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

Prepared for:
Texas Health and Human Services Commission

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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 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.
- 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 and Delivery Supplemental Payment rates by risk group for each HMO.
- The number of maternity deliveries by HMO and risk group for the period September 2008 through December 2011.
- 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 regarding FY2011 third party reimbursement from each of the HMOs.
- FY2011 acuity risk adjustment analysis provided by the EQRO for each participating health plan.
- Information from the HMOs regarding current and projected reinsurance premium rates.

- Historical enrollment and claims experience data for the Medicaid Primary Care Case Management (PCCM) plan.
- 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 DRG rebasing.
- Information provided by HHSC regarding historical FQHC wrap payments previously paid by HHSC.
- Information provided by HHSC regarding newly capitated services previously paid by HHSC.

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

II. Overview of the Rate Setting Methodology

This report details the development of the medical component of the total premium rate. 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 State Fiscal Year 2013.

The actuarial model used to derive the FY2013 STAR 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, 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)
- El Paso County Service Area (El Paso)
- Harris County Service Area (Houston)
- Lubbock County Service Area (Lubbock)
- 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 Jefferson, Hidalgo and MRSA SDAs can be found in the report titled State of Texas Medicaid Managed Care STAR Program Rate Setting Hidalgo, Jefferson and MRSA Service Delivery Areas State Fiscal Year 2013.

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

- TANF Children Over Age One Year
- TANF Children Under Age One Year
- TANF Adults
- Pregnant Women
- Newborns
- Expansion Children Over Age One Year
- Expansion Children Under Age One Year
- Federal Mandate Children

The services used in the analysis include the following:

- Inpatient Hospital
- Outpatient Hospital

- Physician Services
- Other Professional Services
- Lab, X-ray and Radiology Services
- Medical Supplies
- Behavioral Health Services (except in the Dallas service area)
- EPSDT Medical Services
- Family Planning and Genetics Services
- Comprehensive Care Program Services
- Vision Services
- Hearing Services
- Home Health Services
- Emergency Room Services
- Ambulance Services
- Prescription Drugs

Services specifically excluded from the analysis include:

- Dental and Orthodontia Services

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), a net cost of reinsurance, 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.

Beginning September 1, 2011, several of the existing STAR regions saw an expansion in their service area. For these areas, the PCCM experience for the new expansion counties has been included in the rating analysis. Estimated FY2011 PCCM claims experience was projected to FY2013 using the same methodology and trends as those used to project HMO experience. A managed care efficiency factor was applied to adjust the PCCM claims to an assumed HMO level. More information about this managed care efficiency factor is presented in Section III. The resulting PCCM projected claims were used to develop the FY2013 incurred claims assumption for use in the community rates.

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 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 projected FY2013 average total per-capita cost in a service area is called the unadjusted premium rate. This rate includes provision for all health care and administrative services to be provided by the HMO. This rate is then separated into two components – (i) non-maternity related expenses and (ii) maternity expenses. The premium rate for non-maternity expenses is called the adjusted premium rate. These are the monthly rates paid to the HMO. The amount paid for maternity expenses is called the Delivery Supplemental Payment. More information on this adjustment is provided in Section III below under Risk Adjustment and in Attachment 8.

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 9.

III. Adjustment Factors

This section contains a description of the adjustment factors used in the FY2013 STAR 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. 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 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 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 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 which are discussed further in this report. The trends for the final eight months of FY2012 for risk groups other than Newborns were projected using experience from FY2009 (3/10 weight), FY2010 (3/10 weight), FY2011 (3/10 weight) and the first four months of FY2012 (1/10 weight). The FY2013 trend assumptions for risk groups other than Newborns were then developed from a simple average of the FY2009 trend, FY2010 trend, FY2011 trend and projected FY2012 trend. The trend for the final eight months of FY2012 for Newborns was projected using experience from FY2009 (3/7 weight), FY2010 (3/7 weight) and the first four months of FY2012 (1/7 weight). The FY2013 trend assumption for Newborns was based on the average of the FY2009, FY2010 and projected FY2012 trends. The FY2011 trend was excluded from these calculations because the movement of former CHIP Perinatal newborns under 185% FPL to STAR resulted in a one-time reduction in the newborn trend for FY2011.

