STATE OF TEXAS
MEDICAID MANAGED CARE
STAR+PLUS PROGRAM RATE SETTING
STATE FISCAL YEAR 2014

Prepared for:
Texas Health and Human Services Commission
UMCC V2.6 and STAR+PLUS EXP V1.11

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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 2014 (FY2014, September 1, 2013 through August 31, 2014) 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 FY2014 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 2009 and a projection of future enrollment through August 2014. These projections were prepared by HHS System Forecasting staff.
- Claim lag reports by risk group for each health plan for the period September 2009 through February 2013. These reports include monthly paid claims by month of service.
- Inpatient claims data by health plan and risk group 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 FY2011, FY2012 and the first six months of FY2013. 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 (FY2013) 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
- FY2012 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 Fee-For-Service (FFS) and Primary Care Case Management (PCCM) plans.
- Information provided by HHSC regarding FY2012 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 FY2014 Medicaid provider reimbursement rates.
- 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

The actuarial model used to derive the FY2014 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 (FY2012) were developed. These estimates were then projected forward to FY2014 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 FY2014 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)
- Hidalgo County Service Area (Hidalgo)
- Jefferson County Service Area (Beaumont)
- Lubbock County Service Area (Lubbock)
- Nueces County Service Area (Corpus Christi)
- Tarrant County Service Area (Fort Worth)
- Travis County Service Area (Austin)

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

- Medicaid Only – Other Community Care (OCC)
- Medicaid Only – Home and Community Based Services (HCBS)
- Dual Eligible - OCC
- Dual Eligible - HCBS

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

<u>Long Term Care Services</u>

- 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 2014.

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 FY2014 cost for each individual HMO by estimating their base period (FY2012) 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 FY2014 cost for each health plan in the service area. The weights used in this formula are the projected FY2014 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 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 10. The final FY2014 premium rates were defined as the community rates with acuity risk adjustment for acute care services and community rates for long term care services.

III. Adjustment Factors

This section contains a description of the adjustment factors used in the FY2014 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 (FY2013 and FY2014).

The trend analysis included a review of HMO claims experience data through February 28, 2013. Based on this information, estimates of monthly incurred claims were made through December 2012. The claims cost and trend experience were 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 FY2013 non-inpatient acute care trend assumptions were developed from two components: (i) the actual estimated trend for the period September 2012 through December 2012 and (ii) the projected trend for the period January 2013 through August 2013. The experience trends for all time periods were adjusted to remove the impact of various provider reimbursement changes and other revisions that have impacted the program. The trends for the final eight months of FY2013 were projected using experience from FY2010 (3/10 weight), FY2011 (3/10 weight), FY2012 (3/10 weight) and the first four months of FY2013 (1/10 weight). The FY2014 non-inpatient acute care trend assumptions were developed based on an average of the HMO trends for the most recent four fiscal years (FY2010, FY2011, FY2012 and FY2013).

The inpatient facility trend assumptions were developed from an analysis of inpatient claims previously 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 FY2013 and FY2014 trend assumptions were developed based on an average of the trends for the most recent three fiscal years (FY2010, FY2011 and FY2012). Only claims prior to the carve-in of inpatient services on March 1, 2012 were considered during the FY2012 time period. Inpatient claims after March 1, 2012 were not considered in the trend analysis due to the significant programmatic changes that impacted inpatient claims once carved into the STAR+PLUS program.

The FY2013 long term care trend assumptions by risk group were developed from two components: (i) the actual estimated trend for the period September 2012 through December 2012 and (ii) the projected trend for the period January 2013 through August 2013. 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 FY2013 were projected using experience from FY2010 (3/10 weight), FY2011 (3/10 weight), FY2012 (3/10 weight) and the first four months of FY2013 (1/10 weight). The FY2014 long term care trend assumptions were developed based on an average of the HMO trends for the most recent four fiscal years (FY2010, FY2011, FY2012 and FY2013).

Attachment 5 is a summary of the cost trend analysis. The chart below presents the assumed annual trend rates for FY2013 and FY2014.

	FY2013	FY2014
Acute Care (non-inpatient)		
Medicaid Only - OCC	0.9%	3.3%
Medicaid Only - HCBS	-3.1%	0.0%
Acute Care (inpatient)		
Medicaid Only - OCC	2.9%	2.9%
Medicaid Only - HCBS	2.9%	2.9%
Long Term Care		
Medicaid Only - OCC	10.7%	12.4%
Medicaid Only - HCBS	1.1 %	0.0%
Dual Eligible - OCC	6.6 %	7.4 %
Dual Eligible - HCBS	-0.5 %	0.0 %

Provider Reimbursement Adjustments

Medicaid provider reimbursement changes were included for the following services: APR DRG implementation, Potentially Preventable Readmission reimbursement reductions, 10% reimbursement reduction for inpatient outlier reimbursement, revisions to the therapy and DME fee schedules, outpatient facility reimbursement reductions, outpatient imaging reimbursement reductions, ambulance reimbursement reductions, reduction of Medicaid rates in excess of Medicare and revisions to emergency room reimbursement provisions for non emergent services.

