Rudd and Wisdom, Inc.

CONSULTING ACTUARIES

Mitchell L. Bilbe, F.S.A.
Evan L. Dial, F.S.A.
Philip S. Dial, F.S.A.
Philip J. Ellis, A.S.A.
Charles V. Faerber, F.S.A., A.C.A.S.
Mark R. Fenlaw, F.S.A.
Brandon L. Fuller, F.S.A.
Christopher S. Johnson, F.S.A.
Oliver B. Kiel, F.S.A.
Robert M. May, F.S.A.
Edward A. Mire, F.S.A.
Rebecca B. Morris, A.S.A.
Amanda L. Murphy, F.S.A.
Michael J. Muth, F.S.A.
Khiem Ngo, F.S.A., A.C.A.S.
Elizabeth A. O'Brien, F.S.A.
Raymond W. Tilotta
Ronald W. Tobleman, F.S.A.
David G. Wilkes, F.S.A.

January 5, 2018

Ms. Rachel Butler
Chief Actuary
Health and Human Services Commission
4900 North Lamar
Austin, Texas 78751

Re: STAR+PLUS Rate Amendment UMCC 529-12-0002 V2.25, STAR+PLUS Expansion 529-10-0020 V1.29, STAR+PLUS MRSA 529-13-0042 V1.14

Dear Ms. Butler:

This letter amends the report titled State of Texas Medicaid Managed Care STAR+PLUS Program Rate Setting State Fiscal Year 2018 and dated September 14, 2017 which was amended in the letter titled STAR+PLUS Rate Amendment and dated October 10, 2017. The amended FY2018 capitation rates were developed using identical methods and assumptions as the rates described in this report. The amended rates are assumed to be payable for the period March 1, 2018 through August 31, 2018.

A. Summary of the Revisions

Uniform Hospital Rate Increase

Effective December 1, 2017, HHSC implemented a pilot of the Uniform Hospital Rate Increase Program (UHRIP) in the Bexar and El Paso service delivery areas. The program will expand statewide effective March 1, 2018. UHRIP is a Medicaid managed care hospital directed payment program authorized under federal regulations at 42 CFR 438.6(c). CMS approved HHSC's statewide implementation of the program on August 18, 2017. The UHRIP program will increase the reimbursement to contracted hospitals by a level percentage that varies by hospital class. HHSC has identified the following classes of hospitals within each SDA and the rate increase for each:

9500 Arboretum Blvd., Suite 200
Austin, Texas 78759
Phone: (512) 346-1590
Fax: (512) 345-7437
www.ruddwisdom.com
Post Office Box 204209
Austin, Texas 78720-4209

SDA	Children's	Non-Urban Public	Rural Private	Rural Public	State-owned	Urban Public	Other
Bexar	1%	24%	12%	0%	0%	37%	22%
Dallas	2%	53%	13%	0%	0%	58%	58%
El Paso	2%	0%	0%	0%	0%	33%	25%
Harris	0%	44%	15%	18%	0%	49%	49%
Hidalgo	0%	0%	0%	14%	0%	0%	37%
Jefferson	0%	0%	7%	7%	0%	0%	56%
Lubbock	0%	0%	16%	20%	0%	53%	53%
Nueces	0%	44%	15%	18%	0%	49%	49%
Tarrant	2%	0%	20%	24%	0%	65%	65%
Travis	0%	0%	0%	0%	0%	0%	0%
MRSA Central	0%	0%	20%	23%	0%	0%	63%
MRSA Northeast	0%	0%	18%	21%	0%	0%	58%
MRSA West	0%	61%	21%	25%	0%	67%	67%

All MCOs within the SDA will be required to increase their reimbursement rates to contracted hospitals by the established percentage rate increase.

UHRIP will only apply to the STAR and STAR+PLUS Medicaid managed care programs. The UHRIP increase will apply to all services provided by a hospital with the following exceptions:

1. Services provided to members at a non-contracted facility.
2. Non-emergent services provided in an emergency room for non-rural facilities.

Quality Incentive Payment Program for Nursing Facilities (QIPP)

Effective March 1, 2018 HHSC will make slight changes to the QIPP including adding an additional facility to the list of eligible participants and adjusting the total contracted cost applicable to each service delivery area.

