STATE OF TEXAS
MEDICAID MANAGED CARE
STAR PROGRAM RATE SETTING
STATE FISCAL YEAR 2017

Prepared for:
Texas Health and Human Services Commission
Uniform Managed Care Contract 529-12-0002 V2.19

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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 2017 (FY2017, September 1, 2016 through August 31, 2017) premium rates for health plans participating in the Texas Medicaid STAR program. This report presents the rating methodology and assumptions used in developing the premium rates.

Medicaid's State of Texas Access Reform (STAR) program provides primary, acute care, and pharmacy services for low-income families, children, pregnant women, and some former foster care youth. The program operates statewide with services delivered through managed care organizations under contract with HHSC. There are thirteen STAR service delivery areas (SDAs). STAR Medicaid members can select from at least two MCOs in each service delivery area. There are a total of 18 MCOs serving different STAR SDAs throughout the state. STAR is the program through which most people in Texas get their Medicaid coverage.

Rudd and Wisdom has provided actuarial services to the Texas Medicaid program for over 30 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 FY2017 health plan premium rates.

Rudd and Wisdom has relied on the following data sources as provided by HHSC, the participating health plans 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 2012 and a projection of future enrollment through August 2017. 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 2012 through February 2016. These reports were prepared by the health plans and include monthly paid claims by month of service.
- Financial Statistical Reports (FSR) for each participating health plan for FY2014, FY2015 and the first six months of FY2016. The FSR contains detailed information regarding monthly enrollment, revenue, incurred claims and administrative expenses, as reported by the health plan. These reports are prepared by the health plans and are audited by an external audit organization.
- Reports from the EQRO summarizing their analysis of the health plan's encounter claims data.
- Reports from the health plans providing information on high volume claimants during the experience period.
- Current (FY2016) premium rates and Delivery Supplemental Payment rates by risk group for each health plan.
- The number of maternity deliveries by health plan and risk group for the period September 2012 through December 2015.
- Information from both HHSC and the health plans regarding recent changes in covered

services and provider reimbursement under the Medicaid program.

- Information from the health plans regarding current and projected payment rates for certain capitated services, such as behavioral health and vision.
    - Subcapitated services make up less than 1.4% of total plan cost and are most commonly vision and behavioral health arrangements. Information about these arrangements was provided by the health plans and verified with the audited FSRs. These items were reviewed for reasonableness by comparing the reported expense amounts from the various health plans to those arrangements of other health plans.
- Information regarding FY2015 third party reimbursement from each of the health plans.
- FY2015 acuity risk adjustment analysis provided by the EQRO for each participating health plan.
- Information from the health plans regarding current and projected reinsurance premium rates.
- Information provided by HHSC regarding FY2015 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 FY2017 Medicaid provider reimbursement rates.

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. Information submitted by the health plans was compared to information submitted in prior years, the audited Financial Statistical Reports (FSRs) and the detailed encounter data. All comparisons were done by risk group as well as in aggregate. In the case of inconsistent information, follow up inquiries were made with each applicable health plan until all information was corrected and reconciled with the other data sources. Ultimately there was satisfactory consistency between all data sources. Although the above data was reviewed for reasonableness, Rudd and Wisdom did not audit the data. Based on this review it has been determined that the data collected and used in the FY2017 rate development process is complete, accurate and credible.

In addition to the review for reasonableness performed by Rudd and Wisdom, HHSC employs the Institute for Child Health Policy (ICHP) as an External Quality Review Organization. ICHP reviews the detail encounter data and provides certification of the data quality. Below is an excerpt from their data certification report:

Based on an administrative review, the EQRO considers the required data elements for all MCO/(R)SA combinations in STAR to be accurate, and complete, meeting the following components of Texas Government Code § 533.0131 for data certification purposes:

1. *The encounter data for the most recent measurement year are complete, accurate, and reliable.*

2. *No statistically significant variability in the encounter data is attributable to incompleteness, inaccuracy, or other deficiency as compared to equivalent data for similar populations and when evaluated against professionally accepted standards.*

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 2017.