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
TANF Children Over Age 1	6.7 %	8.9 %
TANF Children Under Age 1	6.7 %	8.9 %
TANF Adults	6.8 %	7.3 %
Pregnant Women	0.2 %	1.8 %
Newborns	-2.3 %	1.5 %
Expansion Children Over Age 1	4.2 %	4.9 %
Expansion Children Under Age 1	4.2 %	4.9 %
Federal Mandate Children	3.8 %	5.2 %

Managed Care Efficiency Factor

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

The basic premise regarding the future cost of current PCCM clients is that their FY2013 gross cost under the MCO model (including administrative expenses and risk margin) will be the same as the projected FY2013 gross cost under the PCCM model. Since administrative expenses and risk margin are significantly higher under the HMO model, in order for the gross cost to be the same as the PCCM it is necessary for the medical claims cost to be lower than that under the PCCM. We prepared an analysis which considered all of the cost factors (including PCCM case management fees and TMHP costs) and concluded that the managed care efficiency under the HMO model would need to be 10.1%, relative to the PCCM, in order for the gross cost for the two models to be equal. Therefore, we have applied a 10.1% managed care efficiency (or claims adjustment factor) to the FY2011 PCCM claims experience. Our analysis is presented in Attachment 10.

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 5 presents a summary of the derivation of these adjustment factors.

Newly Capitated Services

Effective March 1, 2012 several services previously carved out of the STAR program became capitated services. Certain Early Childhood Intervention (ECI) services and hearing and audiology services for children will now be the responsibility of the participating MCOs. Exhibits J and K of attachment 5 present a summary of the derivation of these adjustment factors.

Related Party Adjustments

Beginning in FY2011, HHSC revised the rating methodology to exclude from the claims experience base any amounts paid by a health plan to a related party in excess of 100% of Medicaid. HHSC staff met with the health plans individually to determine (i) which providers had an owner-relationship to the health plan and (ii) the basis on which the health plan reimbursed the provider. All health plans in the affected service areas were impacted because the related party adjustment lowered the community rate applicable to all of the plans in that area. Exhibit B of Attachment 5 presents a summary of the derivation of these adjustment factors.

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 was intended to update 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 D of Attachment 5 presents a summary of the resulting adjustment factors.

Family Planning Exclusion

Some of the MCOs that participate in the STAR program are not able to provide family planning services. HHSC provided us with a listing of those services that will not be provided by these MCOs. Adjustment factors were determined through an evaluation of the base period experience for the areas in which these plans operate. The premium rates for these MCOs have been reduced to reflect the reduced services provided. Attachment 6 provides additional information regarding this adjustment.

Third Party Recoveries

The rating methodology included a factor to recognize those health plans that do not satisfy a minimum level of recoveries for coordination of benefits. Any plan that did not recover at least 2.0% of claims had its projected claims cost reduced by 2.0% less their actual percentage of recoveries. For example, if a health plan has third party recoveries (TPR) of 1.5% of claims, then their projected claims cost would be reduced by 0.5%. Any plan that exceeded the minimum standard of 2.0% had no penalty applied. Additional information regarding TPR is included in Attachment 7.

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 an attempt to treat the health plans more equitably regarding maternity expenses, the methodology includes a separate rate for maternity services. In addition, the rating methodology includes a health status adjustment.

The rate setting methodology incorporates a risk adjustment technique that is designed to provide uniform treatment of the health plans for costs related to maternity services. Maternity cases occur in several risk groups – Pregnant Women, TANF Adults, TANF Children and Federal Mandate Children. As a result, it is possible for one health plan to enroll a higher percentage of TANF Adults, for example, who are pregnant and therefore generally more expensive. In order to recognize the potential inequity that may arise between health plans, HHSC developed this risk adjustment methodology. The goal is to reimburse the plans uniformly for maternity delivery costs.

The State pays a delivery supplemental payment (DSP) for each delivery in a managed care plan. The amount of the payment is a function of the average delivery cost in the service area. Attachment 8 contains additional information regarding the DSP payment amounts.

In order to achieve cost neutrality, the projected cost of maternity expenses is subtracted from the unadjusted premium rates. The resulting adjusted premium rates are the rates actually paid to the HMOs, in addition to any DSP amounts.

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 9.

