%	0.0%	0.0%	15.0%	15.0%	15.0%	15.0%	15.0%	10.0%
Non-Harris Dual Eligible CBA	22.0%	22.0%	15.0%	15.0%	0.0%	0.0%	15.0%	15.0%	15.0%	15.0%	15.0%	10.0%
Harris County Medicaid Only OCC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Harris County Medicaid Only CBA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Harris County Dual Eligible OCC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Harris County Dual Eligible CBA	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Administrative Adjustments

Risk Adjustment

Under the STAR program, the state adjusts the acute care rates based on an analysis using the Chronic Illness and Disablity Payment System (CDPS) risk adjustment methodology. The risk adjustment mechanism is intended to better align reimbursement with risk (or costs) and to be cost-neutral.

Since this adjustment is based on the health risk of members enrolling within an MCO historically, this adjustment cannot be made until sufficient credible experience exists under the STAR+Plus Expansion program. Because the capitation rate in Harris County has been blended with the counties contiguous to Harris County, it is not appropriate to base this adjustment on the historical managed care experience within Harris County only.

Third Party Liability (TPL)

Third Party Liability collections were compiled by the State for the populations in the STAR+Plus expansion program. For SFY09 rates this adjustment represents 0.425% of paid dollars.

Investment Income Adjustments

An adjustment was made to account for potential investment income due to timing of capitation payments. An assumed 2.5% interest rate was used. For the FFS acute care portion of the capitation rates this adjustment is applied for 1.38 months, while it is applied for 2.20 months for the LTC portion of FFS claims. This resulted in an adjustment factor of .9972 for the acute care portion and .9955 for the LTC portion, respectively, for FFS claims. The following two tables present the adjustments applied separately to the financial and encounter data.

Encounters	Bexar		Nueces		Travis		Harris County		Harris Contiguous	
	Acute	LTC	Acute	LTC	Acute	LTC	Acute	LTC	Acute	LTC
Lag Period (months)	1.68	1.73	1.28	1.62	2.27	1.72	1.76	2.07	1.77	1.93
Adjustment Factor	0.9966	0.9964	0.9974	0.9967	0.9953	0.9965	0.9964	0.9957	0.9964	0.996

Financials	Bexar		Nueces		Travis		Harris County / Contiguous	
	Acute	LTC	Acute	LTC	Acute	LTC	Acute	LTC
Lag Period (months)	2.25	2.62	1.52	1.53	2.79	1.85	2.36	1.49
Adjustment Factor	0.9954	0.9946	0.9969	0.9969	0.9943	0.9962	0.9952	0.9969

Administrative Fees and Risk Margin

The rating methodology includes an explicit provision for administrative expenses. SFY09 capitation rates include a fixed $50.00 PMPM provisions for administrative expense, risk and contingency margin. This amount is intended to provide for all administrative-related services performed by the MCO. Additionally, this amount also includes a risk and contingency margin equal to 1.4% of the total capitation rate.

IV. Summary of Final Rates

The table below presents a summary of the SFY09 STAR+Plus rates.

Service Area / Risk Group	Estimated Member Months	Capitation Rates
Bexar Medicaid Only OCC	232,786	$526.51
Bexar Medicaid Only CBA	4,849	$2,748.46
Bexar Dual Eligible OCC	250,806	$287.26
Bexar Dual Eligible CBA	21,168	$1,845.00
Nueces Medicaid Only OCC	87,343	$614.57
Nueces Medicaid Only CBA	2,458	$2,487.20
Nueces Dual Eligible OCC	103,828	$393.22
Nueces Dual Eligible CBA	14,503	$1,672.29
Travis Medicaid Only OCC	77,540	$474.53
Travis Medicaid Only CBA	2,119	$2,911.01
Travis Dual Eligible OCC	87,610	$226.06
Travis Dual Eligible CBA	9,803	$1,909.10
Harris County/Contiguous (Combined)		
Medicaid Only OCC	509,386	$543.49
Medicaid Only CBA	11,121	$2,838.51
Dual Eligible OCC	464,295	$221.34
Dual Eligible CBA	29,541	$1,444.19

Statistical error and uncertainty are inherent in any rate development process. The final managed care rates represent a "best estimate" of the anticipated cost to provide services during SFY09 for the populations to be covered. The State offers these rates on a "take it or leave it" basis. In general, these rates are intended to provide sufficient margin so that insolvency is not a significant risk for an appropriately managed MCO, while also mitigating the risk that the capitation revenue received by an MCO is not so large that the State is at risk of paying too much for the provision of health care for eligible recipients. These best estimate rates are actuarial projections of future contingent events. Actual MCO costs will differ from these projections. MCOs are advised that the use of these rates may not be appropriate for their particular circumstance, and Deloitte Consulting disclaims any responsibility for the use of these rates by MCOs for any purpose. Deloitte Consulting recommends that any MCO considering contracting with the HHSC should analyze its own projected medical expense, administrative expense, and any other premium requirements for comparison to these rates before deciding whether to contract with the HHSC.

V. Actuarial Certification of SFY09 STAR+Plus MCO Capitation Rates

I, Steven N. Wander, am a Principal with Deloitte Consulting, LLP. 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.

The Texas Health and Human Services Commission (HHSC) retained Deloitte Consulting to assist in the development of the managed care rate-setting methodology, assumptions and resulting capitation rates, as well as to provide the actuarial certification required under the Centers for Medicare and Medicaid Services (CMS) requirements 42 CFR 438.6(c) for SFY09.

I certify that the SFY09 MCO capitation rates developed by HHSC and Deloitte Consulting satisfy the following:

- The capitation rates have been developed in accordance with generally accepted actuarial principals and practices;
- The capitation rates are appropriate for the populations and services covered under the managed care contract; and
- The capitation rates are actuarially sound as defined in the regulations.

In developing these capitation rates I have relied on historical claim experience data and program information provided to us by HHSC. I have reviewed the data for reasonableness but have not audited the data.

Rates developed by HHSC and Deloitte Consulting are actuarial projections of future contingent events. Actual MCO costs will differ from these projections. HHSC and Deloitte Consulting have developed these rates to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and are in accordance with applicable law and regulations. MCOs are advised that the use of these rates may not be appropriate for their particular circumstance, and Deloitte Consulting disclaims any responsibility for the use of these rates by MCOs for any purpose. Deloitte Consulting recommends that any MCO considering contracting with the HHSC should analyze its own projected medical expense, administrative expense, and any other premium requirements for comparison to these rates before deciding whether to contract with the HHSC. Use of these rates for any purpose beyond that stated may not be appropriate.

Steven N. Wander, F.S.A., M.A.A.A.