B. Report Amendments

This section of the letter details the amendments to the original actuarial report.

Section I. Introduction

No changes applicable to this section. The same data sources were utilized in the calculation of this mid-year adjustment.

Section II. Overview of Rate Setting Methodology

The rates have been calculated for the same service delivery areas, risk groups and services as outlined in the original report using the same general methodology.

The only difference between the rating methodology outlined in the original report and the methodology used to calculated the UHRIP premium add on is that the UHRIP calculations

have been performed at the individual MCO level. The UHRIP analysis has been performed at the individual MCO level because each MCO has a different network configuration resulting in varying distributions of hospital utilization amongst the different hospital classes. This method has been used in order to avoid a situation where the community rate would be disadvantageous (or advantageous) to an MCO in terms of passing on the required reimbursement increase.

Section III. Adjustment Factors

The Provider Reimbursement Adjustments section has been updated to read:

Medicaid provider reimbursement changes were recognized for the following services: hospital inpatient reimbursement revisions, UHRIP reimbursement increases, potentially preventable readmission reimbursement reductions, potentially preventable complications reimbursement reductions, therapy reimbursement revisions, therapy policy revisions, radiology reimbursement reductions, and labor and delivery surgery 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 - Revised presents a summary of the derivation of these adjustment factors.

The Quality Incentive Payment Program for Nursing Facilities (QIPP) section has been updated to read:

Effective March 1, 2018 an additional facility will be eligible for and participate in the QIPP which is designed to incentivize nursing facilities to improve quality and innovation in the provision of nursing facility services, using the CMS five-star rating system as its measure of success. The QIPP provides enhanced payment for nursing facilities which demonstrate improvement on specific quality goals.

Attachment 14 - Revised presents the development of the QIPP add-on amounts to be included in the capitation rates effective March 1, 2018 along with additional information concerning the QIPP program.

No other changes are applicable to this section.

Section IV. Administrative Fees, Taxes and Risk Margin

The following information amends the information included in this section of the actuarial report.

The UHRIP component of the rate will have separate administrative fees, taxes and risk margin from the medical and pharmacy components of the rate. These amounts are defined as follows:

- Administrative Fee – 2.5% of premium
- Risk Margin – 5.0% of premium
- Premium Tax – 1.75% of premium
- Health Insurance Providers Fee Non-Exempt – 3.1% of premium
- Health Insurance Providers Fee Exempt – 0.0% of premium

The 2.5% administrative fee was developed based on discussions between HHSC, the MCOs and the contracted hospitals. While there is an expectation of increased administrative cost associated with the UHRIP program as a result of contract negotiations, claims processing and other system changes it is not expected that this increased burden will be significant. As a result, the standard 5.75% of premium applicable to the overall rate development was reduced to 2.5% for the UHRIP component only.

The 5.0% risk margin is larger than the 1.75% risk margin applicable to the overall rate development because the MCO will be at greater risk that utilization could shift between the hospital classes, between the facilities and between the MCOs. The MCO will be required to increase their reimbursement rates according to the defined increases and could experience deviations from historical utilization patterns that are beyond their control.

The 1.75% premium tax remains unchanged from the overall rate development.

Unlike the rate development for the medical and pharmacy components of the rate, the UHRIP premium will include a provision for the ACA Health Insurance Providers Fee where applicable. The 3.1% was calculated as national average health insurance providers fee as a percentage of net premiums grossed up for federal income tax and state premium tax.

Section V. Summary

The tables in this section are replaced in their entirety with the following mid-year rates effective March 1, 2018 through August 31, 2018.

