Rudd and Wisdom, Inc.

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January 3, 2019

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 V2.28, STAR+PLUS Expansion 529-10-0020 V1.32, STAR+PLUS MRSA 529-13-0042 V1.16

Dear Ms. Butler:

This letter amends the report titled State of Texas Medicaid Managed Care STAR+PLUS Program Rate Setting State Fiscal Year 2019 and dated June 29, 2018. The amended FY2019 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, 2019 through August 31, 2019.

A. Summary of the Revisions

UHRIP

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 expanded 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). The UHRIP program increases the reimbursement to contracted hospitals by a level percentage that varies by hospital class.

The method by which the maximum payment to each hospital was calculated has been revised due to the outcome of litigation that vacated a CMS rule regarding the application of other insurance and Medicare payments in calculating each hospital specific limit (HSL). As a result of the changes to the HSL calculations, HHSC allowed participants to submit new requests for provider class rate increases applicable to each SDA. Subsequently, there have been

modifications to the SDA specific increases by hospital class; however, the overall program size has not increased or decreased.

HHSC has identified the following classes of hospitals within each SDA and the rate increase for each which is applicable to the period March 1, 2019 through August 31, 2019:

SDA	Children's	Non-Urban Public	Rural Private	Rural Public	State-owned	Urban Public	Other
Bexar	2%	31%	11%	13%	0%	34%	34%
Dallas	2%	50%	4%	0%	55%	55%	55%
El Paso	2%	0%	0%	0%	0%	40%	40%
Harris	2%	39%	13%	16%	0%	43%	43%
Hidalgo	0%	0%	2%	3%	0%	0%	48%
Jefferson	0%	0%	3%	6%	0%	0%	49%
Lubbock	2%	0%	4%	8%	0%	66%	37%
Nueces	0%	47%	3%	19%	0%	51%	51%
Tarrant	2%	0%	4%	8%	0%	66%	66%
Travis	2%	0%	3%	0%	0%	51%	51%
MRSA Central	0%	0%	3%	6%	0%	0%	46%
MRSA Northeast	0%	0%	5%	10%	0%	0%	79%
MRSA West	0%	62%	4%	25%	0%	68%	68%

There are no other changes to the UHRIP program associated with this amendment.

QIPP

The total funding available for the Quality Incentive Payment Program for the period March 1, 2019 through August 31, 2019 is slightly less than assumed during the original FY2019 rate development. As a result, the QIPP add-on component of the premium will be reduced for the final six months of the year. In addition to the reduction in overall funding for the program, HHSC has updated the caseload forecast to be consistent with the most recent estimates prepared by HHSC System Forecasting. This results in slight variations to the rates because the rates are based upon a total anticipated provider payment divided by the anticipated caseload for that service delivery area. These changes do not impact the period September 1, 2018 through February 28, 2019.

There are no other changes to the QIPP program associated with this amendment.

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 revised UHRIP premium add on is the application of the updated UHRIP increases by hospital class and SDA and revisions to the QIPP add-on component of the premium.

Section III. Adjustment Factors

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

Effective September 1, 2017 HHSC implemented the QIPP program 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 12 presents the development of the QIPP add-on amounts to be included in the capitation rates effective September 1, 2018 along with additional information concerning the QIPP program. Revisions to the total available funding impact the program effective March 1, 2019. Attachment 12 – Exhibit B Revised presents the development of the revised QIPP add-on amounts to be included in the capitation rates effective March 1, 2019.

The Uniform Hospital Reimbursement Program (UHRIP) section has been updated to read:

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 expanded 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 increases 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:

Effective September 1, 2018 – February 28, 2019

SDA	Children's	Non-Urban Public	Rural Private	Rural Public	State-owned	Urban Public	Other
Bexar	2%	38%	14%	17%	0%	38%	38%
Dallas	2%	57%	0%	0%	62%	62%	62%
El Paso	2%	0%	0%	0%	0%	43%	43%
Harris	0%	42%	14%	17%	0%	46%	46%
Hidalgo	0%	0%	0%	14%	0%	0%	36%
Jefferson	0%	0%	6%	6%	0%	0%	50%
Lubbock	3%	0%	4%	9%	0%	72%	40%
Nueces	0%	46%	7%	19%	0%	51%	51%
Tarrant	2%	0%	24%	24%	0%	66%	66%
Travis	1%	0%	7%	0%	0%	56%	56%
MRSA Central	0%	0%	16%	18%	0%	0%	50%
MRSA Northeast	0%	0%	15%	19%	0%	0%	52%
MRSA West	0%	62%	4%	25%	0%	68%	68%