The actuarial model used to derive the FY2017 STAR health plan premium rates relies primarily on health plan financial experience. The historical claims experience for each health plan (by area and risk group) was analyzed and estimates for the base period (FY2015) were developed. Estimates of the FY2015 base period include an estimate of incurred but unpaid claims (IBNR). The IBNR estimate is based on claims paid through February 2016 and represents less than 0.3% of total claims. These estimates were then projected forward to FY2017 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 FY2017 cost under the health plan. These projected total cost rates were determined separately for each risk group for each health plan in each service area. The results of this analysis were then combined for all health plans 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)
- Medicaid Rural Service Area - Central (MRSA Central)
- Medicaid Rural Service Area - Northeast (MRSA Northeast)
- Medicaid Rural Service Area - West (MRSA West)

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

- Children under Age One Year
- Children ages 1 - 5
- Children ages 6 - 14
- Children ages 15 - 18
- Children ages 19 - 20
- TANF Adults
- Pregnant Women

*Due to a small sample size, the Children ages 19-20 have been combined with the Children ages 15-18.

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 where these services are carved out and provided through the North Star program)
- 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

Examples of services specifically excluded from the analysis include:

- Dental and Orthodontia Services
- Early Childhood Intervention (ECI) case management/service coordination
- Texas School Health and Related Services (SHARS)
- Health and Human Services Commission's Medical Transportation
- Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation)

All expenses related to these and other non-capitated services are excluded from the FY2017 rating analysis.

We projected the FY2017 cost for each individual health plan by estimating their base period (FY2015) 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 health plan (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 health plan. 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 however no adjustments were deemed to be necessary.

HHSC utilized the combination of two rating methodologies in setting the FY2017 STAR premium rates – individual plan experience rating and community rating. The individual plan experience rating method is described above and documented in Attachment 2. The community rates are developed by a weighted average of the projected FY2017 cost for each health plan in the service area. The weights used in this formula are the projected FY2017 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 FY2017 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 health plan. 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 health plan. 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 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.

The FY2017 STAR health plan premium rates were then defined as the following: the minimum of (a) 108% of the rate developed using the individual experience of the plan and (b) community rate with risk adjustment. This is a slight variation to the methodology that was used during the FY2016 STAR rate development and has been implemented in order to limit the excessive profits achieved by health plans with significantly lower costs than the community average. By limiting the final premium rates to no greater than 108% of the rate developed using the individual experience of the plan, the STAR rates continue to incentivize the efficient provision of services while limiting the ability of a relatively low cost plan from benefiting from the higher community average premium rates.

III. Adjustment Factors

This section contains a description of the adjustment factors used in the FY2017 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 health plans. Trend assumptions for FY2016 vary by service area and are established on a statewide basis for FY2017. All trend assumptions vary by risk group.

The trend analysis included a review of health plan claims experience data through February 29, 2016. Based on this information, estimates of monthly incurred claims were made through December 2015. 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. All historical trends have been calculated as the average cost per member per month during a specified time period (monthly, quarterly or annually) compared to the same time period from the prior year. For example, the FY2015 trend has been calculated as the change in average cost per member per month during the period September 1, 2014 through August 31, 2015 (FY2015) compared to the average cost per member per month during the period September 1, 2013 through August 31, 2014 (FY2014). 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 cost of the program.

The FY2016 trend assumptions were developed from two components: (i) the actual estimated trend by service area for the period September 2015 through December 2015 and (ii) the projected trend for the period January 2016 through August 2016. The actual trends for the period September 2015 through December 2015 were calculated separately for each service delivery area. The projected trend for the period January 2016 through August 2016 were projected using experience data from FY2013 (3/10 weight), FY2014 (3/10 weight), FY2015 (3/10 weight) and the first four months of FY2016 (1/10 weight). The weighting of each time period was based on the number of months within each time period.

Blending the area specific trends for the period September 2015 through December 2015 with the statewide projected trend for the period January 2016 through August 2016 was done via the following formula:

$$\text{FY2016 SDA Trend} = \frac{(\text{9/15-12/15 actual SDA trend}) \times 4 + (\text{1/16-8/16 Statewide}) \times 8}{12}$$

The FY2017 trend assumptions were then developed on a statewide basis from a simple average of the FY2013 trend, FY2014 trend, FY2015 trend and FY2016 trend.

The FY2016 and FY2017 trend assumptions were limited to no less than 0.0%.

Attachment 4 is a summary of the cost trend analysis. The chart below presents the assumed annual trend rates for FY2016 and FY2017.