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.

Amount, Duration and Scope

The following cost containment initiatives have been implemented:

- Effective October 1, 2012, hearing aids for adults were limited to one per client. In addition, a variety of reimbursement changes for various hearing-related services were implemented.

- Effective January 1, 2012, renal dialysis services became reimbursable on an outpatient basis.

- Effective July 1, 2012, coverage of adjustable cranial helmets became limited to aiding the correction of congenital skull anomalies such as synostotic plagiocephaly.

Exhibit B of attachment 6 presents a summary of the derivation of this adjustment factor.

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 Exhibits C and D of Attachment 6.

APR DRG Adjustments

Effective September 1, 2012, HHSC implemented the APR DRG reimbursement system for most hospitals. Effective September 1, 2013 rural hospital and children's hospitals will transition to the APR DRG reimbursement system. HHSC staff has utilized the FY2012 encounter data to determine the cost impact from the APR DRG implementation on each service area and risk group. Exhibit L of Attachment 6 presents a summary of the resulting adjustment factors.

Attendant Care Rate Changes

Effective September 1, 2013 the minimum wage paid to attendant care providers will be increasing for various Personal Assistance Services (PAS) and Day Activity Health Services (DAHS). In addition, effective September 1, 2013 attendant care enhanced payments will be increasing to allow attendant care providers to qualify for increased enhanced payment levels. Exhibits A and B of Attachment 7 presents a summary of the adjustment factors.

Service Coordination Enhancement

Effective September 1, 2013 the STAR+PLUS health plans will be required to enhance their service coordination services. The enhancement requirements will include increased member outreach along with an increase in the number of face to face visits with high priority members. These increased requirements will increase the current service coordination costs by an estimated $2.45 per member per month. This increased cost has been reflected through an increase in the assumed care coordination expense included in the base period.

End Stage Renal Disease and Ventilator Dependent Members

Effective September 1, 2013 STAR+PLUS HMOs will no longer be permitted to disenroll members with end stage renal disease or members who are ventilator dependent. Transitioning these previously disenrolled members back to the STAR+PLUS program and preventing future disenrollment will increase the average cost as these tend to be very high cost members. Attachment 8 presents a summary of the resulting adjustment factors for acute care and long term care separately.

Spell of Illness

Effective September 1, 2013 STAR+PLUS HMOs will be permitted to include the spell of illness policy provisions in their inpatient reimbursement contracts. Due to this policy revision reimbursement for adults in the STAR+PLUS program will be limited to the first 30 days of inpatient care for a spell of illness. Attachment 9 presents a summary of the policy change and the resulting adjustment factors.

Seasonality Adjustment

The base period used in calculating the FY2014 premium rates for the El Paso, Hidalgo and Lubbock service areas and the inpatient rates for all service areas only included managed care claims incurred during the period March 2012 through August 2012. Managed care did not exist in these areas prior to March 2012 thus a full year of data was unavailable. The seasonal differences in the cost of medical care throughout the year were studied and it was determined that an adjustment for seasonality was not necessary for these populations and services.

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 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 10.

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 ($0.1025 pmpm) and a risk margin (2.0% of premium).

V. Summary

The chart below presents the results of the FY2014 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 2014.

