STATE OF TEXAS
MEDICAID MANAGED CARE
STAR PROGRAM RATE SETTING
STATE FISCAL YEAR 2019

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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 2019 (FY2019, September 1, 2018 through August 31, 2019) 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. Effective September 1, 2017 Medicaid members in the Texas Department of Family and Protective Services (DFPS) Adoption Assistance or Permanency Care Assistance (AAPCA) programs began getting their Medicaid services through managed care. 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 SDA. There is a total of 16 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 FY2019 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 SDA and risk group for each health plan. This includes historical enrollment since September 2014 and a projection of future enrollment through August 2019. These projections were prepared by HHS System Forecasting staff.
- Detailed MCO encounter data for FY2017. The encounter data is a dataset that includes the detail claim information for every claim incurred during FY2017 and paid through November 30, 2017. The dataset includes but is not limited to (1) individual member information – date of birth, risk group, health plan; (2) provider information – type of provider, NPI, bill type, taxonomy code; (3) procedure information – diagnosis, procedure code, claim modifier; and (4) payment information – paid amount, billed amount. This information is used to identify the providers and services which will receive or have received reimbursement changes in order to determine the cost impact of such changes.
- Claim lag reports by SDA and risk group for each health plan for the period September 2014 through February 2017. These reports were prepared by the health plans and include monthly paid claims by month of service. These reports summarize the detail encounter data.
- Financial Statistical Reports (FSR) for each participating health plan for FY2016, FY2017 and the first six months of FY2018. 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. A health plan that participates in multiple programs and/or service areas submits a separate FSR for each individual area and program combination.

- 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 (FY2018) 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 2014 through January 2018.
- 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 approximately 1.0% of total medical 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 FY2017 third party recoveries from each of the health plans.
- FY2017 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 FY2017 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 FY2019 Medicaid provider reimbursement rates.
- A listing of individuals enrolled in the AAPCA programs during the period September 2012 through August 2017.
- Monthly medical fee-for-service claims data for each AAPCA member. Note that prescription drug expenses were based on actual AAPCA member claims from September 2017 through February 2018.

After accumulating all of the information to be used in the rate setting process, a comparison of the various sources of claims data was performed to check for consistency. We compared (i) the claim lag reports provided by the MCOs, (ii) the claim amounts reported in the FSRs and (iii) the claim amounts in the encounter data files. The three data sources are compared to ensure consistent results such that the three are considered interchangeable in aggregate. Although

interchangeable in total, each data source has a unique role in the analysis. FSR data provides high level summary information of claims data, subcapitated expenses, reinsurance expenses and administrative costs. In some cases, this information is available at the risk group level while for others it is only provided at an aggregated level. MCO summary reports provide HHSC-specified data points at a more granular level such as subcapitated expenses by service, claim lag data by service, other medical expenses and large claimant information. The detail encounter data provides claim data at the most granular level including information for individual claims such as provider, procedure code, diagnostic information, etc. The use of these multiple data sources allows for a dynamic, flexible rating model that is not constrained to the data limitation of a single source.

All data requested by the actuary was provided by HHSC and the participating MCOs. Although the above data was reviewed for reasonableness, Rudd and Wisdom did not audit the data.

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/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.*

Based on the review of the data by the EQRO, HHSC and Rudd and Wisdom, we have concluded that all data sources are consistent, complete and accurate. It is our opinion that the data collected for the rate development is high quality and we have no concerns over the availability or applicability to the FY2019 rate development. The accumulation of data sources noted above have been assigned full credibility.

Given the history of managed care data available for the STAR program, the rate development is based exclusively on managed care data with the exception of the medical premium for the AAPCA members which were new to managed care effective September 1, 2017. The development of the AAPCA risk group premium rates is described further in Attachment 10.

II. Overview of the Rate Setting Methodology

This report details the development of the medical and prescription drug components of the STAR premium rate. The two components are developed separately but follow similar methodologies in their calculations.

The actuarial model used to derive the FY2019 STAR premium rates relies primarily on historical health plan experience. The historical claims experience for the program was analyzed and estimates for the base period were developed. Due to the significant differences between claim run out patterns, different base periods were selected for medical and prescription drug. The base period for the medical component was defined as FY2017 (September 1, 2016 through August 31, 2017) while the base period for the prescription drug component was defined as CY2017 (January 1, 2017 through December 31, 2017). The primary reason for varying the base periods between medical and prescription is that prescription drug claims complete much faster and therefore require minimal estimation of incurred but unpaid claims. Estimates of the base period include an estimate of incurred but unpaid claims (IBNR). The IBNR estimate is based on claims paid through February 2018 and represents the following percentage of claims by type of service:

- Medical - 0.32%
- Prescription Drug - 0.0%

These estimates were then projected forward to FY2019 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 FY2019 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
- Adoption Assistance or Permanency Care Assistance (AAPCA)

*Due to a small sample size and large variation from year to year, the Children ages 19-20 have been combined with the Children ages 15-18 for purposes of the medical rate development. Annual variation in pharmacy costs is not as significant for this risk group and therefore the risk groups have not been combined for pharmacy rating purposes.

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
- 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 Non-Emergency Medical Transportation
- Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation)
- Certain high cost carve-out prescription drugs

All expenses related to these and any other non-capitated services are excluded from the FY2019 rating analysis.

We projected the FY2019 cost for each individual health plan by estimating their base

period 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 such adjustments were deemed to be necessary.

HHSC utilized the combination of two rating methodologies in setting the FY2019 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 FY2019 cost for each health plan in the service area. The weights used in this formula are the projected FY2019 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 FY2019 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 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 FY2019 STAR premium rates (medical and pharmacy combined) 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. 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 excessively from the higher community average premium rates. The 108% minimum impacts four of the forty-four health plan/SDA options in the STAR program.

III. Adjustment Factors

This section contains a description of the adjustment factors used in the FY2019 STAR rate setting process.

Trend Factors - Medical

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 FY2018 vary by service area and are established on a statewide basis for FY2019. All trend assumptions vary by risk group.

The trend analysis included a review of health plan claims experience data through February 2018. Based on this information, estimates of monthly incurred claims were made through December 2017. The claims cost and trend experience were 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 FY2017 trend has been calculated as the change in average cost per member per month during the period September 1, 2016 through August 31, 2017 (FY2017) compared to the average cost per member per month during the period September 1, 2015 through August 31, 2016 (FY2016). 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 FY2018 trend assumptions were developed from two components: (i) the actual estimated trend by service area for the period September 2017 through December 2017 and (ii) the projected trend for the period January 2018 through August 2018. The actual trends for the period September 2017 through December 2017 were calculated separately for each service delivery area. The projected trends for the period January 2018 through August 2018 were projected using a simple average of the FY2015 trend, FY2016 trend and FY2017 trend.

Blending the area specific trends for the period September 2017 through December 2017 with the statewide projected trend for the period January 2018 through August 2018 was done via the following formula:

$$\text{FY2018 SDA Trend} = \frac{\text{(9/17-12/17 actual SDA trend)} \times 4 + \text{(1/18-8/18 Statewide)} \times 8}{12}$$

The FY2019 trend assumptions were then developed on a statewide basis from a simple average of the FY2015 trend, FY2016 trend and FY2017 trend.

Attachment 4 Exhibits A-C include a summary of the medical trend analysis. The chart below presents the assumed annual trend rates for FY2018 and FY2019.

	Under Age 1	Ages 1-5	Ages 6-14	Ages 15-20	TANF Adult	Pregnant Women
FY2018						
Bexar SDA	7.7%	5.1%	3.8%	1.3%	1.4%	0.5%
Dallas SDA	2.7%	2.6%	7.1%	9.3%	0.0%	-1.4%
El Paso SDA	-0.6%	3.5%	2.3%	2.3%	1.0%	0.0%
Harris SDA	1.6%	2.2%	2.6%	0.9%	1.2%	-1.6%
Hidalgo SDA	4.2%	5.6%	6.2%	3.5%	-2.5%	-0.5%
Jefferson SDA	0.9%	0.5%	2.5%	0.3%	3.5%	-0.9%
Lubbock SDA	-4.1%	0.4%	5.4%	4.4%	-0.4%	-2.0%
Nueces SDA	1.2%	4.2%	1.6%	-0.8%	-0.7%	-1.4%
Tarrant SDA	6.1%	3.0%	2.4%	0.8%	1.0%	-1.5%
Travis SDA	1.8%	2.7%	4.1%	-0.4%	0.7%	-2.6%
MRSA Central SDA	-1.3%	4.1%	4.6%	4.6%	-3.6%	-1.2%
MRSA Northeast SDA	9.4%	4.2%	3.7%	3.3%	0.9%	0.2%
MRSA West SDA	4.4%	2.9%	3.2%	-2.2%	1.8%	-1.6%
FY2019	2.7%	1.3%	2.9%	1.9%	0.1%	-1.8%

Trend Factors - Rx

The rating methodology uses assumed pharmacy trend factors to adjust the base period (CY2017) claims cost to the rating period (FY2019). The trend rate assumptions were developed by the actuary based on an analysis of recent pharmacy claims experience under the STAR program and the actuary's professional judgment regarding anticipated future cost changes. The trend rate assumptions vary by risk group but are the same for all service areas.