Effective March 1, 2019 – August 31, 2019

SDA	Children's	Non-Urban Public	Rural Private	Rural Public	State-owned	Urban Public	Other
Bexar	2%	31%	11%	13%	0%	34%	34%
Dallas	2%	50%	4%	0%	55%	55%	55%
El Paso	2%	0%	0%	0%	0%	40%	40%
Harris	2%	39%	13%	16%	0%	43%	43%
Hidalgo	0%	0%	2%	3%	0%	0%	48%
Jefferson	0%	0%	3%	6%	0%	0%	49%
Lubbock	2%	0%	4%	8%	0%	66%	37%
Nueces	0%	47%	3%	19%	0%	51%	51%
Tarrant	2%	0%	4%	8%	0%	66%	66%
Travis	2%	0%	3%	0%	0%	51%	51%
MRSA Central	0%	0%	3%	6%	0%	0%	46%
MRSA Northeast	0%	0%	5%	10%	0%	0%	79%
MRSA West	0%	62%	4%	25%	0%	68%	68%

All MCO are required to increase their reimbursement rates to contracted hospitals by the established percentage rate increase. Attachment 13 - Revised presents the development of the UHRIP add-on amounts to be included in the capitation rates effective March 1, 2019 along with additional information concerning the UHRIP program.

No other changes are applicable to this section.

Section IV. Administrative Fees, Taxes and Risk Margin

No changes applicable to this section.

Section V. Summary

The tables in this section are replaced in their entirety with the following mid-year rates effective March 1, 2019 through August 31, 2019.

Health Plan	Medicaid Only OCC	Medicaid Only HCBS	Dual Eligible OCC	Dual Eligible HCBS
Monthly Premium Rates				
Amerigroup - Bexar	$1,493.35	$5,248.54	$395.96	$2,119.64
Molina - Bexar	1,349.09	4,417.61	402.58	1,989.36
Superior - Bexar	1,652.77	4,893.67	459.44	2,087.13
Molina - Dallas	1,640.36	4,548.80	421.98	1,846.32
Superior - Dallas	1,551.65	4,820.01	379.94	1,895.56
Amerigroup - El Paso	1,535.46	4,871.34	522.75	1,972.31
Molina - El Paso	1,842.16	4,972.39	612.09	2,158.55
Amerigroup - Harris	1,700.57	5,528.92	353.65	2,159.07
Molina - Harris	1,562.65	5,399.53	370.98	2,153.05
United - Harris	1,957.38	5,347.46	412.25	2,174.87
Health Spring - Hidalgo	1,906.81	5,080.86	1,023.79	2,488.25
Molina - Hidalgo	1,891.58	5,186.66	899.83	2,449.64
Superior - Hidalgo	2,124.98	5,188.26	1,163.21	2,483.50
Amerigroup - Jefferson	1,361.15	4,830.74	308.92	1,784.71
Molina - Jefferson	1,426.08	4,336.58	303.06	1,631.22
United - Jefferson	1,619.63	4,393.59	201.12	1,519.28
Amerigroup - Lubbock	1,471.16	4,118.87	157.90	1,476.81
Superior - Lubbock	1,386.05	4,872.38	199.23	1,598.72
Superior - Nueces	1,641.24	4,484.70	571.25	2,150.10
United - Nueces	1,879.49	4,739.72	460.15	2,111.09
Amerigroup - Tarrant	1,634.06	5,103.57	324.03	1,800.70
Health Spring - Tarrant	1,427.46	4,852.69	279.47	1,823.41
Amerigroup - Travis	1,500.40	5,631.72	361.14	1,929.37
United - Travis	1,558.66	5,583.36	180.40	1,856.01
Superior - MRSA Central	1,430.90	4,733.45	230.43	1,807.45
United - MRSA Central	1,368.33	5,155.37	238.93	1,937.94
Health Spring - MRSA Northeast	1,310.56	4,659.63	228.90	1,735.55
United - MRSA Northeast	1,436.89	4,960.19	254.01	1,594.02
Amerigroup - MRSA West	1,372.08	5,264.03	281.77	1,662.72
Superior - MRSA West	1,472.28	4,624.69	287.82	1,579.01