Health Plan	Medicaid Only OCC	Medicaid Only HCBS	Dual Eligible OCC	Dual Eligible HCBS
Monthly Premium Rates				
Amerigroup - Bexar	$1,162.60	$3,982.68	$338.71	$1,729.07
Molina - Bexar	$1,084.26	$4,010.35	$338.71	$1,729.07
Superior - Bexar	$1,231.43	$4,000.93	$338.71	$1,729.07
Molina - Dallas	$1,040.82	$3,933.47	$258.52	$1,536.41
Superior - Dallas	$1,067.19	$4,020.24	$258.52	$1,536.41
Amerigroup - El Paso	$1,117.01	$4,351.43	$380.43	$2,079.20
Molina - El Paso	$1,213.16	$4,065.16	$380.43	$2,079.20
Amerigroup - Harris	$1,314.96	$4,856.94	$318.53	$1,532.27
Molina - Harris	$1,248.28	$4,821.36	$318.53	$1,532.27
United - Harris	$1,469.64	$4,546.21	$318.53	$1,532.27
Health Spring - Hidalgo	$1,414.76	$3,727.71	$907.66	$2,010.46
Molina - Hidalgo	$1,405.57	$3,973.18	$907.66	$2,010.46
Superior - Hidalgo	$1,473.42	$3,808.59	$907.66	$2,010.46
Amerigroup - Jefferson	$1,042.16	$3,440.47	$197.69	$1,413.79
Molina - Jefferson	$1,147.09	$3,372.68	$197.69	$1,413.79
United - Jefferson	$1,183.86	$4,056.32	$197.69	$1,413.79
Amerigroup - Lubbock	$1,058.05	$3,086.79	$143.59	$1,221.83
Superior - Lubbock	$1,086.78	$3,324.11	$143.59	$1,221.83
Superior - Nueces	$1,378.31	$4,012.40	$437.79	$1,605.55
United - Nueces	$1,295.83	$3,798.23	$437.79	$1,605.55
Amerigroup - Tarrant	$1,154.73	$4,159.51	$195.28	$1,481.52
Health Spring - Tarrant	$1,024.10	$4,400.54	$195.28	$1,481.52
Amerigroup - Travis	$1,300.05	$4,546.06	$233.37	$1,678.42
United - Travis	$1,205.91	$4,265.05	$233.37	$1,678.42

Attachment 1 presents additional information regarding the FY2014 rates including a comparison to current (FY2013) rates.

VI. Actuarial Certification of FY2014 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 2014 (FY2014) 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 FY2014 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 FY2014 STAR+PLUS Rating Analysis

The attached exhibit presents summary information regarding the FY2014 rates. Included on the exhibit are current premium rates by component, FY2014 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 2009 through February 2013. 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 February 2013.

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 28, 2013, (iii) estimated proportion of that month's incurred claims paid through February 28, 2013 (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 FY2014 cost based on the HMO's actual experience. The top of the exhibit shows summary base period (FY2012) enrollment, premium and claims experience. Next are projected FY2013 enrollment and premium based on current (FY2013) rates. Trend assumptions for FY2013 and FY2014 are used to project the average base period claims cost to FY2014. Adjustment factors are used to recognize the cost impact of benefit and provider reimbursement changes. Combining these factors results in projected FY2014 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 ($0.1025 pmpm) and risk margin (2.0% of premium).

At the bottom of Exhibit D is a summary of the projected FY2014 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 FY2014 cost for each health plan in the service area. The weights used in this formula are the projected number of FY2014 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 FY2014 STAR+PLUS HMO community rates for the following service areas:

Exhibit A – Bexar Service Area
Exhibit B – Dallas Services Area
Exhibit C – El Paso Services Area
Exhibit D – Harris Service Area
Exhibit E – Hidalgo Service Area
Exhibit F – Jefferson Service Area
Exhibit G – Lubbock Service Area
Exhibit H – Nueces Service Area
Exhibit I – Tarrant Service Area
Exhibit J – Travis Service Area

These exhibits show projected FY2014 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 (FY2012) experience and projected FY2014 enrollment, premium and incurred claims experience. An exception to the base experience period was made for the El Paso, Hidalgo and Lubbock service areas. STAR+PLUS expanded into these three areas effective March 1, 2012. For these three areas the base period used to develop the FY2014 experience is the period March 1, 2012 through August 31, 2012. 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 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 ($0.1025 pmpm) and risk margin (2.0% of premium).

The bottom of the exhibit shows a summary of the projected FY2014 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 FY2014 cost for each health plan in the service area. The weights used in this formula are the projected number of FY2014 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 FY2014 STAR+PLUS HMO community rates for the following service areas:

Exhibit A – Bexar Service Area
Exhibit B – Dallas Services Area
Exhibit C – El Paso Services Area
Exhibit D – Harris Service Area
Exhibit E – Hidalgo Service Area
Exhibit F – Jefferson Service Area
Exhibit G – Lubbock Service Area
Exhibit H – Nueces Service Area
Exhibit I – Tarrant Service Area
Exhibit J – Travis Service Area

These exhibits show projected FY2014 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 (FY2012) experience and projected FY2014 enrollment, premium and incurred claims experience. STAR+PLUS carved inpatient services into the STAR+PLUS program effective March 1, 2012. For all areas the base period used to develop the FY2014 inpatient experience is the period March 1, 2012 through August 31, 2012. 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 base period experience.

The cost of reinsurance is also considered. 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 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 FY2014 cost based on these assumptions.