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 $8.00 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 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 rating analysis and includes all components of the premium – medical and prescription drug. This report details the development of the medical component 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	TANF Children (over age 1)	TANF Children (<1)	TANF Adults	Pregnant Women	Newborns
Monthly Adjusted Premium Rates					
Aetna - Bexar	$142.10	$454.46	$475.87	$442.52	$541.99
Amerigroup – Bexar	165.89	385.62	496.70	446.94	603.82
CFHP – Bexar	161.76	337.41	464.91	438.27	547.16
Superior – Bexar	176.80	399.16	532.57	454.42	669.47
Amerigroup – Dallas	161.05	387.92	342.65	455.74	551.82
Molina – Dallas	168.13	369.67	363.40	454.36	577.11
Parkland – Dallas	168.82	367.52	371.60	456.53	601.11
El Paso First - El Paso	130.16	356.35	370.37	342.08	524.10
Molina – El Paso	139.36	330.92	370.63	346.76	528.46
Superior - El Paso	146.78	309.00	370.88	350.48	532.25
Amerigroup - Harris	145.25	434.35	546.42	503.73	682.77
CHC – Harris	145.11	413.58	516.02	504.67	608.19
Molina – Harris	163.21	581.67	429.94	473.13	720.13
TCHP – Harris	156.79	330.92	439.36	479.42	575.62
United – Harris	144.27	440.29	563.80	481.64	715.80
Amerigroup – Lubbock	146.66	692.52	425.74	422.70	605.14
Firstcare – Lubbock	130.67	782.91	417.02	422.12	586.75
Superior – Lubbock	172.50	565.97	437.93	423.58	630.60
Christus - Nueces	214.66	716.95	454.75	495.53	714.05
Driscoll - Nueces	208.90	810.99	418.17	502.49	734.12
Superior - Nueces	220.65	551.02	510.91	515.94	680.29
Aetna - Tarrant	160.14	257.34	412.58	422.91	632.16
Amerigroup - Tarrant	162.45	278.61	436.42	424.46	562.70
Cook - Tarrant	174.83	284.54	449.01	426.82	607.66
Blue Cross Blue Shield – Travis	150.42	371.30	382.07	605.26	731.84
Sendero – Travis	150.42	371.30	382.07	605.26	731.84
Seton - Travis	149.70	371.30	376.26	592.13	731.84
Superior - Travis	152.09	378.72	398.81	605.47	743.62

Health Plan	Expansion Children (over age 1)	Expansion Children (<1)	Federal Mandate Children	Delivery Supplemental Payment
Monthly Adjusted Premium Rates				
Aetna – Bexar	$151.69	$261.22	$112.04	$3,266.59
Amerigroup – Bexar	163.23	242.58	128.80	3,266.59
CFHP – Bexar	165.97	239.09	128.70	3,266.59
Superior – Bexar	163.99	237.06	133.88	3,266.59
Amerigroup – Dallas	165.92	320.60	128.08	3,537.13
Molina – Dallas	174.17	348.69	131.02	3,537.13
Parkland – Dallas	181.51	371.68	135.92	3,537.13
El Paso First – El Paso	144.63	257.35	114.95	3,443.04
Molina – El Paso	146.64	266.05	117.11	3,443.04
Superior – El Paso	148.22	276.73	119.00	3,443.04
Amerigroup – Harris	147.83	343.30	123.00	3,519.20
CHC – Harris	144.23	264.55	113.63	3,519.20
Molina – Harris	160.74	246.53	129.20	3,519.20
TCHP – Harris	159.96	293.97	132.10	3,519.20
United – Harris	155.95	299.75	139.14	3,519.20
Amerigroup – Lubbock	132.05	324.60	113.71	3,230.39
Firstcare – Lubbock	131.02	408.82	115.93	3,230.39
Superior – Lubbock	133.75	191.77	109.99	3,230.39
Christus – Nueces	204.17	277.21	171.48	3,203.82
Driscoll – Nueces	196.86	275.43	173.33	3,203.82
Superior – Nueces	235.82	231.84	174.80	3,203.82
Aetna – Tarrant	132.19	228.14	115.21	3,635.64
Amerigroup – Tarrant	149.97	220.41	131.75	3,635.64
Cook – Tarrant	177.71	323.00	141.47	3,635.64
Blue Cross Blue Shield – Travis	164.58	279.50	116.39	3,247.49
Sendero – Travis	164.58	279.50	116.39	3,247.49
Seton – Travis	164.40	279.50	115.87	3,247.49
Superior – Travis	165.24	279.51	116.93	3,247.49

The above premium rates include provision for 1915(b)(3) waiver services. The STAR HMOs cover adult inpatient hospital days in excess of thirty. The chart below presents the amount included in the FY2013 STAR HMO premium rates for 1915(b)(3) waiver services.