	Under Age 1	Ages 1-5	Ages 6-14	Ages 15-20	TANF Adult	Pregnant Women
FY2016						
Bexar SDA	0.0%	2.3%	3.1%	2.7%	0.0%	0.0%
Dallas SDA	13.3%	4.1%	1.9%	0.0%	0.0%	0.0%
El Paso SDA	0.0%	4.8%	2.6%	0.7%	2.8%	0.3%
Harris SDA	0.9%	2.4%	1.5%	0.0%	1.3%	0.2%
Hidalgo SDA	4.7%	4.8%	2.5%	1.8%	1.4%	0.0%
Jefferson SDA	0.0%	5.7%	4.7%	0.0%	3.6%	1.1%
Lubbock SDA	0.0%	2.2%	1.1%	4.3%	0.0%	0.0%
Nueces SDA	2.1%	4.8%	2.5%	7.2%	3.3%	0.9%
Tarrant SDA	0.0%	0.9%	3.9%	0.0%	1.8%	0.0%
Travis SDA	0.0%	1.4%	1.0%	2.3%	0.0%	0.0%
MRSA Central SDA	0.0%	2.7%	2.7%	2.8%	2.5%	0.0%
MRSA Northeast SDA	0.6%	4.9%	1.0%	0.2%	0.1%	0.5%
MRSA West SDA	1.0%	6.0%	2.9%	3.8%	5.7%	0.0%
FY2017	1.4%	3.3%	3.0%	0.5%	0.0%	0.0%

Provider Reimbursement Adjustments

Medicaid provider reimbursement changes were recognized for the following services: hospital inpatient reimbursement revisions, potentially preventable readmission reimbursement reductions, potentially preventable complications reimbursement reductions, rural hospital outpatient reimbursement revisions and therapy reimbursement revisions.

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.

Related Party Adjustments

Beginning in FY2011, HHSC revised the rating methodology to exclude from the base period claims experience any amounts paid by a health plan to a related party in excess of 100% of Medicaid. HHSC discussed 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 are impacted because the related party adjustment lowers 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.

Long Acting Reversible Contraceptive (LARC)

Effective January 1, 2016 hospitals began receiving separate, additional compensation for LARC insertion other than their typical maternity related reimbursement. This increase in reimbursement is expected to result in an increase in utilization. Exhibit G of Attachment 5 presents as summary of the derivation of this adjustment factor.

Family Planning Exclusion

One of the health plans that participates in the STAR program does not provide family planning services. HHSC provided a listing of those services that will not be provided by this health plan. Adjustment factors were determined through an evaluation of the base period experience for the area in which this plan operates. The premium rates for this health plan have been reduced to reflect the reduced level of 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.

HHSC 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 health plans, 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 calculate the acuity risk adjustment factors 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.

Network Access Improvement Program (NAIP)

Effective March 1, 2015 several health plans implemented programs aimed at improving network access for Medicaid members. The NAIP is designed to further the state's goal of increasing the availability and effectiveness of primary care for Medicaid beneficiaries by incentivizing various institutions to provide high quality, well-coordinated, and continuous care.

Attachment 10 presents the development of the NAIP add-on amounts to be included in the capitation rates effective September 1, 2016 along with further information concerning the NAIP program.

IV. Administrative Fees, Taxes 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 health plan. The administrative allowance is split between a fixed and variable component in order to allocate a larger percentage of the administrative dollars to the higher cost risk groups.

The administrative fee amounts were determined based on a review of the administrative expenses of the STAR health plans as reported in their audited Financial Statistical Reports (FSRs). The table below summarizes the reported administrative expenses for the past three fiscal years for the STAR program.

	Average
FY13	19.74
FY14	20.34
FY15	18.19
3 Year Average	19.42

Based on the administrative formula included in the rate development the average administrative expense included in the capitation rates is approximately $20 which is in line with the historical averages. This formula is reviewed annually to ensure consistency with the reported administrative costs.

The premium rates also include an amount for premium tax (1.75% of premium), maintenance tax ($0.07 pmpm) and a risk margin (2.0% of premium). The premium tax and maintenance tax are based on Texas Department of Insurance requirements.

The capitation rates included in this document do not include provision for the Affordable Care Act (ACA) Health Insurance Providers Fee. HHSC will develop and implement a procedure for reimbursing the health plans for (i) the ACA Health Insurance Providers Fee, (ii) any applicable federal income tax impact resulting from payment of the ACA Health Insurance Providers Fee and (iii) any applicable state premium tax impact resulting from payment of the ACA Health Insurance Providers Fee. Such reimbursement will be provided based on a CMS-approved methodology.

