STATE OF TEXAS
MEDICAID MANAGED CARE
STAR+PLUS PROGRAM RATE SETTING
STATE FISCAL YEAR 2013

Prepared for:
Texas Health and Human Services Commission

Prepared by:
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Rudd and Wisdom, Inc.

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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 the state fiscal year 2013 (FY2013, September 1, 2012 through August 31, 2013) premium rates for HMOs participating in the Texas Medicaid STAR+PLUS program. 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 FY2013 HMO premium rates.

Rudd and Wisdom has relied on the following data sources as provided by HHSC, the participating HMOs and the agency's External Quality Review Organization (EQRO):

- Monthly enrollment by risk group for each health plan. This includes historical enrollment since September 2008 and a projection of future enrollment through August 2013. These projections were prepared by HHSC System Forecasting staff.
- Claim lag reports by risk group for each health plan for the period September 2008 through February 2012. These reports include monthly paid claims by month of service.
- Inpatient claims data by risk group for members currently enrolled in each health plan for the period September 2009 through February 2012. Prior to March 1, 2012 these services were carved out of the STAR+PLUS program and paid on a fee-for-service basis.
- Financial Statistical Reports (FSR) for each participating HMO for FY2010, FY2011 and the first six months of FY2012. The FSR contains detailed information regarding monthly enrollment, revenue, incurred claims and administrative expenses, as reported by the HMO.
- Reports from the EQRO summarizing their analysis of the HMO's encounter claims data.
- Reports from the health plans providing information on high volume claimants during the experience period.
- Current (FY2012) premium rates by risk group for each HMO.
- Information from both HHSC and the HMOs regarding recent changes in covered services and provider reimbursement under the Medicaid program.
- Information from the HMOs regarding current and projected payment rates for certain capitated services, such as mental health and vision.
- Information from the HMOs regarding attendant care enhanced payments and service coordination expenses
- FY2011 acuity risk adjustment analysis provided by the EQRO for each participating health plan.
- Historical enrollment and claims experience data for the Medicaid Fee-For-Service (FFS) and Primary Care Case Management (PCCM) plans.

- Information provided by HHSC regarding FY2011 health plan claims cost by type of service for certain services. This information was obtained from the encounter database.
- Information provided by HHSC regarding proposed FY2013 Medicaid provider reimbursement rates.
- Information provided by HHSC regarding the proposed DRG rebasing.
- Information provided by HHSC regarding wrap payments paid by HHSC to Federally Qualified Health Centers (FQHCs).

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 FY2013 STAR+PLUS HMO premium rates relies primarily on health plan financial experience. The historical claims experience for each HMO (by area) was analyzed and estimates for the base period (FY2011) were developed. These estimates were then projected forward to FY2013 using assumed trend rates. Other plan expenditures such as capitated amounts, service coordination, reinsurance costs and administrative expenses were added to the claims component in order to project the total FY2013 cost under the health plan. These projected total cost rates were determined separately for each risk group for each health plan. The results of this analysis were then combined for all HMOs in a service area in order to develop a set of community rates for each service area.

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

- Bexar County Service Area (San Antonio)
- Dallas County Service Area (Dallas)
- Harris County Service Area (Houston)
- Nueces County Service Area (Corpus Christi)
- Tarrant County Service Area (Fort Worth)
- Travis County Service Area (Austin)

A description of the rating methodology utilized for the new El Paso, Hidalgo, Jefferson and Lubbock SDAs can be found in the report titled State of Texas Medicaid Managed Care Expansion STAR+PLUS Program Rate Setting El Paso, Hidalgo, Jefferson and Lubbock Service Delivery Areas State Fiscal Year 2013.

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:

<u>Acute Care Services</u>

- 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
- Inpatient Facility Services
- Prescription Drugs

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:

- Nursing Facilities
- Dental and Orthodontia Services

Further information regarding the carve-in of prescription drugs into the STAR+PLUS program can be found in the report titled State of Texas Medicaid Managed Care Rate Setting Pharmacy Carve-in State Fiscal Year 2013.