Health Plan	Medicaid Only NF	Dual Eligible NF	IDD Over 21	MBCCP
Monthly Premium Rates				
Amerigroup - Bexar	$7,481.32	$4,714.18	$826.61	$2,835.78
Molina - Bexar	7,406.75	4,714.18	805.63	2,835.78
Superior - Bexar	7,850.70	4,714.18	1,120.79	2,835.78
Molina - Dallas	8,175.90	4,690.39	822.29	2,875.99
Superior - Dallas	8,612.39	4,690.39	871.84	2,875.99
Amerigroup - El Paso	9,252.76	4,304.92	1,521.49	2,075.38
Molina - El Paso	8,950.16	4,304.92	1,683.82	2,075.38
Amerigroup - Harris	7,907.79	4,569.34	970.16	3,049.64
Molina - Harris	7,894.85	4,569.34	939.96	3,049.64
United - Harris	8,115.14	4,569.34	1,069.71	3,049.64
Health Spring - Hidalgo	8,131.56	5,127.44	850.43	2,821.85
Molina - Hidalgo	8,618.88	5,127.44	1,003.52	2,821.85
Superior - Hidalgo	8,849.33	5,127.44	1,191.08	2,821.85
Amerigroup - Jefferson	7,392.72	4,360.91	930.23	2,835.78
Molina - Jefferson	7,079.47	4,360.91	843.58	2,835.78
United - Jefferson	7,386.60	4,360.91	985.58	2,835.78
Amerigroup - Lubbock	7,861.54	4,576.91	938.03	2,385.47
Superior - Lubbock	7,805.47	4,576.91	857.97	2,385.47
Superior - Nueces	7,048.12	4,664.08	1,170.47	2,556.60
United - Nueces	6,901.50	4,664.08	1,282.63	2,556.60
Amerigroup - Tarrant	7,696.42	4,467.82	953.50	2,726.93
Health Spring - Tarrant	7,083.87	4,467.82	776.59	2,726.93
Amerigroup - Travis	7,656.69	4,800.30	809.09	3,112.58
United - Travis	7,875.18	4,800.30	1,090.43	3,112.58
Superior - MRSA Central	6,842.03	4,515.44	1,048.02	3,813.47
United - MRSA Central	6,966.06	4,515.44	932.22	3,813.47
Health Spring - MRSA Northeast	7,732.75	4,533.09	871.10	3,168.38
United - MRSA Northeast	7,610.46	4,533.09	953.85	3,168.38
Amerigroup - MRSA West	7,577.09	4,612.33	1,003.77	2,666.36
Superior - MRSA West	7,755.27	4,612.33	960.29	2,666.36

Section VI. Actuarial Certification of FY2019 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, 2019 through August 31, 2019 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 FY2019 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;

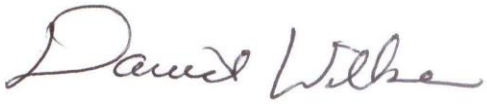
(b) The premium rates are appropriate for the populations and services covered under the managed care contract; and

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

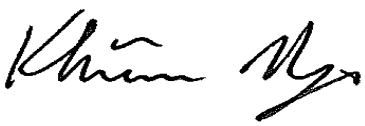
We have relied on historical experience data and program information provided to us by HHSC. We have reviewed the data for reasonableness but have not audited the data.

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 VII. Attachments

The following sections indicate any revisions applicable to each of the attachments in the original actuarial report dated June 29, 2018.

Attachment 1 - *Summary of FY2019 STAR+PLUS Rating Analysis*

Exhibit A Revised. This exhibit presents summary information regarding the FY2019 rates. Included on the exhibit are current (September 1, 2018 – February 28, 2019) premium rates split between medical (acute care and long-term care), prescription drug, NAIP, QIPP and UHRIP rates; March 1, 2019 through August 31, 2019 premium rates split between medical (acute care and long-term care), prescription drug, NAIP, QIPP and UHRIP rates and a comparison of September 1, 2018 and March 1, 2019 premium rates.

Exhibit B Revised. This exhibit presents a comparison of the projected expenditures under the current (September 1, 2018 through February 28, 2019) premium rates and the March 1, 2019 through August 31, 2019 premium rates. The projection is split by each component.

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 FY2017, FY2018 and FY2019*

No changes applicable to this section.

Attachment 6 – *Removal of STAR+PLUS Members Under Age 21*

There have been no changes to this section.

Attachment 7 – *Carve In Relocation Services*

There have been no changes to this section.

Attachment 8 – *Acuity Risk Adjustment – Acute Care*

There have been no changes to this section.

Attachment 9 – *Acuity Risk Adjustment – Long Term Care*

There have been no changes to this section.

Attachment 10 – *Medicaid Breast and Cervical Cancer Program (MBCCP) Rate Development*

There have been no changes to this section.

