STATE OF TEXAS
MEDICAID MANAGED CARE EXPANSION
STAR+PLUS PROGRAM RATE SETTING
EL PASO, HIDALGO AND LUBBOCK
SERVICE AREAS
MARCH 1, 2012

Prepared for:
Texas Health and Human Services Commission

Prepared by:
Evan L. Dial, F.S.A., M.A.A.A
Rudd and Wisdom, Inc.

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I. Introduction

Effective March 1, 2012 the Medicaid STAR+PLUS program will expand to include three new service areas. The El Paso Service Delivery Area (SDA) will include the two counties currently making up the El Paso SDA in the STAR program. The Lubbock SDA will include the fifteen counties currently making up the Lubbock SDA in the STAR program. The Hidalgo SDA will include ten counties in the South Texas region.

Rudd and Wisdom, Inc. has been retained by the Texas Health and Human Services Commission (HHSC) to develop the March 1, 2012 through August 31, 2012 premium rates for HMOs participating in the Texas Medicaid STAR+PLUS program expansion in the El Paso, Hidalgo and Lubbock Service Areas. This report presents the rating methodology and assumptions used in developing the premium rates.

Rudd and Wisdom has provided actuarial services to the Texas Medicaid program for over 25 years. We have participated in the state's managed care rating process since its inception in 1993. This year, as in previous years, we have worked closely with HHSC in developing the HMO premium rates.

Rudd and Wisdom has relied on the following data sources as provided by HHSC:

- Monthly enrollment by risk group for the fee-for-service program, primary care case management program and SSI members voluntarily enrolled in STAR managed care plans. This includes historical enrollment since September 2007 and a projection of future enrollment through August 2012. These projections were prepared by HHSC System Forecasting staff.
- Acute care fee-for-service claims data. Data was collected separately for inpatient and all other acute care services for the period September 2007 through August 2011. These reports (ST750 and ST650) include paid claim amounts by month of service. Only those services which are the financial responsibility of the health plan were included in the capitation rates.
- Acute care claims data for SSI members enrolled in the primary care case management program or voluntarily enrolled in STAR managed care plans. Data was collected separately for inpatient and all other acute care services for the period September 2007 through August 2011. These reports (ST750 and ST650) include paid claim amounts by month of service split between individuals over and under age 21. Only those services which are the financial responsibility of the health plan were included in the capitation rate.
- Long term care and nursing facility claims data for the period September 2007 through August 2011. Long term care claims were provided separately for individuals over and under age 21.
- Claim lag reports by risk group for each current STAR+PLUS health plan for the period September 2007 through February 2011. These reports include monthly paid claims by type of service and were used to develop trend estimates.
- Information from HHSC regarding recent changes in covered services and provider reimbursement under the Medicaid program.

- Information from current STAR+PLUS HMOs regarding attendant care enhanced payments, nursing facility recoupments and service coordination expenses.
- Information provided by HHSC regarding proposed FY2012 Medicaid provider reimbursement rates.
- Information provided by HHSC regarding DRG rebasing.

Although the above data was reviewed for reasonableness, Rudd and Wisdom did not audit the data.

II. Overview of the Rate Setting Methodology

The actuarial model used to derive the March 1, 2012 through August 31, 2012 El Paso, Hidalgo and Lubbock STAR+PLUS HMO premium rates relies primarily on fee-for-service, voluntary managed care and primary care case management program financial experience. The historical claims experience for each area was analyzed and estimates for the base period (FY2010) were developed. These estimates were then projected forward to FY2012 using actual and assumed trend rates. Other plan expenditures such as service coordination and administrative expenses were added to the claims component in order to project the total March 1, 2012 through August 31, 2012 cost under the STAR+PLUS program. These projected total cost rates were determined separately for each risk group to develop a set of community rates for each service area.