After accumulating all of the information to be used in the rate setting process, a comparison of the various sources of claims data was performed to check for consistency. We compared (i) the claim lag reports provided by the HMOs, (ii) the claim amounts reported in the FSRs and (iii) the claim amounts in the encounter data files as provided by the EQRO. There was satisfactory consistency between the three claims data sources for each of the health plans.

We projected the FY2013 cost for each individual HMO by estimating their base period (FY2011) average claims cost and then applying trend and other adjustment factors. (These adjustment factors are described in Section III.) We added capitation expenses for services capitated by the HMO (such as vision and behavioral health), service coordinator expenses for care coordination services, a reasonable provision for administrative expenses and a risk margin. Attachment 2 presents a description and an example of the experience analysis for a sample HMO. This type of analysis was conducted for each health plan.

The analysis of base period claims experience for each health plan 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. The community rates are developed by a weighted average of the projected FY2013 cost for each health plan in the service area. The weights used in this formula are the projected FY2013 number of clients enrolled in each health plan by risk group. Attachment 3 presents the summary community rating exhibit for each service area along with a description of the analysis.

The non-inpatient acute care portion of the base community rate in each service area was adjusted to reflect the health status, or acuity, of the population enrolled in each health plan. The purpose of acuity risk adjustment is to recognize the anticipated cost differential between multiple health plans in a service area by analyzing the health status of their respective memberships. Additional information regarding risk adjustment is included in Section III below under Risk Adjustment and in Attachment 8. The final FY2013 premium rates were defined as the community rates with acuity risk adjustment.

III. Adjustment Factors

This section contains a description of the adjustment factors used in the FY2013 STAR+PLUS rate setting process.

Trend Factors

The rating methodology uses 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. A single trend assumption applied to all service areas but varies by risk group, type of service and projection year (FY2012 and FY2013).

The trend analysis included a review of HMO claims experience data through February 29, 2012. Based on this information, estimates of monthly incurred claims were made through December 2011. The claims cost and trend experience was reviewed separately by service area, risk group and type of service. The service area trends were then combined into a statewide average using a weighted average formula with estimated incurred claims as the weights.

The FY2012 non-inpatient acute care trend assumptions were developed from two components: (i) the actual estimated trend for the period September 2011 through December 2011 and (ii) the projected trend for the period January 2012 through August 2012. The experience trends for the period September 2011 through December 2011 were adjusted to remove the impact of the various provider reimbursement reductions effective September 1, 2011 and discussed further in this report. The trends for the final eight months of FY2012 were projected using experience from FY2010 (3/7 weight), FY2011 (3/7 weight) and the first four months of FY2012 (1/7 weight). The FY2013 non-inpatient acute care trend assumptions were developed based on an average of the HMO trends for the most recent three fiscal years (FY2010, FY2011 and FY2012).

The inpatient facility trend assumptions were developed from an analysis of inpatient claims currently paid on a fee-for-service basis for clients enrolled in the STAR+PLUS program as well as those clients enrolled in the Primary Care Case Management (PCCM) program outside of STAR+PLUS service areas. Based on this analysis the FY2012 trend was developed from two components: (i) the actual estimated trend for the period September 2011 through December 2011 and (ii) the projected trend for the period January 2012 through August 2012. The trends for the final eight months of FY2012 were projected using experience from FY2010 (3/7 weight), FY2011 (3/7 weight) and the first four months of FY2012 (1/7 weight). The FY2013 inpatient trend assumptions were developed based on an average of the trends for the most recent three fiscal years (FY2010, FY2011 and FY2012).

The FY2012 long term care trend assumptions by risk group were developed from two components: (i) the actual estimated trend for the period September 2011 through December 2011 and (ii) the projected trend for the period January 2012 through August 2012. The experience trends for FY2010 were adjusted to remove the impact of the

minimum wage increases effective during that time period. The trends for the final eight months of FY2012 were projected using experience from FY2010 (3/7 weight), FY2011 (3/7 weight) and the first four months of FY2012 (1/7 weight). The FY2013 long term care trend assumptions were developed based on an average of the HMO trends for the most recent three fiscal years (FY2010, FY2011 and FY2012).