Attachment 11 – *Network Access Improvement Program (NAIP)*

There have been no changes to this section.

Attachment 12 – *Quality Incentive Payment Program (QIPP)*

Effective March 1, 2019 the available funding for the QIPP has been reduced triggering a revision to the QIPP add-on amounts included in the capitation rates. Exhibit B Revised presents a summary of the QIPP add-on amounts effective during the period March 1, 2019 through August 31, 2019. There have been no other changes to the QIPP program.

Attachment 13 – *Uniform Hospital Rate Increase Program*

Uniform Hospital Rate Increase Program

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. CMS approved HHSC's statewide implementation of the program on August 18, 2017 and the program was expanded statewide March 1, 2018. UHRIP is a Medicaid managed care hospital directed payment program authorized under federal regulation 42 CFR 438.6(c). UHRIP increases 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:

Effective September 1, 2018 – February 28, 2019

SDA	Children's	Non-Urban Public	Rural Private	Rural Public	State-owned	Urban Public	Other
Bexar	2%	38%	14%	17%	0%	38%	38%
Dallas	2%	57%	0%	0%	62%	62%	62%
El Paso	2%	0%	0%	0%	0%	43%	43%
Harris	0%	42%	14%	17%	0%	46%	46%
Hidalgo	0%	0%	0%	14%	0%	0%	36%
Jefferson	0%	0%	6%	6%	0%	0%	50%
Lubbock	3%	0%	4%	9%	0%	72%	40%
Nueces	0%	46%	7%	19%	0%	51%	51%
Tarrant	2%	0%	24%	24%	0%	66%	66%
Travis	1%	0%	7%	0%	0%	56%	56%
MRSA Central	0%	0%	16%	18%	0%	0%	50%
MRSA Northeast	0%	0%	15%	19%	0%	0%	52%
MRSA West	0%	62%	4%	25%	0%	68%	68%

Effective March 1, 2019 – August 31, 2019

SDA	Children's	Non-Urban Public	Rural Private	Rural Public	State-owned	Urban Public	Other
Bexar	2%	31%	11%	13%	0%	34%	34%
Dallas	2%	50%	4%	0%	55%	55%	55%
El Paso	2%	0%	0%	0%	0%	40%	40%
Harris	2%	39%	13%	16%	0%	43%	43%
Hidalgo	0%	0%	2%	3%	0%	0%	48%
Jefferson	0%	0%	3%	6%	0%	0%	49%
Lubbock	2%	0%	4%	8%	0%	66%	37%
Nueces	0%	47%	3%	19%	0%	51%	51%
Tarrant	2%	0%	4%	8%	0%	66%	66%
Travis	2%	0%	3%	0%	0%	51%	51%
MRSA Central	0%	0%	3%	6%	0%	0%	46%
MRSA Northeast	0%	0%	5%	10%	0%	0%	79%
MRSA West	0%	62%	4%	25%	0%	68%	68%

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.
3. Services provided to a member at an out of area facility if the facility is located in a SDA in which the MCO does not participate in the STAR or STAR+PLUS program.

The percentage increases by hospital were determined by HHSC according to the following methodology:

Each SDA requests a specific percentage increase within the CMS-approved range for a hospital class (the percentage increase for each hospital class in an SDA must not exceed the rate increase range approved by CMS for each program period) and HHSC confirms that the requested increase for the SDA class is no more than 95% of the Medicaid Shortfall threshold for that class. HHSC then calculates the final percentage rate increases by multiplying the calculated reduction factor by the requested SDA percentage rate increases that comply with the 95% Medicaid Shortfall threshold. The reduction factor is calculated by dividing the budget neutrality room allotment by the respective actuarial forecast for each SDA. The SDA specific percentage increases will be revised effective March 1, 2019 as a result of changes in the calculation of the hospital specific limit calculations resulting from recent litigation. These changes allowed participants to request revised provider class rate increases applicable to each SDA effective March 1, 2019.

In the Texas Medicaid program the actuary does not get involved in the development of provider fee schedules or reimbursement arrangements. The final UHRIP increases were determined by HHSC and the MCOs are mandated to include such increases in their provider reimbursement arrangements.

The UHRIP component of the premium for the period September 1, 2018 through February 28, 2019 is unchanged from the amounts determined in the original actuarial report. The calculation of the revised UHRIP component of the premium described below is based on the exact same methodology described in the original report applying the updated SDA specific increases by hospital class.

Exhibit A 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 FY2017 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 B Revised presents a summary of the calculation of the UHRIP premium add on rates by MCO for all risk groups. 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 FY2019 claims increased by the applicable UHRIP adjustment factor plus provision for risk margin, taxes and administrative fees.