The trend analysis included a review of STAR utilization and cost experience data paid through March 2018. Utilization (days supply per member) and cost per service (plan payments per days supply) statistics were developed by risk group and drug type (brand, generic and specialty) through February 2018. From this experience, the average annual utilization and cost per service were determined for each of the five 12-month periods ending February 2018.

Only those drugs covered under the capitated arrangement are included in the trend analysis. Anti-viral agents used for the treatment of the Hepatitis C virus and the drug Orkambi are not included in the analysis as those drugs are currently carved out of the managed care contract. In addition, experience for the drugs Tamiflu and Makena were removed from our trend analysis. Tamiflu was removed due to the significant variation in the intensity of flu season from year to year. Makena was removed due to its one-time distortion of pharmacy trends for pregnant women. Please note that while excluded from the pharmacy trend analysis, the historical claims for Tamiflu and Makena were included in the base period experience used in developing the pharmacy component of the rates.

The STAR pharmacy trend assumptions for the remainder of FY2018 and all of FY2019 were developed by risk group using the following formula. The utilization and cost per service trend assumptions were set equal to one-sixth of the experience trend rate for the 12-month period ending February 2016 plus two-sixths of the experience trend rate for the 12-month period ending February 2017 plus three-sixths of the experience trend rate for the 12-

month period ending February 2018. The final cost trend assumptions were then determined by applying the assumed utilization and cost per service trends by individual drug type to actual experience for the 12-month period ending February 2018 and combining the results into a single trend assumption for each risk group.

Exhibit D in Attachment 4 includes a summary of the pharmacy trend analysis for STAR. The chart below presents the assumed annual pharmacy trend rates applicable for the period 1/1/2018 through 8/31/2019.

	Under Age 1	Ages 1-5	Ages 6-14	Ages 15-18	Ages 19-20	TANF Adult	Pregnant Women
All SDAs	0.4%	-1.8%	1.5%	2.6%	4.7%	10.0%	12.6%

Please note that the MCOs were provided a detailed trend analysis file which included the historical utilization and cost experience as well as all of the formulas and assumptions used in developing the trend assumptions.

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, therapy reimbursement revisions, therapy policy revisions, radiology reimbursement reductions, anesthesiology reimbursement revisions and ambulance 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.

Tort and Coordination of Benefit Recoveries

Effective September 1, 2017 HHSC instituted a change in policy that shifts claim recoveries associated with tort and coordination of benefit recoveries beyond 120 days from the MCOs to HHSC. Exhibit I of Attachment 5 presents a summary of the necessary rating adjustment factors.

Removal of Invalid Clinician Administered Drugs (CADs)

By HHSC rule, all outpatient medical claims for clinician-administered drugs must contain a Healthcare Common Procedure Coding System (HCPCS) code, an NDC number, the NDC unit of measure, and the NDC quantity. The MCO must edit claims using the Texas HHSC NDC to HCPCS Crosswalk file. If such a claim is missing the NDC information, or the NDC is not valid for the corresponding HCPCS code, then the drug is not considered a covered Medicaid benefit and the MCO must deny or reject the entire claim or claim line item. As a result, the base period data was reviewed and clinician administered drugs which were submitted under an invalid NDC were excluded from the rating analysis. Exhibit J of Attachment 5 presents a summary of the derivation of this adjustment factor.

Elimination of the NorthSTAR Program

Effective January 1, 2017 the NorthSTAR program was discontinued. Historically the NorthSTAR program provided all behavioral health services for Medicaid clients residing in the Dallas service area. Due to the elimination of the NorthSTAR program, behavioral health services are now carved into the STAR program for the Dallas service area as with all other service areas. As a result, it is necessary to adjust the Dallas service area base period data to include these behavioral health services. Exhibit K of Attachment 5 presents a summary of these adjustment factors.

IMD Cost Removal

By regulation, cost for managed care members ages 21 through 64 who have an IMD stay in excess of 15 days during a month may not be used in the rate development. Claims data for all such members has been identified and removed from the rate analysis. A summary of the derivation of these adjustment factors is presented in Attachment 5 - Exhibit L.

FQHC Wrap Payment Removal

Effective September 1, 2017, MCOs are no longer required to reimburse FQHC’s the full encounter rate. The MCO are expected to reimburse FQHCs at a rate that is comparable to the reimbursement of all other non-FQHC providers providing similar services. Subsequently, the FQHC will be reimbursed up to their full encounter rate outside of the capitation rate. The rating adjustment was calculated by repricing all FQHC claims at the fee-for-service equivalent paid for non-FQHC providers for the same services. The difference between the full encounter rate and this estimated fee-for-service equivalent was assumed to be the wrap payment that is no longer covered under the capitation rate. Exhibit M of Attachment 5 presents a summary of the derivation of these adjustment factors.

Hepatitis C Drug Carve In

HHSC currently excludes several low-utilization, high-cost drugs from the capitated arrangement. These drugs are covered services under the plan but their cost is reimbursed to the MCOs using a non-risk arrangement. We have now accumulated sufficient experience to project utilization and cost for some of these “carve-out” drugs. Anti-viral medications for the treatment of Hepatitis C (Epclusa, Harvoni, Viekira Pak, etc.) and Orkambi (a

treatment for Cystic Fibrosis) will be added to capitated services effective September 1, 2018. Exhibit N of Attachment 5 includes additional information regarding the derivation of the rate adjustment factors for these services.

Preferred Drug List Changes

HHSC has recently implemented numerous changes to the Preferred Drug List (PDL). These changes include some of the program's highest expenditure drugs and will have a significant impact on managed care pharmacy cost. Some of the PDL changes were implemented during the experience period used to develop the rates and some were implemented after the experience period. We developed adjustment factors to reflect the anticipated cost impact of the PDL changes. Exhibit O of Attachment 5 includes additional information regarding the application of the PDL changes adjustment factors.

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 11 presents the development of the NAIP add-on amounts to be included in the capitation rates effective September 1, 2018 along with further information concerning the NAIP program.

Uniform Hospital Reimbursement Program (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). 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:

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%

All MCO are required to increase their reimbursement rates to contracted hospitals by the established percentage rate increase. Attachment 12 presents the development of the UHRIP add-on amounts to be included in the capitation rates effective September 1, 2018 along with additional information concerning the UHRIP 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 $7.50 pmpm plus 5.75% of gross premium for medical services and $1.80 pmpm for pharmacy services. 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 data used in developing the administrative expense assumption are the detailed administrative costs reported by the health plans in their audited financial statistical reports (FSRs) for the past five fiscal years. These reports provide a detailed breakdown of monthly administrative expenses by category including salaries, technology, equipment, marketing, legal, PBM and other expenses. These reports are provided quarterly and audited annually by an external auditor.

The table below summarizes the reported per capita administrative expenses for the past five fiscal years for the STAR program.

	Average
FY14	20.34
FY15	17.80
FY16	18.45
FY17	18.03
FY18	17.88
5 Year Average	18.50

Based on the administrative formula included in the rate development the average administrative expense included in the capitation rates is approximately $19 which is in line with the historical averages. The fixed and variable components of the administrative cost assumption are not intended to account for different administrative cost categories. The combined administrative assumption is intended to be a reasonable amount to cover all administrative costs. 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 ($0.06 pmpm) and a risk margin (1.5% 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's (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, if necessary or applicable. HHSC has included the Health Insurance Providers Fee in the managed care capitation rates for each of 2014, 2015 and 2016 through amendments to the initially certified rates for these time periods.

V. Summary

The following chart presents the results of the FY2019 STAR rating analysis and includes all components of the premium – medical, prescription drug, NAIP and UHRIP. Texas is eligible for an enhanced match rate for family planning services. Attachment 6 details the development of the family planning component of the total premium rate.