Attachment 4 is a summary of the cost trend analysis. The chart below presents the assumed annual trend rates for FY2012 and FY2013.

	FY2012	FY2013
Acute Care (non-inpatient)		
Medicaid Only - OCC	5.8%	4.3%
Medicaid Only - CBA	3.0%	1.5%
Acute Care (inpatient)		
Medicaid Only - OCC	2.3%	2.9%
Medicaid Only - CBA	2.3%	2.9%
Long Term Care		
Medicaid Only - OCC	12.3%	10.5%
Medicaid Only - CBA	1.5 %	0.0%
Dual Eligible - OCC	6.3 %	5.0 %
Dual Eligible - CBA	1.1 %	0.0 %

Managed Care Efficiency Factor

Effective September 1, 2011, HHSC implemented service area expansions for all existing STAR+PLUS areas. This resulted in the elimination of PCCM in these expansion counties and the movement of those clients along with some current FFS clients to MCOs. We have considered this in our analysis by including the actual PCCM and FFS claims experience in our rating model. In each of the expansion counties we used FY2011 PCCM and FFS claims experience in deriving the FY2013 community rates.

Our rating analysis includes an explicit assumption regarding the anticipated reduction in claims cost resulting from the implementation of managed care in these expansion areas. In deriving the managed care efficiency factor, we relied upon experience from the previous STAR+PLUS expansion into the current STAR+PLUS service areas effective February 1, 2007. The following table includes the managed care savings assumptions by type of service:

Acute Care (non-inpatient)	10%
Acute Care (inpatient)	22%
Long Term Care	10%
Nursing Facility Care	5%

Although nursing facility services are excluded from the STAR+PLUS capitation rates, the estimated savings on these services have been analyzed in determining the overall savings associated with the STAR+PLUS expansion. The reduction in nursing facility services is assumed to be partially offset by an increase in other acute care and long term care

services.

These discount factors are intended to reflect the reduction in average claim costs when moving to the STAR+PLUS managed care model.

Further expansion of the STAR+PLUS program occurred on March 1, 2012 with the carve-in of inpatient hospital services. Prior to March 1, 2012 inpatient hospital services for STAR+PLUS members were managed by the participating health plans but carved out and paid on a fee-for-service basis. With the transition of these services back into STAR+PLUS under a fully capitated arrangement a savings of 5.75% of claims cost has been assumed.

Provider Reimbursement Adjustments

Medicaid provider reimbursement changes were provided for the following services: the two 1% provider rate cuts effective 9/1/2010 and 2/1/2011, the inclusion of wrap payments for FQHCs effective 9/1/2011, 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, and further revision to the DME and therapy fee schedules.

The legislative mandated provider rate reductions included the following:

- 8% hospital rate reduction
- 10.5% laboratory rate reduction (excludes DSHS and physician lab)
- Varying durable medical equipment reductions.
  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 rating adjustments for these provider reimbursement changes were calculated by applying actual health plan encounter data to the old and new reimbursement basis and the resulting impact determined. Attachment 6 presents a summary of the derivation of these adjustment factors.

Impact of Newly Capitated Services

Effective March 1, 2012 certain early childhood intervention services along with hearing and audiology services for children became 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 6.

DRG Rebasing Adjustments

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 updated the Standard Dollar Amounts and Relative Weights used in the Medicaid DRG payment system. HHSC staff has utilized the FY2011 encounter data to determine the cost

impact from DRG Rebasing on each service area and risk group. Exhibit J of Attachment 6 presents a summary of the resulting adjustment factors.

SSI 8% Restoration

Effective March 1, 2012 inpatient reimbursement was further amended with the restoration of the 8% reimbursement reduction previously implemented for SSI clients. This restoration was included in the inpatient analysis by increasing the FY2011 base period claims data by 8%.