The managed care service areas used in the analysis were as follows:

- El Paso County Service Area (El Paso)
- Hidalgo County Service Area (Hidalgo)
- Lubbock County Service Area (Lubbock)

The two counties included in the El Paso SDA are:

- El Paso County
- Hudspeth County

The ten counties included in the Hidalgo SDA are:

- Cameron County
- Duval County
- Hidalgo County
- Jim Hogg County
- Maverick County
- McMullen County
- Starr County
- Webb County
- Willacy County
- Zapata County

The fifteen counties included in the Lubbock SDA are:

- Carson County
- Crosby County
- Deaf Smith County
- Floyd County
- Garza County
- Hale County
- Hockley County
- Hutchinson County
- Lamb County
- Lubbock County

- Lynn County
- Potter County
- Randall County
- Swisher County
- Terry County

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

- Medicaid Only – Other Community Care (OCC)
- Medicaid Only – Community Based Alternative (CBA)
- Dual Eligible - OCC
- Dual Eligible - CBA

The services used in the analysis include the following:

Acute Care Services
- Ambulance Services
- Audiology Services
- Behavioral Health Services
- Birthing Center Services
- Chiropractic Services
- Dialysis
- Durable Medical Equipment and Supplies
- Emergency Services
- Family Planning Services
- Home Health Services
- Hospital Services - outpatient
- Lab, X-ray and Radiology Services
- Medical Check-ups and CCP Services for children under age 21
- Optometry
- Podiatry
- Prenatal Care
- Primary Care Services
- Specialty Physician Services
- Therapies – physical, occupational and speech
- Transplantation of Organs and Tissues
- Vision

Long Term Care Services
- Adult Foster Care
- Adaptive Aids and Medical Equipment
- Assisted Living
- Emergency Response Services
- Home Delivered Meals
- Medical Supplies
- Minor Home Modifications
- Nursing Services (in home)
- Personal Attendant Services
- Therapies – physical, occupational and speech

- Transition Services

Services specifically excluded from the analysis include:

- Inpatient Facility Services
- Nursing Facilities
- Prescription Drugs
- Dental and Orthodontia Services

Information regarding the carve-in of inpatient facility services into the STAR+PLUS program can be found in the report titled State of Texas Medicaid Managed Care Rate Setting STAR+PLUS Inpatient Carve-in March 1, 2012 and dated January 16, 2012. Information regarding the carve-in of prescription drugs into the STAR program can be found in the report titled State of Texas Medicaid Managed Care Rate Setting Pharmacy Carve-in March 1, 2012 and dated January 16, 2012.

The analysis of base period claims experience for each service area attempted to identify and adjust for any distortions in the data. Significant variations in experience, including the impact from unusually large individual claims, were investigated and adjustments were made if deemed appropriate.

HHSC utilizes a community rating methodology in setting the STAR+PLUS base premium rates. The base rates vary by service area and risk group but are the same for each HMO in a service area. Attachment 2 presents the summary community rating exhibit for each service area along with a description of the analysis.

III. Adjustment Factors

This section contains a description of the adjustment factors used in the El Paso, Hidalgo and Lubbock March 1, 2012 through August 31, 2012 STAR+PLUS rate setting process.

Trend Factors

The rating methodology uses actual and assumed trend factors to adjust the base period claims cost to the projection period. The cost trend factors used in this analysis are a combination of utilization and inflation components. Separate trend factors were developed by type of service – acute care and long term care services. The projected trend rate assumptions were developed by the actuary based on an analysis of recent experience under the various HMO plans in the current STAR+PLUS areas (Bexar, Harris, Nueces and Travis) along with the Medicaid Fee-for-Service (FFS) and Primary Care Case Management (PCCM) plans. A single trend assumption applied to all service areas but varies by risk group, type of service and projection year (FY2011 and FY2012).

The El Paso, Hidalgo and Lubbock rating analysis uses actual FY2011 trend experience by area and type of service during the period September 2010 through June 2011. FY2011 trend information can be found in Attachment 3 and Attachment 4. The FY2012 trend assumptions are the same as those trend assumptions used in the FY2012 STAR+PLUS rate setting project for the existing STAR+PLUS areas. Additional information regarding the assumed trends is available from the report titled "State of Texas Medicaid Managed Care STAR+PLUS Program Rate Setting State Fiscal Year 2012". The chart below presents the assumed annual trend rates for FY2011 and FY2012 by area and type of service.