	Under Age 1	Ages 1-5	Ages 6-14	Ages 15-18	Ages 19-20
FY2019 STAR Premium Rate					
Aetna - Bexar	683.58	135.50	121.38	149.53	124.90
Amerigroup - Bexar	663.36	142.53	111.92	125.80	115.59
CFHP - Bexar	690.20	170.81	153.27	186.60	172.24
Superior - Bexar	831.93	160.57	148.24	171.07	169.80
Amerigroup - Dallas	656.40	180.64	153.40	192.95	179.31
Molina - Dallas	698.44	180.21	138.59	156.79	175.23
Parkland - Dallas	748.35	200.23	159.90	208.98	207.83
El Paso Health - El Paso	627.60	174.30	163.61	179.21	197.21
Molina - El Paso	543.98	156.37	134.71	123.42	122.77
Superior - El Paso	730.09	161.20	148.55	167.86	195.37
Amerigroup - Harris	804.96	168.48	149.44	183.66	213.02
CHC - Harris	831.41	196.19	159.61	212.75	256.53
Molina - Harris	646.65	160.53	131.44	194.22	207.98
TCHP - Harris	611.14	162.37	144.03	194.10	226.71
United - Harris	840.27	209.45	164.88	225.82	299.01
Driscoll - Hidalgo	642.85	195.99	150.71	157.85	166.73
Molina - Hidalgo	616.57	176.64	143.82	154.58	169.21
Superior - Hidalgo	725.99	208.94	160.87	167.06	178.58
United - Hidalgo	647.69	222.46	181.58	177.93	165.73
Amerigroup - Jefferson	831.09	158.82	173.58	164.02	186.54
CHC - Jefferson	972.76	183.69	171.89	213.14	250.84
Molina - Jefferson	958.75	167.84	142.92	214.53	217.31
TCHP - Jefferson	807.61	147.85	158.30	189.41	240.84
United - Jefferson	889.44	186.07	182.14	215.46	230.29
Amerigroup - Lubbock	876.18	186.57	148.06	166.69	219.98
Firstcare - Lubbock	808.29	164.32	153.22	208.30	189.48
Superior - Lubbock	780.32	172.61	149.10	176.67	190.79
Driscoll - Nueces	852.33	213.16	196.51	232.19	197.65
Superior - Nueces	1,050.76	243.47	207.46	214.87	212.98
United - Nueces	946.57	251.75	190.22	232.07	134.42
Aetna - Tarrant	685.43	134.09	117.20	145.87	167.63
Amerigroup - Tarrant	690.42	149.90	138.06	184.81	200.43
Cook - Tarrant	694.93	151.75	144.60	191.36	172.36
Blue Cross - Travis	703.00	169.44	112.68	152.22	135.22
DCHP - Travis	554.15	131.00	110.01	151.70	155.45
Superior - Travis	785.60	150.67	126.33	165.10	169.21
Amerigroup - MRSA Central	534.79	114.00	107.90	164.65	155.23
Scott & White - MRSA Central	800.16	156.46	141.25	188.78	170.49
Superior - MRSA Central	726.82	135.59	124.16	171.87	180.35
Amerigroup - MRSA Northeast	781.30	142.24	133.86	164.69	160.89
Superior - MRSA Northeast	782.91	137.73	129.95	157.56	160.95
Amerigroup - MRSA West	728.02	167.52	163.37	204.71	231.58
Firstcare - MRSA West	752.88	167.02	157.36	206.03	225.99
Superior - MRSA West	809.67	155.59	143.90	208.08	182.94

	TANF Adults	Pregnant Women	Adoption Assistance	Delivery Supplemental Payment
FY2019 STAR Premium Rate				
Aetna - Bexar	474.63	503.43	272.04	3,114.65
Amerigroup - Bexar	507.06	507.65	272.04	3,114.65
CFHP - Bexar	506.60	568.47	271.73	3,114.65
Superior - Bexar	539.95	594.64	272.04	3,114.65
Amerigroup - Dallas	419.44	629.27	262.46	3,285.03
Molina - Dallas	423.05	618.07	262.46	3,285.03
Parkland - Dallas	481.26	704.52	262.23	3,285.03
El Paso Health - El Paso	514.45	621.83	232.13	3,141.81
Molina - El Paso	710.35	597.43	232.33	3,141.81
Superior - El Paso	472.39	635.11	232.33	3,141.81
Amerigroup - Harris	635.74	709.16	297.46	3,451.70
CHC - Harris	524.84	724.18	297.20	3,451.70
Molina - Harris	599.78	634.95	297.46	3,451.70
TCHP - Harris	450.01	651.35	297.20	3,451.70
United - Harris	694.71	722.11	297.46	3,451.70
Driscoll - Hidalgo	363.07	563.78	438.91	3,035.69
Molina - Hidalgo	592.41	587.44	439.21	3,035.69
Superior - Hidalgo	586.17	601.36	439.21	3,035.69
United - Hidalgo	572.71	583.71	439.21	3,035.69
Amerigroup - Jefferson	751.08	625.44	260.02	3,807.39
CHC - Jefferson	483.17	632.05	259.77	3,807.39
Molina - Jefferson	636.71	543.46	260.02	3,807.39
TCHP - Jefferson	468.44	595.17	259.77	3,807.39
United - Jefferson	680.59	609.96	260.02	3,807.39
Amerigroup - Lubbock	539.90	627.63	240.47	3,484.73
Firstcare - Lubbock	576.98	609.66	240.47	3,484.73
Superior - Lubbock	528.01	627.37	240.47	3,484.73
Driscoll - Nueces	424.85	660.18	243.14	3,299.69
Superior - Nueces	740.04	764.31	243.25	3,299.69
United - Nueces	567.63	702.72	243.25	3,299.69
Aetna - Tarrant	469.40	629.99	323.18	3,028.58
Amerigroup - Tarrant	553.77	656.69	323.18	3,028.58
Cook - Tarrant	444.84	623.43	322.85	3,028.58
Blue Cross - Travis	435.53	592.95	233.56	3,597.39
DCHP - Travis	419.32	485.19	233.56	3,597.39
Superior - Travis	467.82	638.59	233.56	3,597.39
Amerigroup - MRSA Central	445.82	527.98	336.27	3,580.19
Scott & White - MRSA Central	534.59	640.37	336.27	3,580.19
Superior - MRSA Central	520.31	581.30	336.27	3,580.19
Amerigroup - MRSA Northeast	485.25	517.21	303.04	3,690.11
Superior - MRSA Northeast	480.49	530.79	303.04	3,690.11
Amerigroup - MRSA West	531.16	606.59	240.50	3,749.34
Firstcare - MRSA West	567.99	629.41	240.50	3,749.34
Superior - MRSA West	551.50	591.58	240.50	3,749.34

Attachment 1 presents additional information regarding the breakdown of the components of the FY2019 rates. Attachment 14 presents the required rating index summarizing the applicable sections from the 2018-2019 Medicaid Managed Care Rate Development Guide.

VI. Actuarial Certification of FY2019 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 rate for the period September 1, 2018 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 STAR premium rates developed by HHSC and Rudd and Wisdom satisfies the following:

(a) The premium rates have been developed in accordance with generally accepted actuarial principles and practices;

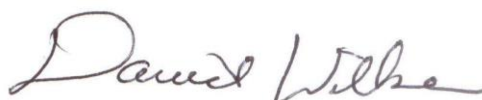
(b) The premium rates are appropriate for the populations and services covered under the managed care contract; and

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

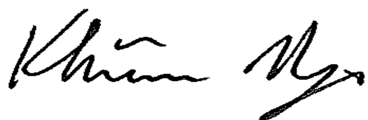
We have relied on historical experience data and program information provided to us by HHSC. We have reviewed the data for reasonableness but have not audited the data.

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.

VII. Attachments

Attachment 1

Summary of FY2019 STAR Rating Analysis

Exhibit A. This exhibit presents summary information regarding the FY2019 rates. Included on the exhibit are current premium rates split between medical, prescription drug, NAIP, UHRIP and delivery supplemental payment (DSP) rates; FY2019 premium rates split between medical, prescription drug, NAIP, UHRIP and DSP rates; and a comparison of current and FY2019 premium rates.

Exhibit B. This exhibit presents a comparison of the projected expenditures under the current premium rates and the FY2019 premium rates. The projection is split by medical (includes DSP), pharmacy, NAIP and UHRIP.

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 2014 through January 2018. All of this information was provided by HHSC.

Exhibit B. This exhibit shows a sample of a claim lag report for each risk group. This report includes claim amounts by payment month and month of service. We analyzed claims experience for the period September 2014 through February 2018.

Exhibit C. This exhibit shows the calculation of estimated monthly incurred claims for each risk group. The report includes the following information: (i) monthly enrollment, (ii) claim amounts incurred in that month and paid through February 28, 2018, (iii) estimated proportion of that month's incurred claims paid through February 28, 2018 (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 FY2019 cost based on the health plan's actual experience. The top of the exhibit shows summary base period (FY2017) enrollment and claims experience. Next is projected FY2019 enrollment. Trend assumptions for FY2018 and FY2019 are used to project the average base period claims cost to FY2019. Adjustment factors are used to recognize the cost impact of benefit and provider reimbursement changes. Combining these factors results in projected FY2019 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 $7.50 pmpm and 5.75% of gross premium. Additional provisions are also included for premium tax (1.75% of premium), maintenance tax ($0.06 pmpm) and risk margin (1.5% of premium).