Attachment 5

Trend Analysis

The FY2014 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 28, 2013. Based on this information, estimates of monthly incurred claims were made through December 2012. 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 FY2013 non-inpatient acute care trend assumptions were developed from two components: (i) the actual estimated trend for the period September 2012 through December 2012 and (ii) the projected trend for the period January 2013 through August 2013. The experience trends for all time periods were adjusted to remove the impact of various provider reimbursement changes and other revisions that have impacted the program. The trends for the final eight months of FY2013 were projected using experience from FY2010 (3/10 weight), FY2011 (3/10 weight), FY2012 (3/10 weight) and the first four months of FY2013 (1/10 weight). The FY2014 non-inpatient acute care trend assumptions were developed based on an average of the HMO trends for the most recent four fiscal years (FY2010, FY2011, FY2012 and FY2013).

The inpatient acute care trend assumptions were developed from an analysis of inpatient claims previously 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 FY2013 and FY2014 trend assumptions were developed based on an average of the trends for the most recent three fiscal years (FY2010, FY2011 and FY2012). Only claims prior to the carve-in of inpatient services on March 1, 2012 were considered during the FY2012 time period. Inpatient claims after March 1, 2012 were not considered in the trend analysis due to the significant programmatic changes that impacted inpatient claims once carved into the STAR+PLUS program.

The FY2013 long term care trend assumptions by risk group were developed from two components: (i) the actual estimated trend for the period September 2012 through December 2012 and (ii) the projected trend for the period January 2013 through August 2013. 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 FY2013 were projected using experience from FY2010 (3/10 weight), FY2011 (3/10 weight), FY2012 (3/10 weight) and the first four months of FY2013 (1/10 weight). The FY2014 long term care trend assumptions were developed based on an average of the HMO trends for the most recent four fiscal years (FY2010, FY2011, FY2012 and FY2013).

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 FY2013 and FY2014.

	FY2013	FY2014
Acute Care (non-inpatient)		
Medicaid Only - OCC	0.9%	3.3%
Medicaid Only - HCBS	-3.1%	0.0%
Acute Care (inpatient)		
Medicaid Only - OCC	2.9%	2.9%
Medicaid Only - HCBS	2.9%	2.9%
Long Term Care		
Medicaid Only - OCC	10.7%	12.4%
Medicaid Only - HCBS	1.1 %	0.0%
Dual Eligible - OCC	6.6 %	7.4 %
Dual Eligible - HCBS	-0.5 %	0.0 %

Attachment 6

Provider Reimbursement and Benefit Revisions Effective During FY2012, FY2013 and FY2014

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 (FY2012) and before the end of FY2014.

Effective March 1, 2012 HHSC implemented revisions to the therapy and Durable Medical Equipment fee schedules. Exhibit A presents a summary of the derivation of the rating adjustment factors.

HHSC implemented the following cost containment initiatives collectively referred to as Amount, Duration and Scope:

- Effective October 1, 2012, hearing aids for adults were limited to one per client. In addition, a variety of reimbursement changes for various hearing-related services were implemented.
- Effective January 1, 2012, renal dialysis services became reimbursable on an outpatient basis.
- Effective July 1, 2012, coverage of adjustable cranial helmets became limited to aiding the correction of congenital skull anomalies such as synostotic plagiocephaly.

Exhibit B presents a summary of the derivation of the rating adjustment factors for Amount, Duration and Scope.

Effective March 1, 2012 certain early childhood intervention (ECI) and hearing and audiology services for children became capitated under the program. Prior to this time these services were paid on a fee-for-service basis. Exhibits C and D presents a summary of the derivation of the rating adjustment factors.

Effective March 1, 2012 and again on September 1, 2013, HHSC implemented revisions to the therapy fee schedules. The reductions that will be effective on September 1, 2013 apply to independent therapists, Comprehensive Outpatient Rehabilitation Facilities/Outpatient Rehabilitation Facilities (CORFs/ORFs), and home health agencies. Reimbursement will be reduced by 5% for therapy services provided outside the home and 3% for therapy services provided inside the home. Exhibit E presents a summary of the derivation of the rating adjustment factors.

Effective September 1, 2013 HHSC will be implementing an outpatient hospital reduction of 5.3 percent, which excludes clinical lab and outpatient imaging services. This reduction does not apply to children's hospitals, rural hospitals, or state-owned teaching hospitals. Exhibit F presents a summary of the derivation of the rating adjustment factors.

Effective September 1, 2013 HHSC will be revising the reimbursement for non emergent services provided in an emergency room. These changes will include the following:

- Reimbursement will be restricted when an individual returns to the emergency department within a 36 hour period.
- Reimbursement will be restricted for non-urgent visits in excess of 24 per year.
- Non-urgent visits will be reimbursed using a flat fee.