	El Paso	Hidalgo	Lubbock
FY2011			
Acute Care			
-Medicaid Only <21	2.5%	5.7%	4.7%
-Medicaid Only >21	2.5%	5.7%	4.7%
-Dual Eligible	N/A	N/A	N/A
Long Term Care			
-Medicaid Only <21	62.0%	31.6%	38.1%
-Medicaid Only >21	5.0%	2.9%	2.1%
-Dual Eligible	6.2%	2.1%	5.8%
FY2012			
Acute Care			
-Medicaid Only <21	7.0%	7.0%	7.0%
-Medicaid Only >21	7.0%	7.0%	7.0%
-Dual Eligible	N/A	N/A	N/A
Long Term Care			
-Medicaid Only <21	5.2%	5.2%	5.2%
-Medicaid Only >21	5.2%	5.2%	5.2%
-Dual Eligible	1.5%	1.5%	1.5%

Provider Reimbursement Adjustments

The legislative mandated provider rate reductions effective September 1, 2011 included the following:

- 8% hospital rate reduction (Outpatient facility is included in this section. Inpatient is included elsewhere.)
- 10.5% laboratory rate reduction (excludes DSHS and physician lab)
- Varying durable medical equipment reductions. Achieve via targeted rate reductions that vary by service
- 5% reduction for all other providers excluding ambulance, private duty nursing (children only), home health (children only), dental, orthodontics, physicians (includes psychiatrists, optometrists, radiologists, podiatrists and orthodontists), FQHCs, Rural Health Centers and TEFRA reimbursed hospitals.

Medicaid provider reimbursement changes were also recognized for the two one percent provider rate cuts effective 9/1/2010 and 2/1/2011 and the transition of outpatient imaging services to a fee schedule. The adjustment factors used for the El Paso, Hidalgo and Lubbock SDAs for legislative reductions, the two one percent provider rate cuts and the outpatient imaging fee schedule were the statewide average of the factors used in developing the STAR rates. Please see the report titled "State of Texas Medicaid Managed Care STAR+PLUS Program Rate Setting State Fiscal Year 2012" and the letter amending this report titled STAR+PLUS Rate Amendment and dated November 10, 2011 for additional information regarding these factors.

Additional Medicaid provider reimbursement changes were provided for the following services: non-emergent services provided in an emergency room, durable medical equipment and therapy services. The adjustment factors for these changes can be found in Attachment 5.

Impact of Newly Capitated Services

Effective March 1, 2012 certain early childhood intervention services along with hearing and audiology services for children will become capitated services. Prior to March 1, 2012 these services were carved out of the STAR+PLUS program and paid on a fee-for-service basis. The adjustment factor for these changes can be found in Attachment 5

Personal Assistance Services Reimbursement Adjustment

Effective September 1, 2011 the reimbursement for personal assistance services (PAS) was reduced by $0.46 per unit for CBA clients. Attachment 5 presents a summary of the derivation of the adjustment factor.

Care Coordination

STAR+PLUS includes enhanced care coordination services provided by the health plans to achieve an integrated care environment. Care Coordination is not included in the fee-for-service program so the average care coordination expense of $12.70 pmpm for the current STAR+PLUS health plans has been included in the expansion area rates.

Managed Care Efficiency

Our rating analysis includes an explicit assumption regarding the anticipated reduction in claims cost resulting from the implementation of managed care. In deriving the managed care efficiency factor, we relied upon experience from previous STAR+PLUS expansions. The following table includes the managed care savings assumptions by type of service for the El Paso and Lubbock service areas:

Acute Care (non-inpatient)	10%
Long Term Care	5%

For clients currently volunteering into managed care in the STAR program no additional managed care efficiency was assumed for their acute care moving to the STAR+PLUS model.

The average acute care cost in the Hidalgo service area has been in excess of 135% of the statewide average for all existing STAR+PLUS areas. Average long term care cost in this area is in excess of 300% of the statewide average for all existing STAR+PLUS areas. Based on the elevated levels of cost, it is anticipated that the managed care savings will be significantly greater than those experienced in the other STAR+PLUS areas. The following table includes the managed care savings assumptions by type of service for the Hidalgo service area:

Acute Care (non-inpatient)	30%
Long Term Care	30%

These discount factors are intended to reflect the reduction in average claim costs during the initial six month period of March 1, 2012 through August 31, 2012. The full difference between the Hidalgo SDA and the statewide STAR+PLUS average will not immediately be achieved; however it is anticipated that the savings will increase over time, particularly on long term care services through increased management of the STAR+PLUS population and a reassessment of the services currently being provided.