Health Plan	Medicaid Only OCC	Medicaid Only HCBS	Dual Eligible OCC	Dual Eligible HCBS
Monthly Premium Rates				
Amerigroup - Bexar	$1,373.71	$4,488.69	$365.54	$1,989.10
Molina - Bexar	1,183.53	3,866.57	372.14	1,893.19
Superior - Bexar	1,475.91	4,359.39	424.35	1,957.32
Molina - Dallas	1,579.06	4,528.53	364.07	1,767.51
Superior - Dallas	1,509.84	4,579.31	339.38	1,761.20
Amerigroup - El Paso	1,399.90	4,263.41	470.49	1,878.39
Molina - El Paso	1,620.52	4,205.69	523.51	1,978.41
Amerigroup - Harris	1,630.46	5,356.68	333.60	1,932.80
Molina - Harris	1,524.87	5,077.33	330.41	1,960.33
United - Harris	1,857.08	5,009.73	356.07	1,977.68
Health Spring - Hidalgo	1,900.08	4,448.55	952.49	2,286.24
Molina - Hidalgo	1,905.67	4,643.05	882.30	2,251.34
Superior - Hidalgo	2,040.99	4,721.36	1,109.95	2,282.44
Amerigroup - Jefferson	1,295.13	4,685.12	274.13	1,674.87
Molina - Jefferson	1,373.42	4,061.18	259.78	1,603.59
United - Jefferson	1,568.69	4,597.60	161.63	1,524.22
Amerigroup - Lubbock	1,348.54	3,952.55	144.53	1,401.05
Superior - Lubbock	1,277.80	4,471.29	170.72	1,471.93
Superior - Nueces	1,570.82	4,282.93	551.48	1,980.53
United - Nueces	1,735.23	4,553.71	441.66	1,946.75
Amerigroup - Tarrant	1,653.37	4,820.15	266.00	1,668.24
Health Spring - Tarrant	1,352.29	4,546.60	225.23	1,715.59
Amerigroup - Travis	1,295.57	4,768.31	319.81	1,784.48
United - Travis	1,299.74	4,702.71	185.00	1,750.06
Superior - MRSA Central	1,379.07	4,456.60	233.25	1,743.94
United - MRSA Central	1,310.23	4,799.40	229.78	1,815.73
Health Spring - MRSA Northeast	1,194.25	4,006.30	214.76	1,589.54
United - MRSA Northeast	1,317.63	4,418.44	212.02	1,501.10
Amerigroup - MRSA West	1,268.11	4,315.01	251.68	1,561.57
Superior - MRSA West	1,403.35	3,991.81	253.28	1,511.84

Health Plan	Medicaid Only NF	Dual Eligible NF	IDD Over 21	MBCCP
Monthly Premium Rates				
Amerigroup - Bexar	$7,752.36	$4,851.60	$900.44	$2,378.88
Molina - Bexar	7,692.85	4,851.60	763.11	2,378.88
Superior - Bexar	7,780.35	4,851.60	1,059.73	2,378.88
Molina - Dallas	8,227.06	4,810.87	732.39	2,768.28
Superior - Dallas	8,455.01	4,810.87	750.17	2,768.28
Amerigroup - El Paso	7,735.48	4,530.35	1,402.78	1,957.02
Molina - El Paso	7,658.80	4,530.35	1,519.60	1,957.02
Amerigroup - Harris	7,944.02	4,689.80	963.90	2,717.38
Molina - Harris	7,802.53	4,689.80	937.11	2,717.38
United - Harris	7,791.71	4,689.80	1,085.30	2,717.38
Health Spring - Hidalgo	7,859.05	5,131.82	818.54	2,560.10
Molina - Hidalgo	8,007.30	5,131.82	1,037.39	2,560.10
Superior - Hidalgo	8,104.43	5,131.82	1,121.10	2,560.10
Amerigroup - Jefferson	7,621.98	4,491.57	847.47	3,311.10
Molina - Jefferson	7,674.89	4,491.57	793.31	3,311.10
United - Jefferson	7,705.05	4,491.57	993.35	3,311.10
Amerigroup - Lubbock	7,595.13	4,651.09	838.17	2,135.39
Superior - Lubbock	7,574.79	4,651.09	894.09	2,135.39
Superior - Nueces	7,416.68	4,811.36	1,176.96	2,615.81
United - Nueces	7,577.23	4,811.36	1,276.22	2,615.81
Amerigroup - Tarrant	7,860.73	4,622.75	975.48	2,816.23
Health Spring - Tarrant	7,529.09	4,622.75	779.34	2,816.23
Amerigroup - Travis	7,526.63	4,920.60	728.70	2,267.47
United - Travis	7,509.19	4,920.60	1,044.37	2,267.47
Superior - MRSA Central	7,137.75	4,583.52	981.49	3,512.90
United - MRSA Central	6,980.12	4,583.52	1,006.92	3,512.90
Health Spring - MRSA Northeast	7,532.61	4,598.89	839.97	2,694.34
United - MRSA Northeast	7,404.84	4,598.89	933.52	2,694.34
Amerigroup - MRSA West	7,632.43	4,735.39	965.10	2,342.57
Superior - MRSA West	7,726.60	4,735.39	953.60	2,342.57