V. Summary

The chart below presents the results of the FY2017 STAR rating analysis and includes all components of the premium – medical, prescription drug and NAIP. This report details the development of the medical and NAIP 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 2017.

	Under Age 1	Ages 1-5	Ages 6-14	Ages 15-18	Ages 19-20
Monthly Adjusted Premium Rate					
Aetna - Bexar	508.47	135.48	108.00	141.89	140.30
Amerigroup - Bexar	686.08	168.87	110.44	116.03	109.79
CFHP - Bexar	623.14	181.58	153.28	169.94	166.18
Superior - Bexar	669.53	186.10	148.35	169.66	169.36
Amerigroup - Dallas	524.21	182.46	145.19	157.10	159.77
Molina - Dallas	576.46	175.45	122.96	150.69	141.09
Parkland - Dallas	611.38	205.40	149.82	168.47	186.36
El Paso First - El Paso	556.95	178.94	156.29	167.63	155.85
Molina - El Paso	559.26	160.21	99.24	136.74	211.10
Superior - El Paso	577.34	156.47	138.06	154.92	163.80
Amerigroup - Harris	620.01	162.64	137.32	157.44	204.43
CHC - Harris	680.66	203.21	159.01	193.40	259.94
Molina - Harris	517.47	155.21	125.50	161.13	194.56
TCHP - Harris	568.59	164.62	140.65	182.09	207.61
United - Harris	661.91	203.83	154.81	232.74	317.31
Driscoll - Hidalgo	590.98	196.43	141.06	145.63	158.52
Molina - Hidalgo	536.86	172.70	139.98	150.59	143.04
Superior - Hidalgo	547.21	214.70	160.88	161.57	176.14
United - Hidalgo	539.56	205.99	156.86	161.09	164.62
Amerigroup - Jefferson	706.79	155.34	138.24	172.33	242.84
CHC - Jefferson	719.54	167.10	174.02	222.07	225.29
Molina - Jefferson	773.74	158.81	152.19	178.02	122.18
TCHP - Jefferson	735.04	163.97	156.32	194.41	215.23
United - Jefferson	562.48	210.03	185.33	228.87	233.45
Amerigroup - Lubbock	533.03	188.36	141.53	164.73	147.98
Firstcare - Lubbock	694.08	183.73	151.41	177.40	157.88
Superior - Lubbock	619.35	180.47	152.79	167.80	150.71
Christus - Nueces	962.33	209.87	188.62	211.99	179.22
Driscoll - Nueces	944.43	237.51	203.94	230.15	203.97
Superior - Nueces	1,253.18	246.58	214.79	243.93	219.04
Aetna - Tarrant	618.73	135.53	120.96	142.93	164.83
Amerigroup - Tarrant	549.22	163.59	138.80	167.85	192.73
Cook - Tarrant	522.31	167.01	151.53	177.07	185.63
Blue Cross - Travis	578.50	170.35	115.30	139.60	133.87
Sendero - Travis	627.06	189.33	122.51	163.31	142.11
Seton - Travis	578.66	165.18	127.39	137.68	127.58
Superior - Travis	716.57	164.60	131.98	156.83	148.39
Amerigroup - MRSA Central	422.54	135.05	109.42	114.85	135.78
Scott & White - MRSA Central	527.93	148.70	132.09	178.54	164.29
Superior - MRSA Central	594.62	141.00	131.38	156.53	139.94
Amerigroup - MRSA Northeast	601.33	160.05	127.30	166.92	142.92
Superior - MRSA Northeast	580.82	138.06	123.92	161.08	163.77
Amerigroup - MRSA West	576.50	171.48	151.12	179.68	212.22
Firstcare - MRSA West	579.60	165.34	152.84	194.66	192.76
Superior - MRSA West	555.11	154.22	146.80	174.37	182.82