At the bottom of Exhibit D is a summary of the projected FY2019 cost based on the above assumptions. Cost projections are presented both with and without the inclusion of maternity expenses.

Attachment 3

Community Experience Analysis – Medical

The following exhibits present a summary of the experience analysis performed for each service area for medical services. 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 FY2019 cost for each health plan in the service area. The weights used in this formula are the projected number of FY2019 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 FY2019 STAR community rates for the following service areas:

Exhibit A.1 – Bexar Service Area
Exhibit B.1 – Dallas Service Area
Exhibit C.1 – El Paso Service Area
Exhibit D.1 – Harris Service Area
Exhibit E.1 – Hidalgo Service Area
Exhibit F.1 – Jefferson Service Area
Exhibit G.1 – Lubbock Service Area
Exhibit H.1 – Nueces Service Area
Exhibit I.1 – Tarrant Service Area
Exhibit J.1 – Travis Service Area
Exhibit K.1 – MRSA Central Service Area
Exhibit L.1 – MRSA Northeast Service Area
Exhibit M.1 – MRSA West Service Area

These exhibits show projected FY2019 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 (FY2017) experience and projected FY2019 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 $7.50 pmpm and 5.75% of gross premium. Additional provisions are also included for premium tax (1.75% of premium), maintenance tax ($0.06 pmpm) and risk margin (1.5% of premium).

The bottom of the exhibit shows a summary of the projected FY2019 cost based on these assumptions. Cost projections are presented both with and without the inclusion of maternity expenses.

Community Experience Analysis – Pharmacy

The following exhibits present a summary of the pharmacy experience analysis performed for each STAR service area for pharmacy services. As with medical, HHSC utilizes a community rating methodology in setting the pharmacy capitation rates. The base community rates by risk group vary by service area but are the same for each health plan in a service area.

Below is a brief description of the exhibits contained in this attachment. The exhibits present the derivation of the FY2019 STAR pharmacy community capitation rates for the following service areas:

Exhibit A.2 – Bexar Service Area
Exhibit B.2 – Dallas Service Area
Exhibit C.2 – El Paso Service Area
Exhibit D.2 – Harris Service Area
Exhibit E.2 – Hidalgo Service Area
Exhibit F.2 – Jefferson Service Area
Exhibit G.2 – Lubbock Service Area
Exhibit H.2 – Nueces Service Area
Exhibit I.2 – Tarrant Service Area
Exhibit J.2 – Travis Service Area
Exhibit K.2 – MRSA Central Service Area
Exhibit L.2 – MRSA Northeast Service Area
Exhibit M.2 – MRSA West Service Area

These exhibits present projected FY2019 experience for each service area and risk group. 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 exhibits show (a) summary base period (CY2017) enrollment and estimated incurred claims, (b) projected rating period enrollment, (c) assumed trend and claims adjustment factor assumptions, (d) projected rating period incurred claims, (e) non-benefit costs for administrative expenses, taxes and risk margin and (f) total projected rating period costs.

A provision for administrative expenses is included in the amount of $1.80 pmpm. Additional provisions are also included for premium tax (1.75% of premium) and risk margin (1.5% of premium).

Information on the medical and pharmacy rate development for the AAPCA population can be found in Exhibits A and B of Attachment 10.

Attachment 4

Trend Analysis - Medical

The FY2019 rating methodology uses assumed trend factors to adjust the base period claims cost to the projection period. The 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 FY2018 and are established on a statewide basis for FY2019. All trend assumptions vary by risk group.

The trend analysis included a review of health plan claims experience data through February 2018. Based on this information, estimates of monthly incurred claims were made through December 2017. The claims cost and trend experience was reviewed separately by service area and risk group.

Exhibit A provides a summary of the FY2015, FY2016, FY2017 and FY2018 trends by category of service, service area and risk group. The FY2018 trend represents the trend during the period September 2017 through December 2017. 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 FY2017 trend is calculated as the average cost per member per month during FY2017 divided by the average cost per member per month during FY2016.

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.

The FY2018 trend assumptions were developed from two components: (i) the actual service area specific estimated trend for the period September 2017 through December 2017 and (ii) the statewide projected trend for the period January 2018 through August 2018. The trends for the final eight months of FY2018 were projected using a simple average of the FY2015 trend, FY2016 trend and FY2017 trend.

Blending the area specific trends for the period September 2017 through December 2017 with the statewide projected trend for the period January 2018 through August 2018 was done via the following formula:

$$\text{FY2018 SDA Trend} = \frac{\text{(9/17-12/17 actual SDA trend)} \times 4 + \text{(1/18-8/18 Statewide)} \times 8}{12}$$

Exhibit B provides a summary of the derivation of the FY2018 service area and statewide trend components.

The FY2019 trend assumptions were then developed from a simple average of the FY2015 trend, FY2016 trend and FY2017 trend.

Exhibit C provides a summary of the final FY2018 and FY2019 trend assumptions.

Although the medical trends were reviewed by component – professional, outpatient, inpatient, etc., a single trend assumption was selected and applied in aggregate. The MCO is paid a single capitation rate that does not vary by medical component. Splitting the analysis into separate components (inpatient, physician, etc.…) does not add any additional accuracy to the analysis but could increase the probability of distortions in the projection due to reporting differences among fiscal years, small sample sizes in a given category of service, or variations in the trend projections that could emerge for a category. There is significant interaction amongst all categories of service as MCOs may shift cost away from inpatient toward outpatient and looking at an individual category in isolation could lead to overgeneralizations. The aggregate analysis performed takes into consideration all service categories and their interactions with one another without sacrificing accuracy.

Use of the aggregate trend captures all interactions between categories of service, including the ongoing shifts that occur, and is reflective of the expected level of trend in future periods.

Because historical trends are adjusted to account for provider reimbursement changes, the primary driver of the trend assumption are utilization changes. As a result, we have not separated the trend assumption into separate utilization and inflation components. Rather our trend combines the full impact of inflation, utilization, changes in mixes of services and all other cost drivers into a single assumption.

Trend Analysis - Pharmacy

The rating methodology uses assumed pharmacy trend factors to adjust the base period (CY2017) claims cost to the rating period (FY2019). The trend rate assumptions were developed by the actuary based on an analysis of recent pharmacy claims experience under the STAR program and the actuary's professional judgment regarding anticipated future cost changes. The trend rate assumptions vary by risk group but are the same for all service areas.

The trend analysis included a review of STAR utilization and cost experience data paid through March 2018. Utilization (days supply per member) and cost per service (plan payments per days supply) statistics were developed by risk group and drug type (brand, generic and specialty) through February 2018. From this experience, the average annual utilization and cost per service were determined for each of the four 12-month periods ending February 2018.

Only those drugs covered under the capitated arrangement are included in the trend analysis. Anti-viral agents used for the treatment of Hepatitis C virus and the drug Orkambi are not included in the analysis as those drugs are currently carved out of the managed care contract. In addition, experience for the drugs Tamiflu and Makena were removed from our trend analysis. Tamiflu was removed due to the significant variation in the intensity of flu season from year to year. Makena was removed due to its one-time distortion of pharmacy trends for pregnant women.

An additional adjustment to the trend analysis was made to the recent experience for the drug Nasonex. Nasonex was removed from the preferred drug list (PDL) on July 27, 2017. The PDL change resulted in Nasonex utilization shifting to Fluticasone (a generic drug in the same drug class as Nasonex). Our rating methodology includes an adjustment factor to recognize the impact of the PDL changes (discussed in Attachment 5). Since the PDL change for Nasonex overlaps the experience period used in our trend analysis, we adjusted the trend analysis in order to avoid "double-counting" the cost impact of the Nasonex change. For purposes of our trend analysis, we revised the utilization and cost experience for the period between the PDL change (7/27/2017) and the end of the trend experience period (2/28/2018) for Nasonex and Fluticasone to reflect the experience prior to the PDL change. Please note that we did not change total pharmacy utilization. We only changed the mix of services between the two drugs.

Please note that while excluded from (or adjusted in) the pharmacy trend analysis, the historical claims for Tamiflu, Makena and Nasonex were included in the base period experience used in developing the pharmacy component of the rate.

The STAR pharmacy trend assumptions for the remainder of FY2018 and all of FY2019 were developed by risk group using the following formula. The utilization and cost per service trend assumptions were set equal to one-sixth of the experience trend rate for the 12-month period ending February 2016 plus two-sixths of the experience trend rate for the 12-month period ending February 2017 plus three-sixths of the experience trend rate for the 12-month period ending February 2018. The final cost trend assumptions were then determined by applying the assumed utilization and cost per service trends by individual drug type to actual experience for the 12-month period ending February 2018 and combining the results into a single trend assumption for each risk group.

