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

Prepared for:
Texas Health and Human Services Commission
UMCC V2.6

Prepared by:
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Rudd and Wisdom, Inc.

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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 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 and age 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 and age group for each health plan for the period September 2009 through February 2013. These reports include monthly paid claims by month of service.
- 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 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 2009 through December 2012.
- 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 FY2012 third party reimbursement from each of the HMOs.
- 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 Primary Care Case Management (PCCM) plan.
- 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

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 2014.

The actuarial model used to derive the FY2014 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 (FY2012) were developed. These estimates were then projected forward to FY2014 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 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)
- Central Medicaid Rural Service Area (MRSA Central)
- Northeast Medicaid Rural Service Area (MRSA Northeast)
- West Medicaid Rural Service Area (MRSA West)

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

- Under Age One Year
- Ages 1 - 5
- Ages 6 - 14
- Ages 15 - 18
- Ages 19 - 20
- TANF Adults
- Pregnant Women
- SSI (MRSA only)

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 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), 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.

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 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 projected FY2014 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 FY2014 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 applies to all service areas but varies by risk group 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 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 FY2013 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 trend assumptions were then developed from a simple average of the FY2010 trend, FY2011 trend, FY2012 trend and projected FY2013 trend.

The FY2013 and FY2014 trend assumptions for the SSI population in the MRSA SDA were developed based on the historical managed care experience of the SSI population in the STAR+PLUS program. Additional information regarding the SSI trend assumptions can be found in the report titled State of Texas Medicaid Managed Care STAR+PLUS Program Rate Setting State Fiscal Year 2014.

Attachment 4 is a summary of the cost trend analysis. The chart below presents the assumed annual trend rates for FY2013 and FY2014.

	FY2013	FY2014
Under Age 1 Year	4.0 %	1.7 %
Ages 1 - 5	7.9 %	6.2 %
Ages 6 - 14	7.5 %	5.4 %
Ages 15 - 18	5.0 %	4.0 %
Ages 19 - 20	1.4 %	4.1 %
TANF Adults	2.1 %	3.2 %
Pregnant Women	0.3 %	0.4 %
SSI (MRSA Only)	1.6 %	3.2 %

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 5 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 C of attachment 5 presents a summary of the derivation of this adjustment factor.

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 D and E 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 A of Attachment 5 presents a summary of the derivation of these adjustment factors.

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 M of Attachment 5 presents a summary of the resulting adjustment factors.

Managed Care Efficiency

The rating analysis includes an explicit assumption regarding the anticipated reduction in claims cost resulting from the implementation of managed care in the Hidalgo SDA. Although managed care has been in place in the Hidalgo SDA since March 2012 the efficiency of managed care continues to improve. In deriving the managed care efficiency factor we relied upon managed care data through December 2012. The time period September 2012 through December 2012 was compared to the base period March 2012 through August 2012 to determine the continued reduction in medical cost. The managed care savings factor of 3.5% is equal to the average reduction in medical cost between these two time periods. Attachment 10 presents the derivation of the adjustment factor.

Seasonality Adjustment

The base period used in calculating the FY2014 premium rates for the Hidalgo and MRSA 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. Due to seasonal differences in the cost of medical care

throughout the year this shortened base period has been adjusted to account for seasonality. Attachment 11 presents a summary of the adjustment factors

Family Planning Exclusion

Some of the MCOs that participate in the STAR program do not 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 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 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, Ages 15-18, and Ages 19-20. 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 ($0.1025 pmpm) and a risk margin (2.0% of premium).

V. Summary

The chart below presents the results of the FY2014 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 2014.