Section VI. Actuarial Certification of FY2018 STAR+PLUS Premium Rate

We, Evan L. Dial, Khiem D. Ngo and David G. Wilkes are principals with the firm of Rudd and Wisdom, Inc., Consulting Actuaries (Rudd and Wisdom). We are Fellows of the Society of Actuaries and members of the American Academy of Actuaries. We 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 the STAR+PLUS premium rates for the period March 1, 2018 through August 31, 2018 and to provide the actuarial certification required under Centers for Medicare and Medicaid Services (CMS) requirements 42 CFR 438.4.

We certify that the amended FY2018 STAR+PLUS 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;

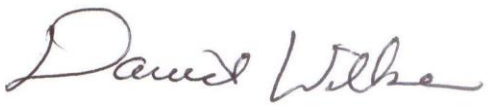
(b) The premium rates are appropriate for the populations and services covered under the managed care contract; and

(c) The premium rates are actuarially sound as defined in the regulations.

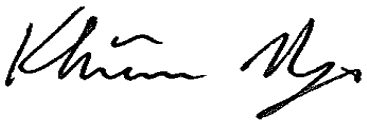
We have relied on historical experience data and program information provided to us by HHSC. We have reviewed the data for reasonableness but have not audited the data.

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 438.3(c), 438.3(e), 438.4, 438.5, 438.6 and 438.7. 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.



David G. Wilkes, F.S.A., M.A.A.A.



Khiem D. Ngo, F.S.A., M.A.A.A.

Section V11. Attachments

The following sections indicate any revisions applicable to each of the attachments in the original actuarial report dated September 14, 2017.

Attachment 1 - *Summary of FY2018 STAR+PLUS Rating Analysis*

Exhibit A. This exhibit presents summary information regarding the FY2018 rates. Included on the exhibit are current (December 1, 2017 – February 28, 2018) premium rates split between medical (acute care and long term care), prescription drug, NAIP, QIPP and UHRIP rates; March 1, 2018 through August 31, 2018 premium rates split between medical (acute care and long term care), prescription drug, NAIP, QIPP and UHRIP rates; and a comparison of the December 1, 2017 and March 1, 2018 premium rates.

Exhibit B. This exhibit presents a comparison of the projected expenditures under the current (December 1, 2017 through February 28, 2018) premium rates and the March 1, 2018 through August 31, 2018 premium rates. The projection is split by medical, pharmacy, NAIP/QIPP and UHRIP.

Attachment 2 - *Individual Health Plan Experience Analysis*

No changes applicable to this section.

Attachment 3 - *Community Experience Analysis*

No changes applicable to this section.

Attachment 4 - *Trend Analysis*

No changes applicable to this section.

Attachment 5 - *Provider Reimbursement and Benefit Revisions Effective During FY2016, FY2017 and FY2018*

The following description has been added to this section:

Effective December 1, 2017 HHSC implemented the pilot UHRIP in the Bexar and El Paso SDAs. Effective March 1, 2018 the UHRIP program will be expanded statewide. All MCOs will be required to uniformly increase their contracted hospital reimbursement rates by the following amounts which vary by hospital class:

SDA	Children's	Non-Urban Public	Rural Private	Rural Public	State-owned	Urban Public	Other
Bexar	1%	24%	12%	0%	0%	37%	22%
Dallas	2%	53%	13%	0%	0%	58%	58%
El Paso	2%	0%	0%	0%	0%	33%	25%

SDA	Children's	Non-Urban Public	Rural Private	Rural Public	State-owned	Urban Public	Other
Harris	0%	44%	15%	18%	0%	49%	49%
Hidalgo	0%	0%	0%	14%	0%	0%	37%
Jefferson	0%	0%	7%	7%	0%	0%	56%
Lubbock	0%	0%	16%	20%	0%	53%	53%
Nueces	0%	44%	15%	18%	0%	49%	49%
Tarrant	2%	0%	20%	24%	0%	65%	65%
Travis	0%	0%	0%	0%	0%	0%	0%
MRSA Central	0%	0%	20%	23%	0%	0%	63%
MRSA Northeast	0%	0%	18%	21%	0%	0%	58%
MRSA West	0%	61%	21%	25%	0%	67%	67%