Exhibit D includes a summary of the STAR pharmacy trend analysis and the derivation of the trend assumptions used in the rating analysis.

Information on the medical and pharmacy trend assumptions for the AAPCA population can be found in Attachment 10.

Attachment 5

Provider Reimbursement and Benefit Revisions Effective During FY2017, FY2018 and FY2019

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 (FY2017) and before the end of FY2019.

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 FY2017 encounter data was repriced using the FFS reimbursement in place during FY2017, the FFS reimbursement that will be in place during FY2019 and the applicable percentage change determined. Although the MCOs are not required to change their reimbursement levels based on changes implemented by HHSC, the Medicaid fee schedule serves as a primary negotiating tool for both MCOs and providers in Texas. Many MCO/provider reimbursement contracts are directly tied to the Medicaid FFS fee schedule through established percentages (e.g. 100%, 102%, 95% etc.) As a result, MCO reimbursement has historically changed in conjunction with Medicaid FFS fee schedule changes, both increases and decreases. Furthermore, it is common for provider reimbursement contracts that are directly tied to the Medicaid fee schedule (i.e. set at a % of Medicaid) to automatically adjust when the Medicaid fee schedule changes with no further need for recontracting. The correlation between managed care reimbursement and FFS fee schedules has been consistently observed throughout the history of the Texas managed care programs and is reiterated through discussions with the MCOs.

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.

During FY2017 and FY2018 several hospitals have had their inpatient Standard Dollar Amount (SDA) revised as a result of annual reevaluations. Exhibit B presents a summary of the derivation of the rating adjustment factors.

Beginning 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 hospital's performance during the evaluation time period and can change from one fiscal year to the next. A new PPR reduction list will become effective September 1, 2018. As a result, the adjustment factors shown in Exhibit C represent the restoration of those reductions that were in place during FY2017 net of those reductions that will be in place during FY2019.

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 hospital's performance during the evaluation time period and can change from one fiscal year to the next. A new PPC reduction list will become effective September 1, 2018.

As of the completion of this report, the final FY2019 PPC list was not yet available. When completed, HHSC and its actuaries will evaluate if there is a material difference between the updated PPC list and the list in place during the FY2017 base period. If determined to be material a mid-year rate adjustment may be necessary.

Effective September 1, 2018 HHSC will make revision to the reimbursement for ambulance services. Exhibit D presents a summary of the derivation of the rating adjustment factors.

Effective December 15, 2016 HHSC made revisions to the reimbursement for certain speech, physical and occupational therapy services. Further revisions for these services became effective September 1, 2017. Exhibit E presents a summary of the derivation of the rating adjustment factors as a result of the aggregated changes.

Effective September 1, 2018 HHSC will make revisions to the therapy policies which impact the reimbursement for therapy services provided by an assistant. Therapy assistant services will be reimbursed at a rate that is 70% of the therapy fee schedule. Exhibit F presents a summary of the derivation of the rating adjustment factors.

Effective February 1, 2017 HHSC revised the fee schedule for diagnostic radiology services, which includes hospital outpatient diagnostic radiology services. Fee schedule changes varied for professional, urban hospitals and rural hospitals. Exhibit G presents a summary of the derivation of the rating adjustment factors.

Effective November 1, 2017 HHSC made revisions to the reimbursement for anesthesiology services. Exhibit H presents a summary of the derivation of the rating adjustment factors.

Effective September 1, 2017 HHSC instituted a change in policy that shifts claim recoveries associated with tort and coordination of benefit recoveries beyond 120 days from the MCOs to HHSC. Exhibit I presents a summary of the necessary rating adjustment factors.

Invalid clinician administered drugs (CAD) have been removed from the base period. HHSC has provided guidance to the MCOs which specifies the reporting requirements for a CAD to be considered a valid claim. Those claims not meeting these requirements are assumed to be invalid and have been removed from the rating analysis. Exhibit J presents a summary of the derivation of the rating adjustment factors.

On January 1, 2017, the NorthSTAR program, which was a managed care program for the delivery of mental health services in the Dallas SDA, was discontinued. As a result, behavioral health services previously carved out of the STAR program for the Dallas SDA became capitated services like all other STAR SDAs. As a result of data issues, the most recent complete, credible data for the North STAR program that the Department of State Health Services (DSHS) could provide the actuaries was FY2013. Exhibit K presents a summary of the derivation of the rating adjustment factor in the Dallas SDA. The adjustment was calculated by comparing FY2013 NorthSTAR claims to all other STAR claims in the Dallas SDA and assuming a comparable distribution moving forward. In aggregate, the resulting adjustment is in the range of $4.25-4.50 which was compared to the behavioral health services reported for the non-Dallas SDAs in the

STAR program. The other SDAs reported average behavioral health costs that ranged from $2-7 with the overall average around $4.50-5.00. Given that the FY2013 data produces a result that is within the range of the other SDAs we believe this to be a reasonable proxy until actual utilization data is available. As behavioral health claims data emerges for the Dallas SDA this assumption will be reevaluated and updated with actual STAR claims data for future rate developments.

Base period data has been analyzed and costs for members age 21 to 64 with an IMD stay in excess of 15 days in a month have been removed from the analysis. The rating adjustment factors were estimated by the following steps:

1. Identifying a list of all members age 21-64 who had an IMD stay in excess of 15 days in a month.

2. For these members and their applicable eligibility month, collect all IMD and non-IMD claims.

3. Remove these claims from the base period via the adjustment factors presented in Exhibit L.

Additional IMD utilization statistics:

	# of Unique Members	Count	Range	Average per Utilizer	Minimum	Maximum	Median	Admits	Average LOS
Months	1,447	2,015	1-8	1.4	1.0	8.0	1.0	1,845	NA
Days	1,447	13,694	1-106	9.5	1.0	106.0	7.0	1,845	7.4

Overall, the impact of IMD utilization for members ages 21-64 is very small in the STAR program. Total expenditures were $6.6 million during the base period which is approximately 0.1% of total medical claims. The average cost per day at the IMD facilities was compared to the average cost per day for similar services at non IMD facilities and it was noted that, while IMD's were slightly less costly on average, the resulting difference was immaterial in the overall STAR program. For many reasons it is difficult to compare non-IMD reimbursement to IMD reimbursement including the following:

- Non-IMD state plan service unit costs are not uniform across all facilities/providers. Each hospital that participates in the Texas Medicaid program has a unique standard dollar amount which forms the basis for its reimbursement.
- MCOs have unique contracts with each facility/provider.
- Reimbursement can vary based on the acuity of needs of the member being served.

In order to estimate the impact of repricing IMD utilization at the non-IMD provider "cost" it is necessary to make a variety of assumptions. In order to calculated this estimated adjustment, we have "repriced" the IMD claims to the average cost at non-children's hospitals for the primary

behavioral health services provided at IMDs. Children's hospitals were excluded because (a) they don't provide a large volume of these services and (b) their average reimbursement is significantly greater. Estimates of the repricing of these IMD claims results in an immaterial impact to rate development. Given the immaterial size of such an adjustment and the uncertainty regarding the reimbursement levels at non-IMD facilities for these services, no further adjustment was deemed necessary to the IMD data other than removing those expenditures for members ages 21-64 who had an IMD stay in excess of 15 days in a month.

Effective September 1, 2017 FQHC wrap payments were carved out of managed care. HHSC has developed policy language to ensure that FQHCs are reimbursed their full encounter rate; however, the MCOs are only responsible for reimbursing the FQHC an amount no less than the rate paid to non-FQHC providers providing similar services. This adjustment was calculated by repricing all FQHC claims to the corresponding fee-for-service equivalent using the Medicaid fee schedule by procedure code. The difference between the full encounter rate and the fee-for-service equivalent is assumed to be the wrap payment which will be carved out and paid outside the monthly capitation rate based on an HHSC-approved methodology. Exhibit M presents a summary of the derivation of the rating adjustment factors.

HHSC currently excludes certain low-utilization, high-cost drugs from the capitated arrangement. These drugs are covered under the plan but their cost is reimbursed to the MCOs using a non-risk arrangement. We have now accumulated sufficient experience to project utilization and cost for some of these "carve-out" drugs. Anti-viral medications for the treatment of Hepatitis C (Epclusa, Harvoni, Viekira Pak, etc.) and Orkambi (a treatment for Cystic Fibrosis) will be added to capitated services effective September 1, 2018. Exhibit N presents a summary of the derivation of the rating adjustment factors.

