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January 5, 2018

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

Re: STAR Rate Amendment UMCC 529-12-0002 V2.25

Dear Ms. Butler:

This letter amends the report titled State of Texas Medicaid Managed Care STAR Program Rate Setting State Fiscal Year 2018 and dated July 10, 2017 which was amended in the letter titled STAR 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 and the amendment. The amended rates are assumed to be payable for the period March 1, 2018 through August 31, 2018.

A. Summary of the Revisions

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:

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 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.

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.

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 1.5% 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.

	Under Age 1	Ages 1-5	Ages 6-14	Ages 15-18	Ages 19-20
Monthly Adjusted Premium Rate					
Aetna - Bexar	550.42	152.27	113.54	158.58	151.84
Amerigroup - Bexar	763.27	127.41	109.29	127.17	107.37
CFHP - Bexar	637.92	165.57	149.90	176.05	158.17
Superior - Bexar	717.81	173.25	148.56	176.60	173.28
Amerigroup - Dallas	660.80	191.88	148.63	165.35	184.23
Molina - Dallas	687.40	184.98	128.79	145.18	187.59
Parkland - Dallas	758.40	207.23	153.26	176.96	194.72
El Paso First - El Paso	581.69	171.86	157.36	168.02	169.84
Molina - El Paso	563.29	134.25	104.14	108.57	81.41
Superior - El Paso	666.03	156.73	136.29	159.27	157.55
Amerigroup - Harris	780.60	175.45	150.38	179.66	192.29
CHC - Harris	813.46	203.19	163.43	212.80	235.41
Molina - Harris	639.00	141.69	135.09	196.26	179.13
TCHP - Harris	608.78	165.86	142.48	189.33	193.14
United - Harris	818.78	216.70	165.92	234.51	277.67
Driscoll - Hidalgo	603.02	193.44	142.32	154.12	159.07
Molina - Hidalgo	569.09	177.02	144.72	158.72	137.45
Superior - Hidalgo	632.26	209.86	159.76	166.29	167.94
United - Hidalgo	579.26	204.96	165.53	168.30	168.08
Amerigroup - Jefferson	778.27	169.89	154.94	164.97	249.25
CHC - Jefferson	842.53	196.83	168.45	199.48	176.95
Molina - Jefferson	887.30	168.86	140.41	150.81	149.20
TCHP - Jefferson	682.89	162.88	162.92	186.26	177.48
United - Jefferson	743.91	193.82	195.39	202.82	225.98
Amerigroup - Lubbock	703.77	187.48	144.15	161.54	181.26
Firstcare - Lubbock	705.79	181.78	154.88	183.96	178.02
Superior - Lubbock	742.21	179.33	144.53	178.39	155.53
Christus - Nueces	886.13	209.80	197.33	187.92	149.91
Driscoll - Nueces	876.49	215.11	192.02	239.59	219.00
Superior - Nueces	1,249.04	237.12	211.88	253.18	255.99
Aetna - Tarrant	737.59	136.74	124.38	159.72	151.96
Amerigroup - Tarrant	647.52	158.81	142.69	187.95	172.76
Cook - Tarrant	597.38	158.40	150.39	194.05	174.94
Blue Cross - Travis	535.99	164.32	109.76	135.78	119.21
Sendero - Travis	481.21	129.19	102.96	131.95	152.10
Dell Children's - Travis	462.63	143.48	117.31	129.23	128.45
Superior - Travis	639.79	155.00	121.54	153.97	132.65
Amerigroup - MRSA Central	619.96	121.23	110.61	128.22	112.18
Scott & White - MRSA Central	714.93	156.58	138.01	180.61	160.25
Superior - MRSA Central	632.11	143.75	127.76	156.26	146.15
Amerigroup - MRSA Northeast	618.63	148.51	132.47	184.06	161.05
Superior - MRSA Northeast	674.10	139.09	128.14	185.64	157.64
Amerigroup - MRSA West	701.77	172.36	154.48	201.78	172.91
Firstcare - MRSA West	682.48	167.58	161.34	196.86	208.98
Superior - MRSA West	749.79	157.90	150.65	188.62	188.69