Exhibit K.1 – Revised presents a summary of the derivation of the rating adjustment factors which have been calculated at the individual plan level due to variations in each MCO's network configuration. The adjustments have been calculated by applying the applicable percentage increase to each MCO's FY2016 encounter data. Unlike other adjustment factors which are applied at the community level, the UHRIP adjustment factors have been calculated at the individual plan level due to the fact that each MCO may have varying levels of utilization at each class of hospital and could be disadvantaged if their actual utilization is higher or lower than the SDA average for a given class.

Exhibit K.2 – Revised presents a summary of the calculation of the UHRIP premium add on rates by MCO for all risk groups except MBCCP. The add on is calculated as an MCO specific amount due to the varying impacts the mandated increases will have on expected reimbursement for each MCO. The add-on is calculated as the projected FY2018 claims increased by the applicable UHRIP adjustment factor plus provision for risk margin, taxes and administrative fees. Development of the UHRIP premium add on for the MBCCP risk group can be found in Attachment 11.

Attachment 6 – *Long Term Care Reimbursement Adjustment*

There have been no changes to this section.

Attachment 7 – *Removal of STAR+PLUS Members Under Age 21*

There have been no changes to this section.

Attachment 8 – *Carve In Relocation Services*

There have been no changes to this section.

Attachment 9 – *Acuity Risk Adjustment – Acute Care*

There have been no changes to this section.

Attachment 10 – *Acuity Risk Adjustment – Long Term Care*

There have been no changes to this section.

Attachment 11 – *Medicaid Breast and Cervical Cancer Program (MBCCP) Rate Development*

The following descriptions have been amended or added to this section:

Provider Reimbursement Adjustment

The UHRIP adjustment is applicable to the MBCCP expansion and the adjustment factors have been calculated in a manner consistent with all other adjustment factors by using the average Medicaid Only adjustment calculated for each SDA as found in Attachment 5 Exhibit K.1 – Revised.

Summary

The attached exhibits present a summary of the community rating exhibit for each service area split between medical (Exhibit A), pharmacy (Exhibit B) and UHRIP (Exhibit F – Revised). The FY2018 premium rates will vary between service delivery areas but will be the same for all health plans within a given area with the exception of the Health Insurance Providers Fee applied to the UHRIP component of the rate.

Attachment 12 – *Community First Choice Initiative (CFC)*

There have been no changes to this section.

Attachment 13 – *Network Access Improvement Program (NAIP)*

There have been no changes to this section.

Attachment 14 – *Quality Incentive Payment Program (QIPP)*

Effective March 1, 2018 HHSC will revise the Quality Incentive Payment Program (QIPP) which is designed to incentivize nursing facilities to improve quality and innovation in the provision of nursing facility services, using the CMS five-star rating system as its measure of success. The revision allows an additional facility to participate and adjusts the contracted cost by service delivery area accordingly.

Attachment B - Revised provides a summary of the revised QIPP add on amounts by service delivery area for the period March 1, 2018 through August 31, 2018. The QIPP program impacts members in both the STAR+PLUS and Dual Demonstration programs. As a result, the eligible expenditures are spread across the two programs based on total membership within the nursing facility risk groups.

Attachment 15 – *Pay for Quality Program*

There have been no changes to this section.

Attachment 16– *FY2018 STAR+PLUS Rate Certification Index*

Section I. Medicaid Managed Care Rates

1. General Information

A. Rate Development Standards

i. Rates are for the period March 1, 2018 through August 31, 2018.

ii. (a) The certification letter is on page 7 of the amendment letter.

(b) The final capitation rates are shown on pages 5 and 6 of the amendment letter.

(c) Not applicable.

(d) (i) See pages 1 and 4 through 6 of the original report.

(ii) See page 1 of the original report and page 1 of the amendment letter.

(iii) See page 1 of the original report.

(iv) Inclusion of the MBCCP population is the only eligibility change that will impact the rate development. Description of the rate development for this group is found in Attachment 11 of the original report.