Health Plan	TANF Adults	Pregnant Women
Monthly Premium Rate for 1915(b)(3) Services		
All Plans/All Areas	$ 3.85	$ 2.56

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

VI. Actuarial Certification of FY2013 STAR 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 Rating Analysis

The attached exhibit presents summary information regarding the FY2013 rates. Included on the exhibit are current (FY2012) premium, split between medical, prescription drug and delivery supplemental payment (DSP) rates, FY2013 premium, split between medical, prescription drug and DSP rates and a comparison of FY2012 and FY2013 premium rates.

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 monthly enrollment, number of maternity deliveries and earned premium by risk group for the period September 2009 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 2009 through December 2011.

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. The cost of reinsurance is also considered. In developing the cost of reinsurance, an assumption is made regarding how much the HMO is expected to receive in reinsurance recoveries (reimbursements from the reinsurance company for large claims). We have assumed that the net cost of reinsurance (reinsurance premium less reinsurance recoveries) is the minimum of (a) the actual reinsurance premium rate and (b) $0.75 pmpm.

A provision for administrative expenses is included in the amount of $8.00 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 both with and without the inclusion of maternity expenses.

Attachment 3

Community Experience Analysis

The following exhibits present a summary of the experience analysis performed for each managed care service area. HHSC utilizes an adjusted community rating methodology in setting the STAR 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 HMO community rates for the following service areas:

Exhibit A – Bexar Service Area
Exhibit B – Dallas Service Area
Exhibit C – El Paso Service Area
Exhibit D – Harris Service Area
Exhibit E – Lubbock Service Area
Exhibit F – Nueces Service Area
Exhibit G – Tarrant Service Area
Exhibit H – 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.

In addition to incurred claims, provision is also made for services that are capitated by the HMOs, such as vision and behavioral health services. The cost of reinsurance is also considered. In developing the cost of reinsurance we make an assumption regarding how much the HMO is expected to receive in reinsurance recoveries (reimbursements from the reinsurance company for large claims). We have assumed that the net cost of reinsurance (reinsurance premium less reinsurance recoveries) is the minimum of (a) the actual reinsurance premium rate and (b) $0.75 pmpm.

A provision for administrative expenses is included in the amount of $8.00 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 both with and without the inclusion of maternity expenses.

Attachment 4

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. 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 and year.

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 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 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 for risk groups other than Newborns were projected using experience from FY2009 (3/10 weight), FY2010 (3/10 weight), FY2011 (3/10 weight) and the first four months of FY2012 (1/10 weight). The FY2013 trend assumptions for risk groups other than Newborns were then developed from a simple average of the FY2009 trend, FY2010 trend, FY2011 trend and projected FY2012 trend. The trend for the final eight months of FY2012 for Newborns was projected using experience from FY2009 (3/7 weight), FY2010 (3/7 weight) and the first four months of FY2012 (1/7 weight). The FY2013 trend assumption for Newborns was based on the average of the FY2009, FY2010 and projected FY2012 trends. The FY2011 trend was excluded from these calculations because the movement of former CHIP Perinatal newborns under 185% FPL to STAR resulted in a one-time reduction in the newborn trend for FY2011.

The attached exhibits present recent trend experience under the HMO plans (Exhibit A) and the trend assumptions used in the rating analysis (Exhibit B). The chart below presents the assumed annual trend rates for FY2012 and FY2013.

	FY2012	FY2013
TANF Children Over Age 1	6.7 %	8.9 %
TANF Children Under Age 1	6.7 %	8.9 %
TANF Adults	6.8 %	7.3 %
Pregnant Women	0.2 %	1.8 %
Newborns	-2.3 %	1.5 %
Expansion Children Over Age 1	4.2 %	4.9 %
Expansion Children Under Age 1	4.2 %	4.9 %
Federal Mandate Children	3.8 %	5.2 %

Attachment 5

Provider Reimbursement and Benefit Revisions Effective During FY2012 and FY2013

This attachment presents information regarding rating adjustments for the various 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, 2010, HHSC revised the rating methodology to exclude from the claims experience base any amounts paid by a health plan to a related party in excess of 100% of Medicaid. Attached Exhibit B presents a summary of the derivation of the rating adjustment factors.