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 7 presents a summary of the derivation of the adjustment factor.

Task Hour Guideline Changes

Effective September 1, 2011 changes were made to the functional assessment guidelines that determine the number of personal attendant service hours for STAR+PLUS members. Prior to September 1, 2011 a maximum of 30 minutes per day were allowed for transfer and ambulation services. This maximum was increased to 30 minutes for transfer and 30 minutes for ambulation services. Attachment 7 presents a summary of the derivation of the adjustment factor.

Risk Adjustment

Several risk adjustment techniques are employed in the rate setting methodology. Premium rates are established separately by area of the state and risk group in order to recognize the inherent geographical and demographical variation in the cost of delivering care. In addition, the rating methodology includes a health status adjustment.

The non-inpatient acute care portion of the base community rate in each service area was adjusted to reflect the health status, or acuity, of the population enrolled in each health plan. The purpose of acuity risk adjustment is to recognize the anticipated cost differential between multiple health plans in a service area by analyzing the health status of their respective memberships. The risk analysis was performed by the University of Florida's Institute for Child Health Policy (ICHP). The methodology used to incorporate the acuity risk adjustment is the Chronic Illness and Disability Payment System (CDPS). Additional information regarding acuity risk adjustment is included in Attachment 8.

Although the results of the risk adjustment analysis were reviewed for reasonableness, Rudd and Wisdom did not audit the risk adjustment data or the results of ICHP's analysis.

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 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 ($0.125 pmpm) and a risk margin (2.0% of premium).

V. Summary

The chart below presents the results of the FY2013 STAR+PLUS rating analysis and includes all components of the premium – acute care non-inpatient, acute care inpatient, long term care and prescription drugs. This report details the development of the acute care (non-inpatient and inpatient) and long term care components of the premium. Further information regarding the prescription drug component of the premium rate can be found in the report titled State of Texas Medicaid Managed Care Rate Setting Pharmacy Carve-in State Fiscal Year 2013.

Health Plan	Medicaid Only OCC	Medicaid Only CBA	Dual Eligible OCC	Dual Eligible CBA
Monthly Premium Rates				
Amerigroup - Bexar	$1,126.37	$3,834.35	$300.91	$1,735.33
Molina - Bexar	1,094.45	3,794.88	300.91	1,735.33
Superior - Bexar	1,163.35	3,947.18	300.91	1,735.33
Molina – Dallas	1,003.22	4,062.25	225.99	1,615.12
Superior – Dallas	1,003.22	4,062.25	225.99	1,615.12
Amerigroup - Harris	1,241.95	4,581.10	269.30	1,498.29
Evercare – Harris	1,297.53	4,329.47	269.30	1,498.29
Molina – Harris	1,217.11	4,475.69	269.30	1,498.29
Evercare - Nueces	1,280.50	3,738.80	427.59	1,651.42
Superior - Nueces	1,339.02	3,927.42	427.59	1,651.42
Amerigroup – Tarrant	1,120.12	3,919.54	144.60	1,511.19
Health Spring - Tarrant	1,120.12	3,919.54	144.60	1,511.19
Amerigroup - Travis	1,246.78	4,328.43	200.51	1,715.53
Evercare - Travis	1,201.88	4,115.34	200.51	1,715.53

The above premium rates include provision for 1915(b)(3) waiver services. The STAR+PLUS HMOs cover adult inpatient hospital days in excess of thirty. The chart below presents the amount included in the FY2013 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		
All Plans/All Areas	$ 3.54	$ 3.54

Attachment 1 presents additional information regarding the FY2013 rates including a comparison to current (FY2012) rates.

VI. Actuarial Certification of FY2013 STAR+PLUS 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 state fiscal year 2013 (FY2013) managed care rate-setting methodology, assumptions and resulting premium rates 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 FY2013 HMO 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 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 FY2013 STAR+PLUS Rating Analysis

The attached exhibit presents summary information regarding the FY2013 rates. Included on the exhibit are current March 1, 2012- August 31, 2012 premium rates by component, FY2013 premium rates by component and the percentage rate change by component.