(v) Pages 223-225 (NAIP), 226-231 (QIPP) and 232-233 (P4Q) of the original report and pages 1-2 (UHRIP) of the amendment letter.

(vi) Not applicable. The change detailed in this amendment is prospective.

iii. Acknowledged.

iv. Acknowledged.

v. Acknowledged.

vi. Acknowledged.

vii. Acknowledged.

viii. Acknowledged.

B. Appropriate Documentation

i. Acknowledged.

ii. Acknowledged.

iii. See pages 213 through 222 of the original report.

iv. Not applicable.

v. Not applicable.

2. Data

A. Rate Development Standards

i. (a) Acknowledged.

(b) Acknowledged.

(c) Acknowledged.

(d) Not applicable.

B. Appropriate Documentation

i. (a) See pages 1 through 3 of the original report.

ii. (a) See pages 1 through 3 of the original report.

(b) See pages 2 through 3 of the original report.

(c) See pages 2 through 3 of the original report.

(d) Not applicable.

iii. (a) Base period data is fully credible.

(b) See page 4 of the original report.

(c) No errors found in the data.

(d) See pages 140 through 171 of the original report and pages 1 and 2 of the amendment letter.

(e) Value added services and non-capitated services have been excluded from the analysis.

3. Projected benefit Costs and Trends

A. Rate Development Standards

i. Acknowledged.

ii. Acknowledged.

iii. Acknowledged.

iv. Acknowledged.

v. See pages 141 through 142 and pages 159 through 162 of the original report.

vi. See page 142 of the original report.

B. Appropriate Documentation

i. See pages 5 and 6 of the amendment letter and Attachment 1 - Revised pages 19 through 39 of the amendment letter.

ii. See Attachment 3 pages 45 through 125 of the original report and Attachment 5 – Exhibit K.2 – Revised pages 48 and 53 of the amendment letter. There have been no significant changes in the development of the benefit cost since the last certification.

iii. (a) See Attachment 4 pages 126 through 139 of the original report.

(b) See Attachment 4 pages 126 through 139 of the original report.

(c) See Attachment 4 pages 126 through 139 of the original report.

(d) See Attachment 4 pages 126 through 139 of the original report.

(e) Not applicable.

iv. Not applicable.

v. The STAR+PLUS program stipulates the following provisions related to in lieu of services:

- The MCO may provide inpatient services for acute psychiatric conditions in a free-standing psychiatric hospital in lieu of an acute care inpatient hospital setting.
- The MCO may provide substance use disorder treatment services in a chemical dependency treatment facility in lieu of an acute care inpatient hospital setting.
- For individuals between the ages of 21 and 64, services are provided in IMDs only in lieu of an acute care hospital setting. IMD services for individuals under age 21 and age 65 and over are covered pursuant to the Texas state plan.

The cost for in lieu of services are not tracked from other services and are included in the rate development and are not treated differently than any other category of service. Historically these services have made up less than 1.0% of total base period claims.

vi. (a) Restorative enrollment can occur when an individual is deemed to have been Medicaid eligible during a prior period. If the individual was eligible for and enrolled in Medicaid managed care during the prior six months, then the individual is retrospectively enrolled in the same managed care plan as their prior enrollment segment. The managed care plan is then retrospectively responsible for all Medicaid expenses incurred during this retrospective period and is also paid a retrospective premium for this time period.

(b) All claims paid during retroactive enrollment periods are included in the base period data used to develop the FY2018 premium rate.

(c) All enrollment data during retroactive enrollment periods are included in the base period data used to develop the FY2018 premium rate.

(d) No adjustments are necessary to account for retroactive enrollment periods because the enrollment criteria has not changed from the base period to the rating period. All retroactive enrollment and claims information has been included in the base period data, the trend calculations and all other adjustment factors.

vii. See Attachments 5 through 8 pages 140 through 171 of the original report and Attachment 5 – Exhibit K.1 – Revised of the amendment letter.

viii. See Attachments 5 through 8 pages 140 through 171 of the original report and Attachment 5 – Exhibit K.1 – Revised of the amendment letter.

4. Special Contract Provisions Related to Payment

A. Incentive Arrangements

i. Rate Development Standards

Acknowledged.

ii. Appropriate Documentation

(a) See Attachment 15 pages 232 through 233 of the original report.