OCC/CBA Adjustment

The base period experience data is categorized by dual eligible (eligible for both Medicare and Medicaid) and Medicaid-only status but does not further stratify the data between the OCC and CBA risk groups. In order to develop capitation rates for the appropriate risk groups, an estimated CBA to OCC ratio has been calculated. This ratio is based on the current relationship between the OCC and CBA capitation rates in the current STAR+PLUS areas (Bexar, Harris, Nueces and Travis) and varies by type of service – acute care and long term care. Attachment 6 presents the derivation of this adjustment and its application.

IV. Administrative Fees and Risk Margin

The rating methodology includes an explicit provision for administrative services. The amount allocated for administrative expenses is $12.50 pmpm plus 5.75% of gross premium. This amount is intended to provide for all administrative-related services performed by the HMO.

The administrative fee amounts were determined based on a review of (i) the administrative fee provision included in Medicaid HMO premium rates in other states, (ii) the reported administrative expenses of the current STAR+PLUS HMOs and (iii) the fees paid for similar services for other large Texas health plans.

The premium rates also include an amount for premium tax (1.75% of premium), maintenance tax ($0.105 pmpm) and a risk margin (2.0% of premium).

V. Summary

The chart below presents the results of the March 1, 2012 through August 31, 2012 El Paso, Hidalgo and Lubbock STAR+PLUS rating analysis.

Health Plan	Medicaid Only OCC	Medicaid Only CBA	Dual Eligible OCC	Dual Eligible CBA
Monthly Premium Rates				
El Paso	$448.86	$2,250.14	$217.91	$1,412.07
Hidalgo	633.69	4,122.70	459.93	2,980.34
Lubbock	471.92	1,987.62	154.62	1,001.91

The above premium rates include provision for 1915(b)(3) waiver services. The STAR+PLUS HMOs in the El Paso, Hidalgo and Lubbock SDAs cover adult inpatient hospital days in excess of thirty. The chart below presents the amount included in the March 1, 2012 through August 31, 2012 STAR+PLUS HMO premium rates for 1915(b)(3) waiver services.

Health Plan	Medicaid Only - OCC	Medicaid Only - CBA
Monthly Premium Rate for 1915(b)(3) Services		
El Paso	$ 0.44	$ 0.44
Hidalgo	0.44	0.44
Lubbock	0.44	0.44

VI. Actuarial Certification of March 1, 2012 through August 31, 2012 STAR+PLUS El Paso, Hidalgo and Lubbock Expansion HMO Premium Rates

I, Evan L. Dial, 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 their March 1, 2012 through August 31, 2012 managed care rate-setting methodology, assumptions and resulting premium rates for the STAR+PLUS expansion to the El Paso, Hidalgo and Lubbock service areas and to provide the actuarial certification required under Centers for Medicare and Medicaid Services (CMS) requirements 42 CFR 438.6(c).

I certify that the March 1, 2012 through August 31, 2012 HMO premium rates developed by HHSC and Rudd and Wisdom for the STAR+PLUS expansion satisfy the following:

(a) The premium rates have been developed in accordance with generally accepted actuarial principals 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.

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 438.6(c). Any health plan contracting with the State should analyze its own projected premium needs before deciding whether to contract with the State.

Evan L. Dial, F.S.A., M.A.A.A.

VII. Attachments

Attachment 1

Summary of March 1, 2012 through August 31, 2012 El Paso, Hidalgo and Lubbock STAR+PLUS Rating Analysis

The attached exhibit presents summary information regarding the March 1, 2012 through August 31, 2012 rates. Included on the exhibit are projected March 1, 2012 through August 31, 2012 enrollment, March 1, 2012 through August 31, 2012 premium rates and projected total March 1, 2012 through August 31, 2012 premium.

Attachment 2

Community Experience Analysis

The following exhibits present a summary of the experience analysis performed for each managed care service area. HHSC utilizes a community rating methodology in setting the STAR+PLUS premium rates. The base community rates by risk group vary by service area but are the same for each HMO in a service area.