Attachment 14– *Community First Choice Initiative (CFC)*

There have been no changes to this section.

Attachment 15– *Pay for Quality Program*

There have been no changes to this section.

Attachment 16– *FY2019 STAR+PLUS Rate Certification Index*

FY2019 STAR+PLUS Rate Certification Index

The index below includes the pages of the original report and this amendment letter that correspond to the applicable sections of the 2018-2019 Medicaid Managed Care Rate Development Guide, dated May 2018.

Section I. Medicaid Managed Care Rates

1. General Information

A. Rate Development Standards

i. Rates are for the period March 1, 2019 through August 31, 2019.

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

(ii) The rates included in this amendment are for the period March 1, 2019 through August 31, 2019.

(iii) See page 1 of the original report.

(iv) Not applicable. There have been no changes since the prior certification.

(v) Pages 223-227 (NAIP), 228-233 (QIPP), 234-249 (UHRIP) and 257-258 (P4Q) of the original report. Changes to the QIPP and UHRIP programs are detailed on pages 1-2 of the amendment letter.

(vi) Not applicable.

iii. Acknowledged.

iv. Acknowledged.

v. Acknowledged.

vi. Acknowledged.

vii. Acknowledged.

viii. Acknowledged.

B. Appropriate Documentation

i. Acknowledged.

ii. Acknowledged.

iii. See pages 250 through 256 of the original report.

iv. See Attachment 1 - Revised on pages 21 through 42 of the amendment letter.

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 and 3 of the original report.

(c) See pages 2 and 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 149 through 182 of the original report.

(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 150 through 151 and pages 170 through 171 of the original report.

vi. See page 151 of the original report.

B. Appropriate Documentation

i. See pages 4 and 5 and Attachment 1 - Revised pages 21 through 42 of the amendment letter.

ii. See Attachment 3 pages 50 through 130 of the original report. There have been no significant changes in the development of the benefit cost since the last certification.

iii. (a) See Attachment 4 pages 131 through 148 of the original report.

(b) See Attachment 4 pages 131 through 148 of the original report.

(c) See Attachment 4 pages 131 through 148 of the original report.

(d) See Attachment 4 pages 131 through 148 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 is 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 roughly 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 FY2019 premium rate.

(c) All enrollment data during retroactive enrollment periods are included in the base period data used to develop the FY2019 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 an all other adjustment factors.

vii. See Attachments 5 through 7 pages 149 through 182 of the original report.

viii. See Attachments 5 through 7 pages 149 through 182 of the original report.

4. Special Contract Provisions Related to Payment

A. Incentive Arrangements

i. Rate Development Standards

Acknowledged.

ii. Appropriate Documentation

(a) See Attachment 15 pages 257 through 258 of the original report.

B. Withhold Arrangements

i. Rate Development Standards

Acknowledged.

ii. Appropriate Documentation

(a) See Attachment 15 pages 257 through 258 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 12 pages 228 through 233 and Attachment 13 pages 234 through 249 of the original report and the revisions included in the amendment letter.

E. Pass-Through Payments

i. Rate Development Standards

Acknowledged.

ii. Appropriate Documentation

(a) See Attachment 11 pages 223 through 227 of the original report.

(b) See Attachment 11 pages 223 through 227 of the original report.

5. Projected Non-Benefit Costs

A. Rate Development Standards

i. Acknowledged.

ii. Acknowledged.

iii. Acknowledged.

iv. Acknowledged.

B. Appropriate Documentation

i. See page 15 of the original report.

ii. See page 15 of the original report.

iii. (a) See page 15 of the original report.

(b) Not applicable.

(c) Not applicable.

(d) See page 15 of the original report.

(e) See Attachment 1 Revised pages 21 through 42 of the amendment letter.

(f) See page 15 of the original report.

6. Risk Adjustment and Acuity Adjustments

A. Rate Development Standards

i. Acknowledged.

ii. Acknowledged.

iii. Acknowledged.

B. Appropriate Documentation

i. See Attachments 8 and 9 pages 183 through 206 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. The long term care risk adjustment factors have been assigned 100% credibility which is an increase from the 75% used in the FY2018 rate development. Risk adjustment has been applied in a budget neutral manner in accordance with 42 CFR 438.5(g).

iv. See Attachments 8 and 9 pages 183 through 206 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 original 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 50 through 130 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 15 of the report. Service coordination expenditures are based on the amounts reported by the MCO as discussed on page 2 of the 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.