B. Withhold Arrangements

i. Rate Development Standards

Acknowledged.

ii. Appropriate Documentation

(a) See Attachment 15 pages 232 through 233 of the original report.

C. Risk-Sharing Arrangements

i. Rate Development Standards

Not applicable.

ii. Appropriate Documentation

HHSC includes an experience rebate provision in its uniform managed care contracts which requires the MCOs to return a portion of net income before taxes if greater than the specified percentages. The net income is measured by the financial statistical reports (FSRs) submitted by the MCOs and audited by an external auditor. Net income is aggregated across all programs and service delivery areas. The aggregated net income is shared as follows:

Pre-tax Income as a % of Revenues	MCO Share	HHSC Share
≤ 3%	100%	0%
> 3% and ≤ 5%	80%	20%
> 5% and ≤ 7%	60%	40%
> 7% and ≤ 9%	40%	60%
> 9% and ≤ 12%	20%	80%
> 12%	0%	100%

D. Delivery System and Provider Payment Initiatives

i. Rate Development Standards

Acknowledged.

ii. Appropriate Documentation

(a) See Attachment 13 pages 223 through 225, Attachment 14 pages 226 through 231 of the original report and Attachment 14 – Exhibit B – Revised page 56 or the amendment letter.

E. Pass-Through Payments

i. Rate Development Standards

Acknowledged.

ii. Appropriate Documentation

(a) See Attachment 13 pages 223 through 225 of the original report.

5. Projected Non-Benefit Costs

A. Rate Development Standards

i. Acknowledged.

ii. Acknowledged.

iii. Acknowledged.

iv. Acknowledged.

v. Acknowledged.

B. Appropriate Documentation

i. See page 13 of the original report and pages 3-4 of the amendment letter.

ii. See page 13 of the original report and pages 3-4 of the amendment letter.

iii. See page 13 of the original report and pages 3-4 of the amendment letter.

6. Risk Adjustment and Acuity Adjustments

A. Rate Development Standards

i. Acknowledged.

ii. Acknowledged.

iii. Acknowledged.

B. Appropriate Documentation

i. See Attachments 9 and 10 pages 172 through 195 of the original report.

ii. Not applicable, risk adjustment is only applied on a prospective basis.

iii. No material changes have been made to the risk adjustment model applied to acute care other than annual updates of the data since the last rating period. Attachment 10 of the original report discusses the newly developed long term care acuity model that has been applied. Risk adjustment has been applied in a budget neutral manner in accordance with 42 CFR 438.5(g).

iv. Attachments 9 and 10 pages 172 through 195 of the original report.

Section II. Medicaid Managed Care Rates with Long-Term Services and Supports

1. Managed Long-Term Services and Supports

A. Acknowledged.

B. Long term care rate development follows the same methodology as all other services described throughout the report.

C. Appropriate Documentation

i. (a) Rates are set for the risk groups specified on page 5 of the report. This is a "non-blended" approach.

(b) Rate cells are specified on page 5 of the original report. Description of the rate setting methodology is included in Attachment 3 pages 45 through 125 of the original report. All trend analysis and other adjustment factors follow the same methodology as described throughout the report.

(c) Not applicable.

(d) LTSS has been managed under STAR+PLUS since its inception. The impact of managing these services on utilization and unit costs of services is reflected in the base period utilized in the rate development and requires no further adjustments.

(e) LTSS has been managed under STAR+PLUS since its inception. The impact of managing these services on utilization and unit costs of services is reflected in the base period utilized in the rate development and requires no further adjustments.

ii. The development of the administrative cost is described on page 13 of the original report and pages 3-4 of the amendment letter. Service coordination expenditures are based on the amounts reported by the MCO as discussed on page 2 of the original report.

iii. The rate setting is based on historical managed care data for all services, including long term care. The managed care data is fully credible and therefore no reliance is necessary on outside studies or research.

C. Final Capitation Rates

The impact of the mid-year rate change has been calculated using identical methods and assumptions as those rates calculated in the original actuarial report. No changes other than those detailed in Section A of this report have been included in this revised calculation. All changes included in this amendment are a result of required changes to hospital reimbursement and the QIPP program for nursing facilities. The following attachments provide the supporting documentation for the amendments to the attachments included in the original actuarial report.

Sincerely,

Evan Dial