	TANF Adults	Pregnant Women	Delivery Supplemental Payment
Monthly Adjusted Premium Rate			
Aetna - Bexar	329.50	359.19	3,266.59
Amerigroup - Bexar	418.92	402.85	3,266.59
CFHP - Bexar	399.90	460.65	3,266.59
Superior - Bexar	433.55	470.66	3,266.59
Amerigroup - Dallas	350.44	480.35	3,537.13
Molina - Dallas	364.87	475.89	3,537.13
Parkland - Dallas	333.72	481.39	3,537.13
El Paso First - El Paso	413.35	489.15	3,443.04
Molina - El Paso	535.85	442.40	3,443.04
Superior - El Paso	382.42	474.67	3,443.04
Amerigroup - Harris	499.23	519.59	3,519.20
CHC - Harris	435.30	565.39	3,519.20
Molina - Harris	621.08	500.99	3,519.20
TCHP - Harris	350.00	511.32	3,519.20
United - Harris	559.53	508.21	3,519.20
Driscoll - Hidalgo	324.83	427.91	3,409.95
Molina - Hidalgo	479.04	415.11	3,409.95
Superior - Hidalgo	472.60	428.52	3,409.95
United - Hidalgo	471.03	427.36	3,409.95
Amerigroup - Jefferson	506.77	465.83	3,394.58
CHC - Jefferson	455.61	508.23	3,394.58
Molina - Jefferson	523.81	457.21	3,394.58
TCHP - Jefferson	402.18	477.67	3,394.58
United - Jefferson	606.87	422.34	3,394.58
Amerigroup - Lubbock	450.20	455.99	3,230.39
Firstcare - Lubbock	435.65	450.37	3,230.39
Superior - Lubbock	424.35	512.01	3,230.39
Christus - Nueces	456.88	560.66	3,203.82
Driscoll - Nueces	361.80	550.37	3,203.82
Superior - Nueces	502.65	641.54	3,203.82
Aetna - Tarrant	394.57	390.36	3,635.64
Amerigroup - Tarrant	457.41	419.43	3,635.64
Cook - Tarrant	315.54	399.22	3,635.64
Blue Cross - Travis	357.55	555.65	3,247.49
Sendero - Travis	351.27	565.42	3,247.49
Seton - Travis	367.02	491.58	3,247.49
Superior - Travis	409.33	557.92	3,247.49
Amerigroup - MRSA Central	331.74	455.23	3,035.27
Scott & White - MRSA Central	422.43	466.91	3,035.27
Superior - MRSA Central	404.71	480.75	3,035.27
Amerigroup - MRSA Northeast	436.05	507.55	3,160.40
Superior - MRSA Northeast	410.59	501.93	3,160.40
Amerigroup - MRSA West	485.03	520.70	3,204.07
Firstcare - MRSA West	471.79	514.35	3,204.07
Superior - MRSA West	452.83	510.05	3,204.07

Attachment 1 presents additional information regarding the breakdown of the components of the FY2017 rates.

VI. Actuarial Certification of FY2017 STAR 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 2017 (FY2017) 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 FY2017 Health Plan 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 principles 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.

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VII. Attachments

Attachment 1

Summary of FY2017 STAR Rating Analysis

Exhibit A. This exhibit presents summary information regarding the FY2017 rates. Included on the exhibit are current (FY2016) premium rates split between medical, prescription drug, NAIP and delivery supplemental payment (DSP) rates; FY2017 premium rates split between medical, prescription drug, NAIP and DSP rates; and a comparison of FY2016 and FY2017 premium rates.

Exhibit B. This exhibit presents a comparison of the projected expenditures under the current (FY2016) premiums rates and the FY2017 premium rates. The projection is split by medical (includes DSP), pharmacy and NAIP.

Attachment 2

Individual Health Plan Experience Analysis

The following exhibits present a summary of the experience analysis performed for each health plan in each service area. The exhibits in this section use hypothetical experience data from a sample health plan. 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 health plan. 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 2012 through February 2016. 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 2012 through February 2016.

Exhibit C. This exhibit shows the calculation of estimated monthly incurred claims for one risk group. The report includes the following information: (i) monthly enrollment, (ii) claim amounts incurred in that month and paid through February 29, 2016, (iii) estimated proportion of that month's incurred claims paid through February 29, 2016 (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 were derived based on the actual historical claims payment pattern of the health plan using standard actuarial techniques. The claims payment patterns were analyzed by duration since incurral to determine the average percentage of claims paid after each successive month.

Exhibit D. This exhibit is a summary of the sample health plan's projected FY2017 cost based on the health plan's actual experience. The top of the exhibit shows summary base period (FY2015) enrollment and claims experience. Next is projected FY2017 enrollment. Trend assumptions for FY2016 and FY2017 are used to project the average base period claims cost to FY2017. Adjustment factors are used to recognize the cost impact of benefit and provider reimbursement changes. Combining these factors results in projected FY2017 incurred claims.