Attachment 2

Individual HMO Experience Analysis

The following exhibits present a summary of the experience analysis performed for each health plan. The exhibits in this section use hypothetical experience data from a sample HMO. The actual analysis is based on experience data provided by each health plan. This data was checked for reasonableness by comparing to other data sources provided by HHSC, the EQRO and the HMO. Below is a brief description of each of the exhibits contained in this attachment.

Exhibit A. This exhibit shows a sample of the monthly enrollment and earned premium by risk group for the period September 2008 through February 2012. All of this information was provided by HHSC.

Exhibit B. This exhibit shows a sample of a claim lag report for one risk group. This report includes claim amounts by payment month and month of service. We analyzed claims experience for the period September 2008 through February 2012.

Exhibit C. This exhibit shows the calculation of estimated monthly incurred claims for one risk group. The report includes the following information: (i) monthly enrollment, (ii) claim amounts incurred in that month and paid through February 29, 2012, (iii) estimated proportion of that month's incurred claims paid through February 29, 2012 (completion factor), (iv) estimated incurred claims, (v) estimated incurred claims pmpm and (vi) the ratio of this month's incurred claims pmpm to the same statistic from one year ago (trend factor). The assumed completion factors and estimated incurred claims were derived based on the actual historical claims payment pattern of the HMO.

Exhibit D. This exhibit is a summary of the sample HMO's projected FY2013 cost based on the HMO's actual experience. The top of the exhibit shows summary base period (FY2011) enrollment, premium and claims experience. Next are projected FY2013 enrollment and premium based on current (FY2012) rates. Trend assumptions for FY2012 and FY2013 are used to project the average base period claims cost to FY2013. Adjustment factors are used to recognize the cost impact of benefit and provider reimbursement changes. Combining these factors results in projected FY2013 incurred claims.

In addition to incurred claims, provision is also made for services that are capitated by the HMO, such as vision and behavioral health services. Other expenses such as those related to the coordination of care are included.

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 ($0.125 pmpm) and risk margin (2.0% of premium).

At the bottom of Exhibit D is a summary of the projected FY2013 cost based on the above assumptions. Cost projections are presented separately for acute care and long term care services.

Similar analyses are done separately for inpatient hospital services.

Attachment 3

Community Experience Analysis – Non-inpatient Acute Care and Long Term Care

The following exhibits present a summary of the non-inpatient acute care and long term care experience analysis performed for each managed care service area. HHSC utilizes an adjusted 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. The community rates are developed by a weighted average of the projected FY2013 cost for each health plan in the service area. The weights used in this formula are the projected number of FY2013 clients enrolled in each health plan.

Below is a brief description of the exhibits contained in this attachment. The exhibits present the derivation of the FY2013 STAR+PLUS HMO community rates for the following service areas:

Exhibit A – Bexar Service Area
Exhibit B – Dallas Services Area
Exhibit C – Harris Service Area
Exhibit D – Nueces Service Area
Exhibit E – Tarrant Service Area
Exhibit F – Travis Service Area

These exhibits show projected FY2013 experience for each of the service areas. These amounts were derived by summing amounts from each individual health plan in the service area. The experience analysis for individual HMOs is described in Attachment 2. The top portion of the exhibit shows summary base period (FY2011) experience and projected FY2013 enrollment, premium and incurred claims experience. An exception to the base experience period was made for the Dallas and Tarrant Service Areas. STAR+PLUS expanded into these two areas effective February 1, 2011 resulting in only a partial year of STAR+PLUS data to be available. For these two areas the base period used to develop the FY2013 experience is the period March 1, 2011 through August 31, 2011. Because this time period does not span a full twelve months an analysis was done to determine if a material seasonality is present in the claims experience for the program. It was determined that no material seasonality existed and no further adjustments were necessary to the Dallas and Tarrant base period experience.