HHSC has recently implemented numerous changes to the Preferred Drug List (PDL). These changes include some of the program's highest expenditure drugs (Abilify, Nasonex, Suprax and Tamiflu) and will have a significant impact on managed care pharmacy cost. Some of the PDL changes were implemented during the experience period used to develop the rates and some were implemented after the experience period. We developed adjustment factors to reflect the anticipated cost impact of the PDL changes. Exhibit O 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 D, E, F, G and H
Other Reimbursement Changes	Exhibits I, J, K, and L
Inpatient Reimbursement Changes	Exhibits A, B, and C
FQHC Adjustment	Exhibit M

The two pharmacy adjustments are included separately in Attachment 3.

Please note that the incurred claims reported on Attachment 5 are developed from the FY2017 detail encounter data which only includes claims paid through November 2017. 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 2018, (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.

All adjustments were calculated independently by both HHSC and the Rudd and Wisdom actuaries to ensure consistent results.

The FFS medical data readily available for the AAPCA population does not provide procedure code or provider identification level of detail. Due to these data limitations, the impact of the medical rate adjustments listed above could not be calculated for the expansion AAPCA population. As a result, the rate adjustments for this population are assumed to be equal to the average rate adjustment for the children's risk groups (Ages 0-20) as calculated for the existing STAR population. We believe this is a reasonable estimate of the impact of the various reimbursement changes as STAR program children are the populations that most closely resemble AAPCA clients that will be enrolled in the STAR program during FY2019.

Attachment 6

Family Planning Adjustment

One of the health plans participating in the STAR program, Dell Children's Health Plan (Travis) does not provide family planning services. For this health plan, family planning services are provided through FFS. HHSC provided a listing of those services that are not 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 A 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.

Aside from this single health plan, family planning services are the only service in the STAR program on which HHSC receives a different FMAP than the regular FMAP. The family planning component of the medical cost was developed as follows:

(a) The adjusted community rates were calculated as detailed in Attachment 3.

(b) Family planning services were then excluded from the base period and the community rates were recalculated. No other adjustments were made to the rating methodology.

(c) The difference between these two calculations was then determined to be the family planning component of the rate.

Exhibit B provides the details of this calculation and the family planning component of the medical premium rate eligible for the enhanced FMAP.

The family planning component of the pharmacy capitation rate was developed similarly. Exhibit C provides the calculation of the family planning component of the pharmacy rates.

Exhibit D provides a summary of the total premium rate eligible for the enhanced FMAP.

Due to the relatively small amounts identified for the children risk groups in the existing STAR population, no family planning component was allocated for the expansion AAPCA population that joined the program effective September 1, 2017. This assumption will be evaluated in future rate developments once AAPCA data becomes available under managed care.

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 FY2017.

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 maternity delivery costs. 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. Based on guidance from CMS Office of the Actuary the DSPs have been evaluated and updated for all SDAs for FY2019 by collecting information on the cost of deliveries during the FY2017 base period. All costs associated with the inpatient, professional and anesthesiology services rendered for all deliveries were collected and the average cost per delivery by service area was determined. The attached exhibit presents the FY2019 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.

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 the 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.

In the Travis SDA, an additional adjustment is made to the raw acuity score as a result of a health plan, Sendero, no longer participating in the program. The acuity factors calculated for this health plan are assumed to be evenly distributed with the enrollment to the other health plans which will continue to operate in the program during FY2019.

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

The expansion AAPCA population was excluded from the risk adjustment analysis described above because the enrollment distribution amongst the health plans for this population will not be known until after September 1, 2017. This population will be incorporated into the acuity analysis in future rate developments once credible enrollment and claims data is available to properly identify the relative acuity amongst the health plans.

Attachment 10

Adoption Assistance or Permanency Care Assistance (AAPCA) Rate Development

Effective September 1, 2017 Medicaid members in the Texas Department of Family and Protective Services (DPFS) Adoption Assistance or Permanency Care Assistance (AAPCA) programs began receiving their Medicaid services through managed care. Rudd and Wisdom worked closely with HHSC to collect a list of Medicaid IDs for members enrolled in the AAPCA program during the period September 1, 2012 through August 31, 2017. Using this ID list, HHSC collected all claims data for these members during their applicable eligibility periods from internal data warehouses. All data was checked for reasonableness by comparing the data collected by multiple internal groups for different analysis. Data was collected independently by HHSC Actuarial Analysis and HHSC System Forecasting. There was reasonable consistency between the multiple data sources and the collected data was assumed to be reasonable and appropriate for the FY2019 rate development calculations.

The actuarial model used to develop the AAPCA medical premium rates follows very closely the model described throughout this report for the existing STAR population with the exception that historical fee-for-service data was used in place of managed care data which is not yet available. The actuarial model used to develop the AAPCA prescription drug premium rates also follows the general STAR rating methodology with the exception that the base period used was September 1, 2017 through February 28, 2018, in order to include managed are experience. Below is a description of the trend, benefit and provider reimbursement adjustments, managed care discount and administrative provisions included in the AAPCA rates.

Trend Factors - Medical

The medical trend assumptions were determined through an evaluation of the historical trends for several populations covered under various programs. Historical trend information was collected for the AAPCA members previously covered under the FFS program, children managed under the STAR program and foster care children managed under the STAR Health program. Multiple populations were evaluated in order to collect multiple data points regarding historical medical trend. Given that no trend information is available for the AAPCA population under managed care, the four-year average of these three populations was determined to be a reasonable estimate of the projected trend to be experienced by the AAPCA population under managed care. The chart below includes the historical trend information for these varying populations along with the four-year average, 0.7%, which was used in the FY2019 medical rate development.

	AAPCA	STAR	STAR Health	Average
FY2014	3.4%	-0.1%	0.5%	1.3%
FY2015	1.8%	3.1%	-0.8%	1.4%
FY2016	-0.8%	2.6%	5.1%	2.3%
FY2017	-5.6%	1.2%	-2.4%	-2.3%
Average	-0.3%	1.7%	0.6%	0.7%

As actual managed care trend information emerges for the AAPCA population this assumption will be updated in future rate developments.

Trend Factors – Rx

The rating methodology uses assumed pharmacy trend factors to adjust the base period (September 1, 2017 through February 28, 2018) claims cost to the rating period (FY2019). The trend rate assumption was developed by the actuary based on an analysis of recent pharmacy claims experience for AAPCA clients. This analysis included experience for AAPCA FFS clients prior to September 1, 2017. The future trend rate assumption is the same for all service areas.

The trend analysis included a review of utilization and cost experience data paid through March 31, 2018. Incurred monthly utilization (days supply per member) and cost per service (plan payments per days supply) statistics were developed by program (FFS and managed care separately), risk group and drug type (brand, generic and specialty) through August 2017. From this experience, the average annual utilization and cost per service were determined for each of the four 12-month periods ending August 2017.

Only those drugs currently covered under the capitated arrangement are included in the trend analysis. Anti-viral agents used for the treatment of the Hepatitis C virus and the drug Orkambi are not included in the analysis as those drugs are currently carved out of the managed care contract. In addition, experience for the drugs Tamiflu and Makena were removed from our trend analysis. Tamiflu was removed due to the significant variation in the intensity of flu season from year to year. Makena was removed due to its one-time distortion of pharmacy trends for pregnant women.

An additional adjustment to the trend analysis was made to the recent experience for the drug Nasonex. Nasonex was removed from the preferred drug list (PDL) on July 27, 2017. The PDL change resulted in Nasonex utilization shifting to Fluticasone (a generic drug in the same drug class as Nasonex). Our rating methodology includes an adjustment factor to recognize the impact of the PDL changes (discussed in Attachment 4). Since the PDL change for Nasonex overlaps the experience period used in our trend analysis, we adjusted the trend analysis in order to avoid "double-counting" the cost impact of the Nasonex change. For purposes of our trend analysis, we revised the utilization and cost experience for the period between the PDL change (7/27/2017) and the end of the trend experience period (8/31/2017) for Nasonex and Fluticasone to reflect the experience prior to the PDL change. Please note that we did not change total pharmacy utilization. We only changed the mix of services between the two drugs.

Please note that while excluded from (or adjusted in) the pharmacy trend analysis, the historical claims for Tamiflu, Makena and Nasonex were included in the base period experience used in developing the pharmacy component of the rate.

The AAPCA pharmacy trend assumptions for FY2018 and FY2019 were developed using the following formula. For each risk group/drug type combination, the utilization and cost per service trend assumptions were set equal to one-sixth of the experience trend rate for the 12-month period ending August 2015 plus two-sixths of the experience trend rate for the 12-month period ending August 2016 plus three-sixths of the experience trend rate for the 12-month period ending August 2017. The final cost trend assumptions were then determined by applying the assumed utilization and cost per service trends by individual drug type to actual experience for the 12-month period ending August 2017 and combining the results into a single trend

assumption for each risk group. Exhibit C presents a summary of the pharmacy trend analysis for AAPCA.