In addition to incurred claims, provision is also made for services that are capitated by the health plan, 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 health plan 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) $0.50 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 ($0.07 pmpm) and risk margin (2.0% of premium).

At the bottom of Exhibit D is a summary of the projected FY2017 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 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 health plan in a service area. The community rates are developed by a weighted average of the projected FY2017 cost for each health plan in the service area. The weights used in this formula are the projected number of FY2017 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 FY2017 STAR 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 FY2017 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 health plans is described in Attachment 2. The top portion of the exhibit shows summary base period (FY2015) experience and projected FY2017 enrollment and incurred claims experience.

In addition to incurred claims, provision is also made for services that are capitated by the health plans, 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 health plan 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) $0.50 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 ($0.07 pmpm) and risk margin (2.0% of premium).

The bottom of the exhibit shows a summary of the projected FY2017 cost based on these assumptions. Cost projections are presented both with and without the inclusion of maternity expenses

Attachment 4

Trend Analysis

The FY2017 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 health plans. Trend assumptions vary by service area for FY2016 and are established on a statewide basis for FY2017. All trend assumptions vary by risk group.

The trend analysis included a review of health plan claims experience data through February 29, 2016. Based on this information, estimates of monthly incurred claims were made through December 2015. The claims cost and trend experience was reviewed separately by service area and risk group.

Exhibit A provides a summary of the FY2013, FY2014, FY2015 and FY2016 trends by category of service, service area and risk group. The FY2016 trend represents the trend during the period September 2015 through December 2015. All trends have been calculated as the average cost per member per month during the specified time period compared to the same time period during the prior fiscal year. For example, the FY2015 trend is calculated as the average cost per member per month during FY2015 divided by the average cost per member per month during FY2014. The FY2012 data was not available by category of service therefore FY2013 trend information by category of service could not be determined.

All trends have been adjusted to remove the impact of the various provider reimbursement changes that have impacted the program. These adjustments are made for all items that have materially impacted historical costs and have distorted the trend from one time period to the next. For example, the carve in of mental health rehabilitation services and targeted case management on September 1, 2014 distorts the FY2015 trend given that the carve in of these services increases the average cost. As a result, the FY2015 observed trends are adjusted to remove the impact of the increased cost associated with these services to ensure the average cost during FY2014 and FY2015 are based on comparable services and reimbursement levels and the underlying trend is calculated.

On Exhibit A, the service area trends have been combined into a statewide weighted average by weighting the service area specific trends by each area's proportion of the total incurred claims. The Hidalgo service area has been excluded from the statewide weighted average because this area has experienced significant managed care savings resulting in reductions in the average cost since its effective date of March 1, 2012. Due to these managed care reductions, the Hidalgo service area experience is not indicative of the underlying statewide trend and has therefore been excluded.

The FY2016 trend assumptions were developed from two components: (i) the actual service area specific estimated trend for the period September 2015 through December 2015 and (ii) the statewide projected trend for the period January 2016 through August 2016. The trends for the final eight months of FY2016 were projected using statewide experience from FY2013 (3/10 weight), FY2014 (3/10 weight), FY2015 (3/10 weight) and 9/2015-12/2015 (1/10 weight). The weighting of each time period was based on the number of months within each time period.

All projected statewide trends were limited to no less than 0.0%. Based on historical experience in the Texas Medicaid Managed Care Programs, negative trends have typically been one-time, short lived reductions in cost that don't repeat in multiple years. Based on our actuarial judgment we deemed it inappropriate to use these negative trends to develop our projections of future trends. We deemed the historical negative trends as temporary aberrations that are not indicative of long term projected average trend rates. For example, although the average trends in the TANF Adult risk group were negative for FY2013-FY2015, they have been positive during the most recent time period (4.0%) and have been positive for every fiscal year dating back to FY2009. A similar pattern has been observed for the pregnant women category. As a result, we believe it is reasonable to limit our assumption of future trends to no less than 0.0%.

Blending the area specific trends for the period September 2015 through December 2015 with the statewide projected trend for the period January 2016 through August 2016 was done via the following formula:

$$\text{FY2016 SDA Trend} = \frac{(\text{9/15-12/15 actual SDA trend}) \times 4 + (\text{1/16-8/16 Statewide}) \times 8}{12}$$

Exhibit B provides a summary of the derivation of the FY2016 service area and statewide trend components.