	TANF Adults	Pregnant Women	Adoption Assistance	Delivery Supplemental Payment
Monthly Adjusted Premium Rate				
Aetna - Bexar	360.43	381.33	306.46	3,266.59
Amerigroup - Bexar	486.73	477.68	306.46	3,266.59
CFHP - Bexar	432.01	485.54	306.04	3,266.59
Superior - Bexar	459.99	512.06	306.46	3,266.59
Amerigroup - Dallas	396.19	622.43	249.34	3,537.13
Molina - Dallas	405.66	643.40	249.34	3,537.13
Parkland - Dallas	444.67	675.90	249.00	3,537.13
El Paso First - El Paso	455.11	495.79	270.63	3,443.04
Molina - El Paso	695.50	492.09	270.89	3,443.04
Superior - El Paso	409.95	495.75	270.89	3,443.04
Amerigroup - Harris	589.18	727.41	334.66	3,519.20
CHC - Harris	484.31	731.56	334.07	3,519.20
Molina - Harris	667.94	702.96	334.66	3,519.20
TCHP - Harris	440.91	687.47	334.07	3,519.20
United - Harris	661.82	731.92	334.66	3,519.20
Driscoll - Hidalgo	328.27	495.25	377.34	3,409.95
Molina - Hidalgo	542.88	518.61	377.90	3,409.95
Superior - Hidalgo	537.83	520.50	377.90	3,409.95
United - Hidalgo	530.48	480.22	377.90	3,409.95
Amerigroup - Jefferson	622.14	597.79	286.33	3,394.58
CHC - Jefferson	484.89	651.96	285.85	3,394.58
Molina - Jefferson	541.03	629.64	286.33	3,394.58
TCHP - Jefferson	456.71	627.33	285.85	3,394.58
United - Jefferson	618.04	628.91	286.33	3,394.58
Amerigroup - Lubbock	480.23	665.32	256.46	3,230.39
Firstcare - Lubbock	512.05	634.68	256.46	3,230.39
Superior - Lubbock	500.06	666.21	256.46	3,230.39
Christus - Nueces	540.87	696.83	276.55	3,203.82
Driscoll - Nueces	423.07	690.00	276.55	3,203.82
Superior - Nueces	672.06	811.92	276.76	3,203.82
Aetna - Tarrant	475.04	547.44	339.42	3,635.64
Amerigroup - Tarrant	535.27	591.40	339.42	3,635.64
Cook - Tarrant	404.30	535.77	338.82	3,635.64
Blue Cross - Travis	319.34	466.30	266.72	3,247.49
Sendero - Travis	307.01	466.86	266.71	3,247.49
Dell Children's - Travis	399.20	453.68	266.72	3,247.49
Superior - Travis	393.66	484.94	266.72	3,247.49
Amerigroup - MRSA Central	422.95	539.39	334.47	3,035.27
Scott & White - MRSA Central	545.41	603.07	334.47	3,035.27
Superior - MRSA Central	486.92	603.96	334.47	3,035.27
Amerigroup - MRSA Northeast	504.29	605.09	335.43	3,160.40
Superior - MRSA Northeast	480.64	588.88	335.43	3,160.40
Amerigroup - MRSA West	515.97	665.04	285.56	3,204.07
Firstcare - MRSA West	511.18	677.20	285.56	3,204.07
Superior - MRSA West	499.98	651.06	285.56	3,204.07

Section VI. Actuarial Certification of FY2018 STAR 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 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 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;

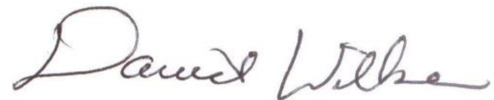
(b) The premium rates are appropriate for the populations and services covered under the managed care contract; and

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

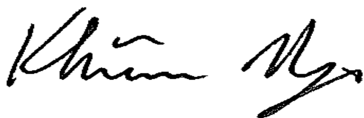
We have relied on historical experience data and program information provided to us by HHSC. We have reviewed the data for reasonableness but have not audited the data.