Please note that the MCOs were provided a detailed trend analysis file which included the historical utilization and cost experience as well as all of the formulas and assumptions used in developing the trend assumptions.

Provider Reimbursement Adjustment

The types of adjustments for benefit and provider reimbursement changes are the same as those detailed in Attachment 5. The adjustment factors used for the AAPCA rate development are the SDA average of the factors for the children's risk groups as previously described. Due to lack of detail data on which to calculate the exact impact of the various provider reimbursement changes, the STAR average adjustment for children (Ages 0-20) is assumed to be a reasonable proxy of the impact on the AAPCA population.

The following adjustments are not applicable to the AAPCA rate development:

- CAD removal – invalid CADs are rejected in the FFS program and therefore not included in the base period data.
- IMD cost removal – AAPCA is limited to members under age 21.

Preferred Drug List Changes

HHSC has recently implemented numerous changes to the Preferred Drug List (PDL). These changes include some of the program's highest expenditure drugs (Abilify, Nasonex, Suprax and Tamiflu) and will have a significant impact on managed care pharmacy cost. Some of the PDL changes were implemented during the experience period used to develop the rates and some were implemented after the experience period. We developed adjustment factors to reflect the anticipated cost impact of the PDL changes. Exhibit D presents a summary of the derivation of the rating adjustment factors.

Drug Carve-In

HHSC currently excludes certain low-utilization, high-cost drugs from the capitated arrangement. These drugs are covered under the plan but their cost is reimbursed to the MCOs using a non-risk arrangement. We have now accumulated sufficient experience to project utilization and cost for some of these "carve-out" drugs. Anti-viral medications for the treatment of Hepatitis C (Epclusa, Harvoni, Viekira Pak, etc.) and Orkambi (a treatment for Cystic Fibrosis) will be added to capitated services effective September 1, 2018. Exhibit E presents a summary of the derivation of the rating adjustment factors.

Seasonality

In developing the pharmacy component of the capitation rate, the base period is less than a full year (September 1, 2017 through February 28, 2018). This was done in order to use managed care experience exclusively in the rate setting. Since the base period and rating period do not include the same months, it is necessary to evaluate the impact of seasonality on the average cost. We performed such an analysis and included a seasonality adjustment factor in the rate

development. The adjustment was calculated as the average of the ratio of the September through February average cost to the full fiscal year for the past four complete fiscal years.

FY2014	FY2015	FY2016	FY2017	Average
1.0278	1.0164	.9542	.9856	.9960

Managed Care Discount Factor - Medical

In developing the FY2019 projected claims, we have assumed that the base period per-capita claims cost for FFS clients will be reduced by 9.4% under managed care. The 9.4% assumption was developed by evaluating past managed care expansions as well as the unique characteristics of the AAPCA program.

The Texas Medicaid STAR Health program is the managed care program for Foster Care clients some of whom move to the AAPCA programs if they are adopted. Based on the compiled list of AAPCA member IDs, we identified a subset of members who met the following criteria:

1. Enrolled in STAR Health managed care program for the full twelve months of FY2014.
2. Enrolled in FFS under the AAPCA program for the full twelve months of FY2016.

By comparing the average cost of this closed group of over 3,700 members under managed care (FY2014), adjusted for reimbursement changes and trend, to the fee-for-service cost (FY2016) we can estimate the impact of managed care on the AAPCA population.

Actual FY2014 - Managed Care	221.92
Projected FY2016 - Managed Care	232.56
Actual FY2016 - FFS	258.06
Managed Care Savings	-9.9%

FY2014 managed care costs were trended forward to FY2016 using the average STAR Health trend of 2.37% experienced during this period.

An additional analysis was performed to estimate the savings necessary such that the cost under the STAR model (including administrative expenses and risk margin) would be the same as the projected FY2019 gross cost under the FFS model.

To determine the managed care efficiency factor necessary in order to satisfy our breakeven cost criteria, we must solve the following equation for X.

$$\$157.26 + \$4.50 \text{ pmpm} = \frac{\$157.26 \text{ pmpm } (1-X) + \$7.50 \text{ pmpm}}{(1 - 5.75\% - 1.5\%)}$$

$157.26 = statewide average FY2016 AAPCA cost
$4.50 = high level estimate of internal administrative costs associated with FFS
$7.50 = fixed administrative cost under STAR
5.75% = variable administrative cost under STAR
1.5% = risk margin under STAR

Therefore, in order for the gross cost under the STAR model to be the same as the projected gross cost under the FFS model, the FFS claims cost would need to be discounted by 9.4%.

Given the proximity of the 9.4% breakeven estimate to the more detailed 9.9% savings estimate, we believe it is reasonable and appropriate to assume a savings of 9.4% for medical services under managed care.

This assumption will be reevaluated as actual managed care experience becomes available for the AAPCA population in future rate developments.

Managed Care Discount Factor - Rx

The base period for this year's AAPCA pharmacy component of the rate (September 1, 2017 through February 28, 2018) includes managed care experience only. Unlike medical expenditures, managed care savings for pharmacy claims are almost immediate as the primary driver for pharmacy savings are directly tied to reimbursement differences between FFS and managed care. As a result, no adjustment is necessary to recognize any difference in pharmacy reimbursement between the base period and the FY2019 rating period.

Administrative Fees and Risk Margin

The rating methodology includes the same provision for health plan administrative services, risk margin, and taxes as the existing STAR program as described in Section IV with the exception of service coordination. In addition to administrative fees, the FY2019 AAPCA rates include a provision for service coordination in the amount of $10.00. This was determined based on discussion with the MCOs and the HHSC policy division regarding the service management requirements for this new population. Some of the MCO requirements include:

- Conduct an initial telephonic Member screening for all Adoption Assistance (AA) and Permanency Care Assistance (PCA) Members.
- Perform an initial assessment and service plan development.
- Service plans must be developed within 30 days of enrollment.

There is no exact population or requirement that matches these criteria currently within managed care. Service coordination in the STAR Health, STAR+PLUS and STAR Kids programs require significantly greater resources and have average costs that range from $25-100 per member per month depending on the population. As actual service coordination experience is collected under managed care for the AAPCA population, this assumption will be updated in future rate developments.

Summary

The attached exhibits present a summary of the community rating exhibit for each service area split between medical (Exhibit A) and pharmacy (Exhibit B). FY2019 premium rates will vary between service delivery areas but will be the same for all health plans within a given area.

Attachment 11

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.

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 with the exception of the newly carved in AAPCA population discussed in Attachment 10. The AAPCA population has been excluded from the calculation of the NAIP amounts per member per month.

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

No additional NAIP arrangements have been permitted since those in place during FY2017 nor have the MCO and providers been permitted to negotiate financial terms that differ from those currently in place.

The following information is provided as requested in the 2018-2019 Managed Care Rate Development Guide:

1. A description of the pass-through payment - CMS approved NAIP as an incentive payment in September 2014. The program was implemented in March 2015. Subsequently, CMS issued final Medicaid managed care rules. Following the publication of those rules, CMS performed an informal review of NAIP and in September 2016 concluded NAIP was a pass-through payment, not an incentive. The program is a voluntary program between MCOs and providers whereby agreements are entered into between these two parties to improve access to care and services for Medicaid managed care members. Examples include the recruitment of new primary care or specialty physicians, expanded physician office hours, and other similar initiatives. Each project had a specific associated cost which translated into a PMPM amount for the MCOs.

2. The amount of the pass-through payments both in total and on a per member per month basis – The overall NAIP program cost is $427,344,142 of which $394,696,813 is attributed to the STAR program. The per member per month amounts are shown in the attached exhibit and in Attachment 1 Exhibit A.

3. The providers receiving the pass-through payments –

   - Texas Tech University Health Sciences Center - El Paso
   - University of Texas Medical School - Houston (UT Physicians)
   - Texas Tech University Health Sciences Center – Lubbock
   - UT Southwestern Accountable Care Network
   - Texas A&M Health Science Center
   - Texas Tech University Health Sciences Center – Lubbock
   - Parkland Health & Hospital System
   - Childress County Hospital District
   - University Health System
   - Midland Memorial Hospital
   - University Medical Center – Lubbock
   - Harris Health System
   - Palo Pinto General Hospital
   - University Medical Center of El Paso
   - Christus Spohn Health System

4. The financing mechanism for the pass-through payments – The non-federal share is provided by local governmental entities, including hospital districts.