	Under Age 1	Ages 1-5	Ages 6-14	Ages 15-18	Ages 19-20
Monthly Adjusted Premium Rate					
Aetna - Bexar	655.81	171.98	118.17	138.52	197.45
Amerigroup - Bexar	550.35	155.13	124.34	133.10	217.72
CFHP - Bexar	609.74	171.74	135.54	164.08	250.19
Superior - Bexar	720.16	187.72	135.50	157.47	259.01
Amerigroup - Dallas	504.45	178.70	130.11	145.43	200.96
Molina - Dallas	482.35	174.86	114.20	133.28	190.63
Parkland - Dallas	559.76	198.69	137.35	155.51	223.29
El Paso First - El Paso	486.83	152.04	109.90	129.38	159.67
Molina - El Paso	368.38	166.77	95.78	105.38	387.63
Superior - El Paso	532.72	144.61	119.75	135.53	170.77
Amerigroup - Harris	702.29	172.50	118.91	148.55	263.54
CHC - Harris	602.47	168.67	111.53	137.48	242.45
Molina - Harris	647.65	195.94	125.69	154.08	278.45
TCHP - Harris	563.33	167.96	133.92	162.38	239.97
United - Harris	678.96	188.04	119.83	183.39	330.77
Driscoll - Hidalgo	399.56	216.17	145.17	134.83	219.53
Molina - Hidalgo	417.37	265.01	172.10	156.44	262.64
Superior - Hidalgo	478.55	277.63	172.73	158.15	236.08
United - Hidalgo	534.56	280.71	171.66	152.49	236.00
Amerigroup - Jefferson	854.12	186.24	120.03	148.69	283.42
CHC - Jefferson	615.40	150.99	126.17	145.47	288.48
Molina - Jefferson	673.11	179.56	121.92	132.93	433.01
TCHP - Jefferson	629.94	170.56	146.58	164.05	261.32
United - Jefferson	609.87	150.34	130.34	151.68	424.19
Amerigroup - Lubbock	494.45	122.23	126.34	107.76	254.52
Firstcare - Lubbock	570.46	139.22	105.15	149.55	293.05
Superior - Lubbock	548.40	150.07	113.92	137.88	243.38
Christus - Nueces	687.06	204.44	160.36	184.37	224.77
Driscoll - Nueces	676.34	226.06	178.92	208.18	227.46
Superior - Nueces	627.05	232.15	161.68	198.32	274.21
Aetna - Tarrant	563.94	184.06	109.42	149.79	255.06
Amerigroup - Tarrant	519.11	165.22	124.47	146.72	227.96
Cook - Tarrant	514.07	199.19	161.43	169.92	221.78
BCBS - Travis	511.04	159.94	115.19	134.44	187.88
Sendero - Travis	536.19	185.26	112.21	127.18	219.62
Seton - Travis	545.10	162.01	115.99	136.09	163.66
Superior - Travis	599.97	178.77	119.77	144.83	190.87
Amerigroup - MRSA Central	486.67	144.97	115.51	136.11	190.36
Scott & White - MRSA Central	490.78	145.32	115.04	146.46	169.14
Superior - MRSA Central	521.06	144.01	119.64	147.56	186.47
Amerigroup - MRSA Northeast	510.71	158.66	119.80	137.12	231.43
Superior - MRSA Northeast	534.82	142.77	124.22	134.39	223.06
Amerigroup - MRSA West	551.19	125.85	105.82	130.20	227.97
Firstcare - MRSA West	538.81	128.13	114.55	126.44	238.28
Superior - MRSA West	568.26	143.53	127.16	144.82	262.13

	TANF Adults	Pregnant Women	SSI	Delivery Supplemental Payment
Monthly Adjusted Premium Rate				
Aetna - Bexar	456.99	518.26		3,266.59
Amerigroup - Bexar	417.08	458.10		3,266.59
CFHP - Bexar	484.18	507.94		3,266.59
Superior - Bexar	521.96	540.39		3,266.59
Amerigroup - Dallas	348.23	432.33		3,537.13
Molina - Dallas	329.90	394.41		3,537.13
Parkland - Dallas	352.00	443.05		3,537.13
El Paso First - El Paso	318.29	319.58		3,443.04
Molina - El Paso	297.67	272.81		3,443.04
Superior - El Paso	340.43	321.87		3,443.04
Amerigroup - Harris	526.83	478.11		3,519.20
CHC - Harris	450.86	474.13		3,519.20
Molina - Harris	475.91	452.98		3,519.20
TCHP - Harris	415.42	464.67		3,519.20
United - Harris	542.08	470.24		3,519.20
Driscoll - Hidalgo	287.43	369.82		3,409.95
Molina - Hidalgo	360.99	345.52		3,409.95
Superior - Hidalgo	358.28	359.85		3,409.95
United - Hidalgo	408.14	359.30		3,409.95
Amerigroup - Jefferson	496.62	452.55		3,394.58
CHC - Jefferson	383.73	439.57		3,394.58
Molina - Jefferson	445.40	439.58		3,394.58
TCHP - Jefferson	367.06	430.82		3,394.58
United - Jefferson	464.04	469.34		3,394.58
Amerigroup - Lubbock	331.27	342.09		3,230.39
Firstcare - Lubbock	380.14	396.74		3,230.39
Superior - Lubbock	331.08	409.37		3,230.39
Christus - Nueces	381.14	455.00		3,203.82
Driscoll - Nueces	369.04	485.22		3,203.82
Superior - Nueces	491.61	512.02		3,203.82
Aetna - Tarrant	428.41	380.29		3,635.64
Amerigroup - Tarrant	443.02	375.41		3,635.64
Cook - Tarrant	343.88	386.85		3,635.64
BCBS - Travis	370.81	527.53		3,247.49
Sendero - Travis	359.88	528.99		3,247.49
Seton - Travis	359.82	522.14		3,247.49
Superior - Travis	406.74	561.01		3,247.49
Amerigroup - MRSA Central	285.70	356.78	829.27	3,035.27
Scott & White - MRSA Central	303.09	354.91	870.16	3,035.27
Superior - MRSA Central	356.62	384.75	983.72	3,035.27
Amerigroup - MRSA Northeast	390.11	433.26	926.15	3,160.40
Superior - MRSA Northeast	400.26	427.48	958.99	3,160.40
Amerigroup - MRSA West	330.97	414.71	853.84	3,204.07
Firstcare - MRSA West	399.72	414.14	882.49	3,204.07
Superior - MRSA West	395.66	426.38	970.34	3,204.07

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 FY2014 STAR HMO premium rates for 1915(b)(3) waiver services.