In addition to incurred claims, provision is also made for services that are capitated by the HMOs, such as vision and behavioral health services. Other expenses such as those related to the coordination of care are included.

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 ($0.125 pmpm) and risk margin (2.0% of premium).

The bottom of the exhibit shows a summary of the projected FY2013 cost based on these assumptions. Cost projections are presented separately for acute care and long term care services.

Attachment 4

Community Experience Analysis – Inpatient

The following exhibits present a summary of the inpatient experience analysis performed for each managed care service area. HHSC utilizes an adjusted 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. The community rates are developed by a weighted average of the projected FY2013 cost for each health plan in the service area. The weights used in this formula are the projected number of FY2013 clients enrolled in each health plan.

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These exhibits show projected FY2013 experience for each of the service areas. These amounts were derived by summing amounts from each individual health plan in the service area. The experience analysis for individual HMOs is described in Attachment 2. The top portion of the exhibit shows summary base period (FY2011) experience and projected FY2013 enrollment, premium and incurred claims experience. An exception to the base experience period was made for the Dallas and Tarrant Service Areas. STAR+PLUS expanded into these two areas effective February 1, 2011 resulting in only a partial year of STAR+PLUS data to be available. For these two areas the base period used to develop the FY2013 experience is the period March 1, 2011 through August 31, 2011. Because this time period does not span a full twelve months an analysis was done to determine if a material seasonality is present the claims experience for the program. It was determined that no material seasonality existed a no further adjustments were necessary to the Dallas and Tarrant base period experience.

A managed care efficiency factor of 5.75% is assumed to be achieved due to the carve-in of inpatient hospital services into the STAR+PLUS program. Prior to March 1, 2012 these services were carved out and paid on a fee-for-service basis.

A provision for administrative expenses is included in the amount of 5.75% of gross premium. Additional provisions are also included for premium tax (1.75% of premium) risk margin (2.0% of premium).

The bottom of the exhibit shows a summary of the projected FY2013 cost based on these assumptions.

Attachment 5

Trend Analysis

The FY2013 rating methodology uses 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 – non-inpatient acute care, inpatient 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 and the Primary Care Case Management (PCCM) program. A single trend assumption applied to all service areas but varies by type of service, risk group and year.

The trend analysis included a review of HMO and PCCM claims experience data through February 29, 2012. Based on this information, estimates of monthly incurred claims were made through December 2011. The claims cost and trend experience was reviewed separately by service area, type of service and risk group. The service area trends were then combined into a statewide average using a weighted average formula with estimated incurred claims as the weights.

The FY2012 non-inpatient acute care trend assumptions were developed from two components: (i) the actual estimated trend for the period September 2011 through December 2011 and (ii) the projected trend for the period January 2012 through August 2012. The experience trends for the period September 2011 through December 2011 were adjusted to remove the impact of the various provider reimbursement reductions effective September 1, 2011 and discussed further in this report. The trends for the final eight months of FY2012 were projected using experience from FY2010 (3/7 weight), FY2011 (3/7 weight) and the first four months of FY2012 (1/7 weight). The FY2013 non-inpatient acute care trend assumptions were developed based on an average of the HMO trends for the most recent three fiscal years (FY2010, FY2011 and FY2012).

The inpatient acute care trend assumptions were developed from an analysis of inpatient claims currently paid on a fee-for-service basis for clients enrolled in the STAR+PLUS program as well as those clients enrolled in the Primary Care Case Management (PCCM) program outside of STAR+PLUS service areas. Based on this analysis the FY2012 trend was developed from two components: (i) the actual estimated trend for the period September 2011 through December 2011 and (ii) the projected trend for the period January 2012 through August 2012. The trends for the final eight months of FY2012 were projected using experience from FY2010 (3/7 weight), FY2011 (3/7 weight) and the first four months of FY2012 (1/7 weight). The FY2013 inpatient trend assumptions were developed based on an average of the HMO trends for the most recent three fiscal years (FY2010, FY2011 and FY2012).