Effective September 1, 2011, HHSC implemented legislative mandated provider rate reductions described above. Attached Exhibit C presents a summary of the derivation of the rating adjustment factors for services other than inpatient facility. Attached Exhibit D 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 E presents a summary of the derivation of the rating adjustment factors.

Effective September 1, 2011, HHSC required STAR MCOs to pay Federally Qualified Health Centers (FQHCs) the full encounter rate. Attached Exhibit F 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 G 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 H and I 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 program. Certain Early Childhood Intervention (ECI) services and hearing and audiology services for children are now the responsibility of the MCOs. Attached Exhibit J and K presents a summary of the derivation of the rating adjustment factors.

Attachment 6

Family Planning Adjustment

Some of the MCOs that participate in the STAR program are not able to provide family planning services. For these MCOs, family planning service will be provided through FFS. HHSC provided us with a listing of those services that will not be provided by these MCOs. Using base period claims experience, we determined the per member per month cost expected to be represented by these family planning services. The premium rates for those MCOs that do not provide family planning services have been reduced accordingly. The attached exhibit presents a summary of the family planning reduction factors associated with these MCOs

Attachment 7

Third Party Recoveries

The rating methodology includes a factor to recognize those health plans that do not satisfy a minimum level of recoveries for coordination of benefits. Any plan that did not recover at least 2.0% of claims had its projected claims cost reduced by 2.0% less their actual percentage of recoveries. For example, if a specific health plan has third party recoveries (TPR) of 1.5% of claims, then their projected claims cost would be reduced by 0.5%. Any plan that exceeded the minimum TPR standard of 2.0% had no penalty applied.

The attached chart presents a summary of TPR experience for FY2011.

Attachment 8

Delivery Supplemental Payment

The rate setting methodology incorporates a risk adjustment technique that is designed to provide uniform treatment of the health plans for costs related to maternity delivery services. Maternity cases occur in several risk groups – Pregnant Women, TANF Adults, TANF Children and Federal Mandate Children. As a result, it is possible for one health plan to enroll a higher percentage of TANF Adults who are pregnant and therefore generally more expensive. In order to recognize the potential inequity that might arise between health plans, HHSC developed this risk adjustment methodology. The goal is to reimburse the plans uniformly for maternity expenses.

The State pays a delivery supplemental payment (DSP) for each delivery in a managed care plan. The amount of the payment is a function of the average delivery cost in the area. The attached exhibit presents the FY2013 DSP payment rates by area.

In order to achieve cost neutrality, the projected cost of maternity expenses is subtracted from the unadjusted premium rates. The resulting adjusted premium rates are the rates actually paid to the HMOs in addition to any DSP amounts.

Attachment 9

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 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.

Representatives of HHSC and the MCOs formed a workgroup to study the acuity risk adjustment methodology and recommend potential revisions prior to the FY2012 rate setting process. Based on this analysis, the following changes were implemented for the FY2012 rate setting process and have been continued into the FY2013 rate development.

- The minimum enrollment period for newborns to be eligible for inclusion in the analysis was reduced from three months to one month
- Five new baby weights were added
- The weights for all risk groups are now determined on a concurrent basis. Previously, the weights for risk groups other than Pregnant Women and Newborns were developed on a prospective basis.

Attachment 10

Managed Care Discount Factor

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

The basic premise regarding the future cost of current PCCM clients is that their FY2013 gross cost under the MCO model (including administrative expenses and risk margin) will be the same as the projected FY2013 gross cost under the PCCM model. Since administrative expenses and risk margin are significantly higher under the HMO model, in order for the gross cost to be the same as the PCCM it is necessary for the medical claims cost to be lower than that under the PCCM. We prepared an analysis which considered all of the cost factors (including PCCM case management fees and TMHP costs) and concluded that the managed care efficiency under the HMO model would need to be 10.1%, relative to the PCCM, in order for the gross cost for the two models to be equal. Therefore, we have applied a 10.1% managed care efficiency (or claims adjustment factor) to the FY2011 PCCM claims experience.

A summary of our analysis is presented in the attached exhibits. Exhibit A presents the counties included in the expansion. Exhibit B documents the calculation of the managed care claims discount factor.