Health Plan	TANF Adults	Pregnant Women	SSI (MRSA Only)
Monthly Premium Rate for 1915(b)(3) Services			
All Plans/All Areas	$ 3.85	$ 2.56	$3.54

Attachment 1 presents additional information regarding the FY2014 rates.

VI. Actuarial Certification of FY2014 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 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 Rating Analysis

The attached exhibit presents summary information regarding the FY2014 rates. Included on the exhibit are FY2014 premiums, split between medical, prescription drug and DSP 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 and number of maternity deliveries by risk group for the period September 2010 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 2010 through December 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 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 and claims experience. Next is projected FY2014 enrollment. 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. 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 ($0.1025 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 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 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 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 – 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
Exhibit K – MRSA Central Service Area
Exhibit L – MRSA Northeast Service Area
Exhibit M – MRSA West 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 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 ($0.1025 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 both with and without the inclusion of maternity expenses

Attachment 4

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. 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 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 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. Only those service areas that had managed care in place prior to March 1, 2012 were included in this analysis.

The FY2013 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 trend assumptions were then developed from a simple average of the FY2010 trend, FY2011 trend, FY2012 trend and projected FY2013 trend.

The FY2013 and FY2014 trend assumptions for the SSI population in the MRSA SDA were developed based on the historical managed care experience of the SSI population in the STAR+PLUS program. Additional information regarding the SSI trend assumptions can be found in the report titled State of Texas Medicaid Managed Care STAR+PLUS Program Rate Setting State Fiscal Year 2014.

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 FY2013 and FY2014.

	FY2013	FY2014
Under Age 1	4.0 %	1.7 %
Ages 1 - 5	7.9 %	6.2 %
Ages 6 - 14	7.5 %	5.4 %
Ages 15 - 18	5.0 %	4.0 %
Ages 19 - 20	1.4 %	4.1 %
TANF Adults	2.1 %	3.2 %
Pregnant Women	0.3 %	0.4 %
SSI (MRSA Only)	1.6 %	3.2 %

Attachment 5

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 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 A presents a summary of the derivation of the rating adjustment factors.

Effective March 1, 2012 HHSC implemented revisions to the therapy and Durable Medical Equipment fee schedules. Exhibit B 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 C 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 D and E 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 F 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 G 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 H and I 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 J presents a summary of the derivation of the rating adjustment factors.

Effective September 1, 2013 HHSC will be reducing ambulance reimbursement by 5%. Exhibit K 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 L 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 M 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 N 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 O 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 do not 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 FY2012.

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, and various children age groups. 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 FY2014 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.

For new MCOs in the Nueces and Travis service areas, we assumed no acuity risk adjustment for the period September 2013 through February 2014 (the first six months of FY2014) and 50% of the applicable risk adjustment factor for the period March 2014 through August 2014. For new MCOs in the other service areas we assumed 50% of the risk adjustment factor applies for FY2014. These revisions to the risk adjustment methodology were applied in order to recognize the significant increase in enrollment for these new MCOs since the fiscal year 2012 experience period. For all MCOs in new STAR service areas (Hidalgo and MRSA) 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.

Attachment 10

Managed Care Discount Factor

The Hidalgo Service Delivery area has experienced continued improvement in the managed care efficiencies since its implementation on March 1, 2012. Much of this managed care efficiency has been captured in the base period used for the rate development, March 2012 through August 2012. However, due to the complexities of the region and significant change in medical cost after the implementation of managed care, the average cost has continued to decrease. This reduction has been captured through the 3.5% managed care discount factor applied to this service area only.

The adjustment factor has been determined through a comparison of the average medical cost during the base period, March 2012 through August 2012, to the time period immediately following, September 2012 through December 2012. Claims during the subsequent time period have continued to decline by an average of 3.5%.

The attached exhibit presents a summary of the managed care discount factor for the Hidalgo service area.

Attachment 11

Seasonality Adjustment

The Hidalgo and MRSA Service Deliveries were new to the STAR program on March 1, 2012. Due to their implementation date these SDAs only have six month of data in the FY2012 base period. This data must be adjusted for the seasonal differences in costs in order to accurately projection forward to the full year of FY2014.

The seasonal adjustment factors are based on the historical differences in average cost in the STAR program during the time period March through August compared to the entire fiscal year September through August. The adjustment factors were calculated as the average during the time period FY2008 through FY2012.

The attached exhibit presents the average seasonal differences in cost and the adjustment factors used in the Hidalgo and MRSA service areas.