The FY2012 long term care trend assumptions by risk group were developed from two components: (i) the actual estimated trend for the period September 2011 through December 2011 and (ii) the projected trend for the period January 2012 through August 2012. The experience trends for FY2010 were adjusted to remove the impact of the minimum wage increases effective during that time period. The trends for the final eight months of FY2012 were projected using experience from FY2010 (3/7 weight), FY2011 (3/7 weight) and the first four months of FY2012 (1/7 weight). The FY2013 long term care trend assumptions were developed based on an average of the HMO trends for the most recent three fiscal years

(FY2010, FY2011 and FY2012).

The attached Exhibit A presents a summary of the recent non-inpatient acute care and long term care trend experience under the HMO plans. Exhibit B presents a summary of the impact of the minimum wage increase on the FY2010 long term care trends. Exhibit C presents a summary of the recent inpatient trend experience across the entire state. Exhibit D presents the trend assumptions used in the rating analysis.

The chart below presents the assumed annual trend rates for FY2012 and FY2013.

	FY2012	FY2013
Acute Care (non-inpatient)		
Medicaid Only - OCC	5.8%	4.3%
Medicaid Only - CBA	3.0%	1.5%
Acute Care (inpatient)		
Medicaid Only - OCC	2.3%	2.9%
Medicaid Only - CBA	2.3%	2.9%
Long Term Care		
Medicaid Only - OCC	12.3%	10.5%
Medicaid Only - CBA	1.5 %	0.0%
Dual Eligible - OCC	6.3 %	5.0 %
Dual Eligible - CBA	1.1 %	0.0 %

Attachment 6

Provider Reimbursement and Benefit Revisions Effective During FY2012 and FY2013

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 (FY2011) and before the end of FY2013.

Medicaid provider reimbursement changes were provided for the following services: the two 1% provider rate cuts effective 9/1/2010 and 2/1/2011, the inclusion of wrap payments for FQHCs effective 9/1/2011, 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, and further revision to the DME and therapy fee schedules.

The legislative mandated provider rate reductions included the following:

- 8% hospital rate reduction
- 10.5% laboratory rate reduction (excludes DSHS and physician lab)
- Varying durable medical equipment reductions.
- 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.

Effective September 1, 2010 and again on February 1, 2011, Medicaid reduced reimbursement by 1% for most providers and services. Attached Exhibit A presents the estimated cost impact for the reimbursement reduction.

Effective September 1, 2011, HHSC implemented legislative mandated provider rate reductions described above. Attached Exhibit B presents a summary of the derivation of the rating adjustment factors for services other than inpatient facility. Attached Exhibit J presents a summary of the derivation of the adjustment factors for reductions to inpatient facility reimbursement and DRG rebasing.

Effective September 1, 2011, HHSC implemented a new fee schedule for outpatient imaging services. Attached Exhibit C presents a summary of the derivation of the rating adjustment factors.

Effective September 1, 2011, HHSC required STAR+PLUS MCOs to pay Federally Qualified Health Centers (FQHCs) the full encounter rate. Attached Exhibit D presents a summary of the derivation of the rating adjustment factors.

Effective September 1, 2011, HHSC implemented a 40% reduction to reimbursement for non-emergent services provided in the emergency room. Attached Exhibit E presents a summary of the derivation of the rating adjustment factors.

Effective March 1, 2012 HHSC made further revisions to the Therapy and Durable Medical Equipment fee schedules. Attached Exhibits F and G presents a summary of the derivation of the rating adjustment factors.

Effective March 1, 2012 HHSC carved in several services previously not capitated under the STAR+PLUS program. Certain Early Childhood Intervention (ECI) services and hearing and audiology services for children are now the responsibility of the MCOs. Attached Exhibit H and I presents a summary of the derivation of the rating adjustment factors.

Effective March 1, 2012 the previous 8% reduction for SSI inpatient hospital reimbursement was restored. This restoration was included in the inpatient analysis by increasing the FY2011 base period claims data by 8%.