The FY2017 trend assumptions were then developed from a simple average of the FY2013 trend, FY2014 trend, FY2015 trend and FY2016 trend.

Exhibit C provides a summary of the final FY2016 and FY2017 trend assumptions.

Attachment 5

Provider Reimbursement and Benefit Revisions Effective During FY2015, FY2016 and FY2017

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 (FY2015) and before the end of FY2017.

All adjustments have been calculated through an analysis of health plan encounter data repriced using the old and new reimbursement terms and the impact determined as the relative change in cost. For each adjustment the applicable FY2015 encounter data was repriced using the FFS reimbursement in place during FY2015, the FFS reimbursement that will be in place during FY2017 and the applicable percentage change determined.

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 September 1, 2015 HHSC revised the standard dollar amounts applied to the inpatient reimbursement for certain children's, safety net and trauma hospitals. Exhibit B 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 and can change from one fiscal year to the next. A new PPR reduction lists will become effective September 1, 2016 however it was not complete at the time these rates were calculated. As a result, the adjustment factors shown in exhibit C represent the restoration of those reductions that were in place during FY2015 which may or may not continue into FY2017. Once the final FY2017 PPR reduction list is available HHSC and the actuary will determine if an adjustment is needed to these capitation rates.

Effective March 1, 2014 HHSC implemented revisions to hospital reimbursement to account for Potentially Preventable Complications (PPC). The reimbursement reductions amount to 2-2.5% depending on a hospitals performance during the evaluation time period and can change from one fiscal year to the next. A new PPC list will become effective September 1, 2016 however it was not complete at the time these rates were calculated. As a result, the adjustment factors shown in exhibit D represent the restoration of those reductions that were in place during FY2015 which may or may not continue into FY2017. Once the final FY2017 PPC reduction list is available HHSC and the actuary will determine if an adjustment is needed to these capitation rates.

Effective September 1, 2015 HHSC implemented revisions to outpatient rural hospital reimbursement. Exhibits E and F present the rating adjustment factors for non-imaging services and imaging services, respectively.

Effective January 1, 2016 HHSC increased the reimbursement for Long Acting Reversible Contraceptives (LARCs). As a result of the increased reimbursement it is expected that

utilization will increase. Exhibit G presents a summary of the derivation of the rating adjustment factor for pregnant women.

Effective July 15, 2016 HHSC will make revisions to the reimbursement for certain therapy services. Attached Exhibit H presents a summary of the derivation of the rating adjustment factors.

For ease of reporting purposes, the numerous provider reimbursement adjustments described above have been consolidated in the community rating exhibits included in Attachment 3. The key below includes a description of where each adjustment has been included in Attachment 3.

Attachment 3 Heading	**Attachment 5 Exhibits**
Provider Reimbursement Adjustment	Exhibits E, F and H
Other Reimbursement Changes	Exhibits G
Inpatient Reimbursement Changes	Exhibits A, B, C and D

Please note that the incurred claims reported on Attachment 5 are developed from the FY2015 detail encounter data which only includes claims paid through November 2015. As a result, the incurred claims reported on Attachment 3 vary slightly from these amounts for several reasons including: (i) Attachment 3 incurred claims include claims paid through February 2016, (ii) Attachment 3 incurred claims include a small amount of IBNR and (iii) certain subcapitated expenses provided by affiliated providers are included in Attachment 3 incurred claims but not available in the detailed encounter data files. As noted on pages 1 and 2 of this report, multiple data sources were used in the rate development process with each being checked for consistency. The detail encounter data is necessary for the adjustment factors detailed in this attachment as it is the only data source that provides information at the claim level allowing for the repricing of claims under varying reimbursement levels.

Attachment 6

Family Planning Adjustment

One of the health plans that participates in the STAR program does not provide family planning services. For this health plan, family planning services will be provided through FFS. HHSC provided a listing of those services that will not be provided by this health plan. 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 the health plan that does not provide family planning services have been reduced accordingly. The attached exhibit presents a summary of the family planning reduction factors associated with the applicable health plan.

In determining the base community rate for this service area, the FFS claims paid for family planning services for this health plan have been included. Inclusion of these claims ensures that the other health plans participating in this service area are not adversely impacted in the community rate calculation.

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 FY2015.