5. The amount of pass-through payments incorporated into the capitation rates in the previous period – The NAIP premiums in effect for FY2018 were estimated to be:

STAR	$394,690,195
STAR+PLUS	$32,612,529
Total	$427,302,725

6. The amount of pass-through payments incorporated into capitation rates for the rating period in effect on July 5, 2016 – The NAIP premiums in effect for FY2016 were

STAR	$479,056,321
STAR+PLUS	$33,638,645
Total	$512,694,966

7. The calculation of the base amount is included in Exhibit B. These amounts were calculated by HHSC based on the following methodology:

   Managed Care Encounter data and Fee for Service claim data was used to perform the upper payment limit (UPL) test for inpatient Medicaid hospital services. The inpatient test was performed by estimating the Medicare rates from the base rate adjusting for Geographic Wage Index, Capital Wage Index and IME Operating and Capital factors. The Medicaid claim and encounter data was mapped from APR DRG to MS DRG to assign Medicare weights to each service. An estimated Medicare payment was determined by multiplying the Medicare rate by the sum of the Medicare weights for each provider. Medicaid payments were estimated in the same way using the Texas specific APR DRG weights and Texas Medicaid specific rates. Medicaid payments were adjusted to include quality incentive payments and NAIP payments.

   The upper payment limit test for outpatient services used a payment to charge ratio. General outpatient services (excluding services reimbursed on a fee schedule) were used from both the Managed Care Encounter data and Fee for Service claim data. Medicare charges and payments from the Medicare cost reports were used to calculate a Payment to Charge Ratio for each hospital. The Medicare payment to charge ratio was then multiplied by the Medicaid outpatient charges to estimate what Medicare would have paid for the Medicaid services.

   The total estimated Medicare payments for each category were compared to the Medicaid payments for each category to perform the UPL tests.

Attachment 12

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 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	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%

All MCOs within the SDA will be required to increase their reimbursement rates to contracted hospitals by the established percentage rate increase. The Travis SDA will begin participation in the UHRIP program on September 1, 2018.

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.

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 estimated impact of the UHRIP increase was then estimated by collecting the encounter data for all UHRIP-eligible facilities. Exclusions to the data were then applied based on the contracting status of the MCO, facility/member location and emergency room status. The UHRIP eligible claims were then increased by the applicable reimbursement change and the impact on the base period for each individual MCO was determined.

Exhibit A 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 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 FY2018 claims increased by the applicable UHRIP adjustment factor plus provision for risk margin, taxes and administrative fees.

The UHRIP component of the rate includes 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 – 1.7% 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 1.7% was calculated as national average health insurance providers fee for the period September 1, 2018 through August 31, 2019 as a percentage of net premiums grossed up for federal income tax and state premium tax and takes into consideration the moratorium on calendar year 2018 premiums. All taxes and fees are included in the UHRIP premium to ensure all costs and taxes associated with the program can be supported by the total funds available. HHSC will reconcile the provision for the UHRIP portion of the HIPF to each MCO's actual HIPF liability.

Attachment 13

Pay for Quality Program

The Pay-for-Quality (P4Q) Program creates incentives and disincentives for managed care organizations based on their performance on certain quality measures. Health plans that excel on meeting the measures are eligible for a bonus while health plans that don't meet their measures are subject to a penalty.

The table below provides a description of the at risk and bonus measures for the 2019 calendar year.

At-Risk Measures			
Source	Measure	Description	Data Period
3M	Potentially Preventable Emergency Room Visits (PPVs)	Hospital emergency room or freestanding emergency medical care facility treatment provided for a condition that could be provided in a nonemergency setting	Jan. 1 - Dec. 31 measurement year
HEDIS	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	Percentage of children 3 months - 18 years of age who were diagnosed with upper respiratory infection and were not dispensed an antibiotic prescription on or three days after the episode	July 1, prior year - June 30, measurement year
HEDIS	Prenatal and Postpartum Care (PPC)*	• Timeliness of Prenatal Care: the percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization • Postpartum Care: the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery	November 6, prior year - December 31, measurement year
HEDIS	Well Child Visits in the First 15 months of Life (W15)*	Percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life	October 1, two years prior - December 31, measurement year
Bonus Pool Measures			
Source	**Measure**	**Description**	
3M	Potentially preventable admissions (PPAs)	Hospital admission that may have been prevented with access to ambulatory care or health care coordination.	Jan. 1 - Dec. 31 measurement year

Source	Measure	Description	
CMS	Low Birth Weight	Percentage of live births that weighed less than 2,500 grams (5.51 pounds)	Jan. 1 - Dec. 31 measurement year
CAHPS	Children with good access to urgent care	Percent of caregivers who, when surveyed, responded their child always got urgent care for illness, injury or condition as soon as needed	Surveys conducted between Jan. 1 - Dec. 31 measurement year
CAHPS	Adults rating their health MCO a 9 or 10	Percent of adult members who rated their MCO a 9 or 10 (on a scale of 0-10) when surveyed	Surveys conducted between Jan. 1 - Dec. 31 measurement year

The medical P4Q program assesses MCOs based on three categories:

- Performance Against Benchmarks
- Performance Against Self (comparison of an MCO's performance to their prior year performance)
- Bonus pool measures

The performance against self and performance against benchmarks measures are the at-risk components of the program: MCOs can lose money based on their performance on these measures. Utilizing both the performance against self and performance against benchmarks rewards high performing MCOs while still incentivizing improvement regardless of current level of performance. The total percent capitation earned/lost for each at-risk measure in a program is added to determine the total capitation earned/lost for each MCO across all at-risk measures for that program.

The bonus pool measures provide an additional way for MCOs to earn rewards, without the risk of losing money. Bonus pool measures encourage improvement in new areas with no financial risk to the health MCOs.

Three percent of the MCOs' capitation is at-risk. The MCO's at-risk capitation is distributed equally across the at-risk measures. Some HEDIS quality measures have submeasures. The capitation at-risk for that measure will be divided evenly across the submeasures.

The maximum bonus or penalty in the P4Q program is 3.0%; however the typical results are far below these limits.

Historically the impact of the P4Q program on total premium has been immaterial. HHSC performed simulations on the FY2014 and FY2015 managed care data and the average impact by MCO was less 0.1%. As a result, we do not believe the P4Q program has a material impact on the premium rate development.

Attachment 14

FY2019 STAR Rate Certification Index

The index below includes the pages of this report 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 September 1, 2018 through August 31, 2019 (FY2019).

ii. (a) The certification letter is on page 18 of the report.

(b) The final capitation rates are shown on pages 16-17 of the report.

(c) (i) See pages 1 and 4 through 5 of the report.

(ii) See page 1 of the report.

(iii) See page 1 of the report.

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

(v) Pages 210-214 (NAIP), Pages 215-323 (UHRIP) and 233-234 (P4Q).

(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 152 through 162 of the report.

iv. See Attachment 1 on pages 20 through 36 of the report.

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 report.

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

(b) See pages 1 through 3 of the report.

(c) See pages 1 through 3 of the report.

(d) Not applicable.

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

(b) See page 4 of the report.

(c) No errors found in the data.

(d) See Attachment 5 on pages 120 through 151 of the 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 122 through 123 and 144 through 145 of the report.

vi. See pages 122 through 123 of the report.

B. Appropriate Documentation

i. See pages 16 through 17 and Attachment 1 pages 20 through 36 of the report.

ii. See Attachment 3 pages 44 through 97 of the report. There have been no significant changes in the development of the benefit cost since the last certification.

iii. (a) See Attachment 4 pages 98 through 119 of the report.

(b) See Attachment 4 pages 98 through 119 of the report.

(c) See Attachment 4 pages 98 through 119 of the report.

(d) See Attachment 4 pages 98 through 119 of the 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 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 Attachment 5 pages 120 through 151 of the report.

viii. See Attachment 5 pages 120 through 151 of the report.

4. Special Contract Provisions Related to Payment

A. Incentive Arrangements

i. Rate Development Standards

Acknowledged.

ii. Appropriate Documentation

(a) See Attachment 13 pages 233 through 234 of the report.

B. Withhold Arrangements

i. Rate Development Standards

Acknowledged.

ii. Appropriate Documentation

(a) See Attachment 13 pages 233 through 234 of the 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 215 through 232 of the report.

E. Pass-Through Payments

i. Rate Development Standards

Acknowledged.

ii. Appropriate Documentation

(a) See Attachment 11 pages 210 through 214 of the report.

(b) See Attachment 11 pages 210 through 214 of the report.

5. Projected Non-Benefit Costs

A. Rate Development Standards

i. Acknowledged.

ii. Acknowledged.

iii. Acknowledged.

iv. Acknowledged.

B. Appropriate Documentation

i. See page 14 of the report.

ii. See page 14 of the report.

iii. (a) See page 14 of the report.

(b) Not applicable.

(c) Not applicable.

(d) See page 14 of the report.

(e) Not applicable.

(f) See page 14 of the report.

6. Risk Adjustment and Acuity Adjustments

A. Rate Development Standards

i. Acknowledged.

ii. Acknowledged.

iii. Acknowledged.

B. Appropriate Documentation

i. See Attachment 9 pages 167 through 190 of the 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).