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 July 10, 2017.

Attachment 1 - *Summary of FY2018 STAR 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, prescription drug, NAIP, UHRIP and delivery supplemental payment (DSP) rates; March 1, 2018 through August 31, 2018 premium rates split between medical, prescription drug, NAIP, UHRIP and DSP rates; and a comparison of 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 (includes DSP), pharmacy, NAIP 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 N.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 MCOs 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 factor has 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 N.2 – Revised presents a summary of the calculation of the UHRIP premium add on rates by MCO for all risk groups except adoption assistance. 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 adoption assistance risk group can be found in Attachment 11.

***Attachment 6** – Family Planning Adjustment*

There have been no changes to this section.

***Attachment 7** – Third Party Recoveries*

There have been no changes to this section.

***Attachment 8** – Delivery Supplemental Payments*

There have been no changes to this section.

***Attachment 9** – Acuity Risk Adjustment*

There have been no changes to this section.

***Attachment 10** – Network Access Improvement Program (NAIP)*

There have been no changes to this section.

Attachment 11 *– Adoption Assistance or Permanency Care Assistance (AAPCA) Rate Development*

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

Provider Reimbursement Adjustment

The UHRIP adjustment is applicable to the AAPCA expansion and the adjustment factors have been calculated in a consistent manner with all other adjustment factors by using the STAR average adjustment for children (Ages 0-20) as found in Attachment 5 Exhibit N.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 D – 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*– Pay for Quality Program*

There have been no changes to this section.

Attachment 13*– FY2018 STAR 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 6 of the amendment letter.

(b) The final capitation rates are shown on pages 4-5 of the amendment letter.

(c) Not applicable.

(d) (i) See pages 1 and 4 through 5 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 AAPCA 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 186-188 (NAIP) and 202-203 (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 147 through 157 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 116 through 146 of the original report and pages 1-2 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 117 through 118 and pages 139 through 142 of the original report.

vi. See page 118 of the original report.

B. Appropriate Documentation

i. See pages 4 and 5 of the amendment letter and Attachment 1 - Revised pages 17 through 31 of the amendment letter.

ii. See Attachment 3 pages 41 through 94 of the original report and Attachment 5 – Exhibit N.2 – Revised pages 41 through 47 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 95 through 115 of the original report.

(b) See Attachment 4 pages 95 through 115 of the original report.

(c) See Attachment 4 pages 95 through 115 of the original report.

(d) See Attachment 4 pages 95 through 115 of the original report.

(e) Not applicable.

iv. Not applicable.

v. The STAR 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 Attachment 5 pages 116 through 146 of the original report and Attachment 5 – Exhibit N.1 – Revised of the amendment letter.

viii. See Attachment 5 pages 116 through 146 of the original report and Attachment 5 – Exhibit N.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 12 pages 202 through 203 of the original report.

B. Withhold Arrangements

i. Rate Development Standards

Acknowledged.

ii. Appropriate Documentation

(a) See Attachment 12 pages 202 through 203 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 10 pages 186 through 188 of the original report.

E. Pass-Through Payments

i. Rate Development Standards

Acknowledged.

ii. Appropriate Documentation

(a) See Attachment 10 pages 186 through 188 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 page 3 of the amendment letter.

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

iii. See page 13 of the original report and page 3 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 Attachment 9 pages 162 through 185 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 other than annual updates of the data since the last rating period.

iv. Risk adjustment has been applied in a budget neutral manner in accordance with 42 CFR 438.5(g).

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. The following attachments provide the supporting documentation for the amendments to the attachments included in the original actuarial report.

Sincerely,

Evan Dial