The adjustment factors shown in Attachment 7 are converted into the SDA adjustment factors found on Attachment 3 by calculating the weighted average TPR adjustment for each SDA. The weighted average is calculated by averaging the plan specific TPR adjustments with the projected claim amounts for each plan being used as the weights.

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 FY2017 DSP payment rates by area.

The capitation rates are developed in total, including all maternity cost which is shown on Attachment 3 under the heading Projected Total Cost With Deliveries (Unadjusted). In order to achieve cost neutrality, the projected cost of maternity expenses is subtracted from the unadjusted premium rates. As a result of this budget neutral calculation the sum of the two components of the premium (i) DSP and (ii) monthly premium amounts equals the total projected cost including deliveries. The resulting adjusted premium rates are the rates actually paid to the health plans in addition to any DSP amounts.

Since this calculation is budget neutral we have determined it to be unnecessary to adjust the DSP amounts for FY2017. Any adjustments to the FY2017 DSP amount would be offset (increase or decrease) by an adjustment to the adjusted premium rates resulting in the same aggregate premium paid to the health plan.

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.

This analysis is performed by University of Florida's Institute for Child Health Policy (ICHP) through their role as the EQRO. ICHP uses the Chronic Illness and Disability Payment System (CDPS) model to perform the acuity analysis. Exhibit A provides a brief description of the CDPS analysis as provided by ICHP in their summary report. Exhibits B-H present a summary of the risk adjustment analysis results by risk group. All information was provided by ICHP and reviewed by the actuary for reasonableness.

The columns titled Case Mix on exhibits B-H are the risk adjustment factors. The case mix factor 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 case mix, or risk adjustment factor is calculated and applied annually.

If necessary, an additional adjustment was made to the risk adjustment factors to ensure that, in total, they produce the same premium as the community rates (budget neutral). Exhibit I summarizes the raw, unadjusted risk adjustment factors (case-mix), the budget neutral adjustment applied equally to each risk group within each service area along with the resulting adjusted risk adjustment factors.

The adjusted risk adjustment factor is applied to the community rate for each health plan and risk group.

Attachment 10

Network Access Improvement Program (NAIP)

Effective March 1, 2015 several health plans implemented programs aimed at improving network access for Medicaid members. The NAIP is designed to further the state's goal of increasing the availability and effectiveness of primary care for Medicaid beneficiaries by incentivizing various institutions to provide quality, well-coordinated, and continuous care. The NAIP is intended to achieve the following objectives regarding health-related institutions (HRI):

- Improve the availability of and Medicaid access to primary care physicians. This program may also target specialist physicians willing to provide a medical home to managed care members with special needs and conditions, and advanced practice registered nurses (APRNs) and physician assistants (PAs) practicing under the supervision of an HRI staff provider.
- Enhance the coordination and continuity of services and quality of care of Medicaid managed care members who receive primary care services through those physician practices.
- Increase access to primary care in these settings, underscoring the importance of primary care residency programs and influencing future physician participation.
- Promote provider education on Medicaid program requirements and the specialized needs of Medicaid recipients.
- Measure progress through increased primary care access and physician compliance with selected quality objectives, to be determined later.

Similarly, the NAIP is intended to achieve the following objectives relating to public hospitals:

- Improve the availability, quality and coordination of primary and specialty care services provided by public hospitals;
- Promote provider education on Medicaid program requirements and the specialized needs of Medicaid recipients;
- Measure progress through increased care access and physician compliance with quality objectives.

The above-stated objectives will lead to better health outcomes for Medicaid beneficiaries and decreased overall healthcare costs for the Medicaid program.

The NAIPs were developed independently by various managed care organizations and providers. The NAIPs outline the services to be provided by the providers, measurements to evaluate their effectiveness and the cost to be paid by the managed care organizations. Once agreed upon by the MCOs and providers, the NAIP arrangements were reviewed by HHSC program staff for quality and content. HHSC program staff then provided the actuary with the contracted financial arrangements agreed to between each MCO and provider. The actuary used this information to prepare the NAIP portion of the premium.

The NAIP amounts impact all STAR risk groups equally as the contracted costs between the participating MCOs and providers are not delineated by risk group but are applicable to the entire population.

The attached exhibit summarizes each of the NAIPs by health plan, service area and program. The participating provider has been removed from the exhibit in order to maintain the privacy of these negotiated arrangements.