Attachment 7

Long Term Care Reimbursement Adjustments

Effective September 1, 2011 Medicaid reduced reimbursement paid for personal assistance services (PAS) rendered to CBA clients by $0.46 per unit of service. PAS are a commonly provided long term care benefit under the STAR+PLUS program. The attached Exhibit A presents the estimated cost impact of this change.

Effective September 1, 2011 changes were made to the functional assessment guidelines that determine the number of personal attendant service hours for STAR+PLUS members. Prior to September 1, 2011 a maximum of 30 minutes per day were allowed for transfer and ambulation services. This maximum was increased to 30 minutes for transfer and 30 minutes for ambulation services. Exhibit B presents a summary of the derivation of the adjustment factor.

Attachment 8

Acuity Risk Adjustment

The rate setting methodology incorporates a risk adjustment technique that is designed to adjust the base community rate in each service area to reflect the health status, or acuity, of the population enrolled in each health plan. The purpose of acuity risk adjustment is to recognize the anticipated cost differential between multiple health plans in a service area by analyzing the health status of their respective memberships. The risk analysis was performed by the University of Florida's Institute for Child Health Policy (ICHP). The methodology used to incorporate the risk adjustment is the Chronic Illness and Disability Payment System (CDPS). The attached exhibits (provided by ICHP) present a summary of the risk adjustment analysis. There is a separate exhibit for each risk group.

The column titled Case Mix on the chart is the risk adjustment factor. It is the ratio of the predicted average cost of the individual health plan's membership divided by the predicted average cost of the entire service area's membership. The risk adjustment factor is applied to the acute care portion of the community rate for each health plan and risk group. If necessary, an additional adjustment was made to the risk adjusted community rates to ensure that, in total, they produce the same premium as the community rates.

Due to the relative infancy of the STAR+PLUS program in the Dallas and Tarrant service areas risk adjustment has not been applied for the health plan operating in these areas.

For FY2013 risk adjustment is only applicable to the non-inpatient acute care component of the community rate.

Attachment 9

Managed Care Discount Factor

Effective September 1, 2011, HHSC implemented service area expansions for all existing STAR+PLUS areas. This resulted in the elimination of PCCM in these expansion counties and the movement of those clients along with some current FFS clients to MCOs. We have considered this in our analysis by including the actual PCCM and FFS claims experience in our rating model. In each of the expansion counties we used FY2011 PCCM and FFS claims experience in deriving the FY2013 community rates.

Our rating analysis includes an explicit assumption regarding the anticipated reduction in claims cost resulting from the implementation of managed care in these expansion areas. In deriving the managed care efficiency factor, we relied upon experience from the previous STAR+PLUS expansion into the current STAR+PLUS service areas effective February 1, 2007. The following table includes the managed care savings assumptions by type of service:

Acute Care (non-inpatient)	10%
Acute Care (inpatient)	22%
Long Term Care	10%
Nursing Facility Care	5%

Although nursing facility services are excluded from the STAR+PLUS capitation rates, the estimated savings on this service have been analyzed in determining the overall savings associated with the STAR+PLUS expansion. The reduction in nursing facility services is assumed to be partially offset by an increase in other acute care and long term care services.

These discount factors are intended to reflect the reduction in average claim costs when moving to the STAR+PLUS managed care model.

The expansion counties are listed below:

SDA	Expansion Counties
Bexar SDA	Bandera
Harris SDA	Austin, Matagorda and Wharton
Nueces SDA	Brooks, Goliad, Karnes, Kenedy and Live Oak
Travis SDA	Fayette

Further expansion of the STAR+PLUS program occurred on March 1, 2012 with the carve-in of inpatient hospital services. Prior to March 1, 2012 inpatient hospital services for STAR+PLUS members have been managed by the participating health plans but carved out and paid on a fee-for-service basis. With the transition of these services back into STAR+PLUS under a fully capitated arrangement an assumed savings of 5.75% of claims cost has been assumed.