Below is a brief description of the exhibits contained in this attachment. The exhibits present the derivation of the March 1, 2012 through August 31, 2012 STAR+PLUS HMO community rates for the following service areas:

Exhibit A – El Paso Service Area
Exhibit B – Hidalgo Service Area
Exhibit C – Lubbock Service Area

These exhibits show projected March 1, 2012 through August 31, 2012 experience for each of the service areas for all dual eligible and Medicaid only clients combined. The experience for Medicaid only clients is categorized according to client age – over and under age 21. The experience has been split by age due to an anticipated difference in the distribution of Medicaid only clients once the STAR+PLUS program begins from what is included in the base period experience. Historical experience data is not separately available based on OCC and CBA classification. A separate adjustment (as discussed in Attachment 6) is included to develop rates separately for the OCC and CBA risk groups.

The top portion of the exhibit shows summary base period (FY2010) experience separately for members in the fee-for-service (FFS) program and disabled clients voluntarily enrolled in a STAR health plan or enrolled in the primary care case management (PCCM) program. The base period experience is also provided separately for acute care and long term care services. The calculation of the average long term care cost per member per month excludes all clients in a nursing facility because these members do not receive long term care services and will not be enrolled in STAR+PLUS.

The next section shows projected March 1, 2012 through August 31, 2012 enrollment based on the program and age (FFS or managed care; over 21 and under 21) from which the STAR+PLUS enrollment will be formed. For example, all dual eligible clients moving into STAR+PLUS will be former FFS clients while the majority of Medicaid only clients moving into STAR+PLUS will be former voluntary managed care clients over age 21 who were previously enrolled in a STAR health plan. Medicaid only clients in the Hidalgo service area were previously enrolled in the PCCM program. In addition, it has been assumed that the STAR+PLUS enrollment will be more heavily concentrated with adults and fewer children will voluntarily enroll. This assumption is based on past experience in the other STAR+PLUS areas.

Projected March 1, 2012 through August 31, 2012 incurred claims are developed separately for acute care and long term care based on the adjustment factors discussed throughout the report. Managed care efficiency factors, which vary by type of service, are intended to reflect the anticipated cost difference of transitioning to the STAR+PLUS program.

A provision of $12.70 pmpm for the care coordination services to be provided by the HMOs is included. Additionally, a provision for administrative expenses is included in the amount of $12.50 pmpm and 5.75% of gross premium. Additional provisions are also included for premium tax (1.75% of premium), maintenance tax ($0.105 pmpm) and risk margin (2.0% of premium).

The bottom of the exhibit shows a summary of the projected March 1, 2012 through August 31, 2012 cost based on these assumptions. Cost projections are presented separately for acute care and long term care services. The Medicaid only cost projection is calculated as the weighted average of the under age 21 and over age 21 cost projection with projected March 1, 2012 through August 31, 2012 enrollment used as the weights.

Attachment 3

Incurred Claims Analysis – Acute Care – Non Inpatient

Exhibit A presents our analysis of Fee-for-Service (FFS) plan incurred claims experience for the El Paso, Hidalgo and Lubbock SDAs for all acute care services excluding inpatient hospital services. The exhibit includes the following information: (i) monthly enrollment, (ii) claim amounts incurred in that month and paid through August 31, 2011, (iii) estimated proportion of that month's incurred claims paid through August 31, 2011 (completion factor), (iv) estimated incurred claims, (v) estimated incurred claims per member per month (pmpm) and (vi) the ratio of this month's incurred claims pmpm to the same statistic from one year ago (trend factor).

Exhibit B presents the same information for those clients enrolled in the PCCM program or voluntarily enrolled in STAR health plans in the El Paso and Lubbock SDAs and those clients enrolled in the PCCM program in the Hidalgo SDA split between over and under age 21.