Exhibits G and H presents a summary of the derivation of the rating adjustment factors for non emergent services delivered in an emergency room.

Effective September 1, 2013 HHSC will be reducing hospital imaging reimbursement to 125% of the amount reimbursed for imaging performed in a physician's office. Exhibit I presents a summary of the derivation of the rating adjustment factors.

Effective September 1, 2013 HHSC will be reducing ambulance reimbursement by 5%. Exhibit J presents a summary of the derivation of the rating adjustment factors.

Effective September 1, 2013 HHSC will be reducing all Medicaid rates that are in excess of Medicare. Exhibit K presents a summary of the derivation of the rating adjustment factors.

Effective September 1, 2012 HHSC implemented the APR-DRG reimbursement system for all hospitals excluding rural, children's and state owned teaching facilities. Effective September 1, 2013 HHSC will transition all rural and children's facilities to the APR-DRG reimbursement system. Exhibit L presents a summary of the derivation of the rating adjustment factors.

Effective May 1, 2013 HHSC implemented revisions to hospital reimbursement to account for Potentially Preventable Readmissions (PPR). The reimbursement reductions amount to 1-2% depending on a hospitals performance during the evaluation time period. Exhibit M presents a summary of the derivation of the rating adjustment factors.

Effective September 1, 2103 HHSC will be reducing the outlier portion of facility reimbursement by 10%. Children's hospitals are excluding from this reduction. Exhibit N presents a summary of the derivation of the rating adjustment factors.

Attachment 7

Long Term Care Reimbursement Adjustments

Effective September 1, 2013 the minimum wage paid to attendant care providers will be increasing for various Personal Assistance Services (PAS) and Day Activity Health Services (DAHS). Exhibit A presents a summary of the derivation of the adjustment factors.

Effective September 1, 2013 attendant care enhanced payments will be increased to allow certain attendant care providers to qualify for increased enhanced payment levels. Exhibit B presents a summary of the derivation of the adjustment factors.

Effective September 1, 2013 the STAR+PLUS health plans will be required to enhance their service coordination services. The enhancement requirements will include increased member outreach along with an increase in the number of face to face visits with high priority members. The estimated impact of these enhancements is an increase of the average service coordination expense of $2.45 per member per month.

Attachment 8

End Stage Renal Disease and Ventilator Dependent Members

Effective September 1, 2013 STAR+PLUS HMOs will no longer be permitted to disenroll members with end stage renal disease (ESRD) or members who are ventilator dependent. Transitioning these previously disenrolled members back to the STAR+PLUS program and preventing future disenrollment will increase the average cost as these tend to be very high cost members. The adjustment factored was determined by collecting the fee-for-service claims incurred during the base period for all ESRD and ventilator dependent members who had been disenrolled from the STAR+PLUS program and determining the net increase on the base period. The attached exhibit presents a summary of the adjustment factors for both acute care and long term care separately.

Attachment 9

Spell of Illness Adjustment

Effective September 1, 2013 STAR+PLUS health plans will be permitted to impose the fee-for-service 30-day spell of illness limit on inpatient services provided to adults. Under the spell of illness limit, Medicaid payment is not made for inpatient services after a Medicaid client has had 30-days of aggregate inpatient care, whether consecutive or not. Payment resumes when a client has been out of the hospital for 60 consecutive days. There are two exceptions to the policy: (1) where there has been a prior approval for solid organ transplant; and (2) THSteps clients 20-year-of-age and younger for medically necessary treatment.

The attached exhibit presents a summary of the adjustment factors. The adjustment factors are based on FY2011 data due to limitations of the FY2012 data which was covered under fee-for-service during the first six months and managed care during the last six months.

Attachment 10

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 a significant shift in the enrollment mix between health plans in the Hidalgo service area, an adjustment was made to the acuity analysis for this area only. The acuity by individual was tracked during this enrollment shift and the acuity scores were reallocated amongst the health plans based on each member's enrollment as of December 2012. This adjustment was intended to track the changes in relative acuity amongst the health plans due to this enrollment shift after the base period used in the rate development.

For all MCOs in new STAR+PLUS service areas (El Paso, Hidalgo and Lubbock) we assumed the greater of (i) 100% of the risk adjustment factor for the period September 2013 through August 2014 and (ii) 50% of the risk adjustment factor for the period September 2013 through February 2014 and 100% of the risk adjustment factor for the period March 2014 through August 2014. This revision was made to recognize that only six months of information was available to determine member acuity as compared to the usual 12 months.