Attachment 4

Incurred Claims Analysis – Long Term Care

The attached exhibit presents our analysis of the incurred claims experience for the El Paso, Hidalgo and Lubbock SDAs for all long term care services for all clients (FFS and managed care combined) split by over and under age 21. The exhibit includes the following information: (i) monthly enrollment, (ii) claim amounts incurred in that month and paid through August 31, 2011, (iii) estimated proportion of that month's incurred claims paid through August 31, 2011 (completion factor), (iv) estimated incurred claims, (v) estimated incurred claims per member per month (pmpm) and (vi) the ratio of this month's incurred claims pmpm to the same statistic from one year ago (trend factor).

Attachment 5

Provider Reimbursement and Benefit Revisions Effective During FY2012

This attachment presents information regarding rating adjustments for the provider reimbursement and benefit revisions that became effective (or will become effective) after the base period used in rate setting (FY2010) and before the end of FY2012.

Medicaid provider reimbursement changes were provided for the following services: the two one percent provider rate cuts effective 9/1/2010 and 2/1/2011, DRG rebasing, legislative mandated provider rate reductions, the transition of outpatient imaging services to a fee schedule, 40% reduction for non emergent services provided in an emergency room, provider reimbursement revision for therapy and durable medical equipment and the capitation of certain early childhood intervention services and hearing and audiology services for children.

The legislative mandated provider rate reductions included the following:

- 8% hospital rate reduction
- 10.5% laboratory rate reduction (excludes DSHS and physician lab)
- Variable durable medical equipment reduction. Achieve via targeted rate reductions that vary by service
- 5% reduction for all other providers excluding ambulance, private duty nursing (children only), home health (children only), dental, orthodontics, physicians (includes psychiatrists, optometrists, radiologists, podiatrists and orthodontists), FQHCs, Rural Health Centers and TEFRA reimbursed hospitals.

The attached exhibit presents a summary of the following adjustments:

Effective September 1, 2010 and again on February 1, 2011, Medicaid reduced reimbursement by 1% for most acute care services.

Effective September 1, 2011, HHSC implemented legislative mandated provider rate reductions described above.

Effective September 1, 2011, HHSC rebased the DRG reimbursement system and required rural hospitals to be reimbursed their full cost standard dollar amount. This rebasing effort was intended to update the Standard Dollar Amounts and Relative Weights used in the Medicaid DRG payment system.

Effective September 1, 2011, HHSC implemented a new fee schedule for outpatient imaging services.

Effective September 1, 2011 Medicaid reduced reimbursement paid for personal assistance services (PAS) rendered to CBA clients by $0.46 per unit of service.

Effective March 1, 2012 Medicaid will reduce reimbursement paid for non emergent services provided in an emergency room by 40%.

Effective March 1, 2012 Medicaid will further revise reimbursement paid for therapy services

and durable medical equipment.

Effective March 1, 2012 certain early childhood intervention services and hearing and audiology services for children will become capitated services under the STAR+PLUS program. Prior to March 1, 2012 these services were carved out of STAR+PLUS and paid on a fee-for-service basis.

The adjustment factors used for the El Paso, Hidalgo and Lubbock SDAs are the statewide average of the factors used in developing the STAR+PLUS rates for the existing service areas. Please see the report titled "State of Texas Medicaid Managed Care STAR+PLUS Program Rate Setting State Fiscal Year 2012" which was amended in letters titled "STAR+PLUS Rate Amendment" and dated November 10, 2011 and January 16, 2012 for additional information regarding these factors. An exception was made to the adjustment for therapy reimbursement in the Hidalgo area due to the significant variation in therapy utilization in comparison to the statewide average. Based on historical claims data, the utilization of therapy services is much greater in the Hidalgo area than other STAR+PLUS areas. Hidalgo area claims data was used to determine the impact of the reimbursement revision on therapy reimbursement.

Attachment 6

OCC/CBA Adjustment

The base period experience data is categorized by Dual Eligible (Medicare and Medicaid) and Medicaid Only status but does not further stratify the data between the OCC and CBA risk groups. As detailed in Attachment 2, capitation rates have been developed separately for Medicaid Only and Dual Eligible clients. In order to separate these capitation rates into the appropriate risk groups, an estimated CBA to OCC ratio has been calculated. This ratio is based on the current relationship between the OCC and CBA capitation rates in the current STAR+PLUS areas (Bexar, Harris, Nueces and Travis). Separate ratios were determined for acute and long term care.