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February 3, 2020

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

Re: STAR+PLUS Rate Amendment UMCC 529-12-0002 V2.30, STAR+PLUS Expansion 529-10-0020 V1.34, STAR+PLUS MRSA 529-13-0042 V1.19

Dear Ms. Butler:

This letter amends the report titled State of Texas Medicaid Managed Care STAR+PLUS Program Rate Setting State Fiscal Year 2020 and dated July 9, 2019. The amended FY2020 capitation rates were developed using identical methods and assumptions as the rates described in this report. The amended rates are assumed to be payable for the period March 1, 2020 through August 31, 2020.

A. Summary of the Revisions

QIPP

The QIPP component of the premium has been revised as a result of several changes within the nursing facility provider community. These changes include: provider type changes for three nursing facilities, two nursing facility mergers, three terminated nursing facilities and one new nursing facility. These changes shift the allocation of Medicaid days and/or funds across the SDAs resulting in adjustments to the premium component. These changes do not impact the period September 1, 2019 through February 29, 2020.

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

B. Report Amendments

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

Section I. Introduction

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

Section II. Overview of Rate Setting Methodology

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

The only difference between the rating methodology outlined in the original report and this amendment is the revisions to the QIPP add-on component of the premium.

Section III. Adjustment Factors

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

Effective September 1, 2017 HHSC implemented a Quality Incentive Payment Program (QIPP) as a performance-based payment platform designed to incentivize nursing facilities to improve on the quality and innovation of their services. As approved by CMS on July 31, 2019, QIPP Year Three, effective September 1, 2019, encompasses one pay-for-report component and three performance-based payment components. Program incentive payments are dependent on improvement in several indices of success using the CMS five-star rating system as well as program specific targets.

Attachment 9 presents the development of the QIPP add-on amounts to be included in the capitation rates effective September 1, 2019 along with additional information concerning the QIPP program. Revisions to the total available funding impact the program effective March 1, 2020. Attachment 9 – Exhibit B Revised presents the development of the revised QIPP add-on amounts to be included in the capitation rates effective March 1, 2020.

No other changes are applicable to this section.

Section IV. Administrative Fees, Taxes and Risk Margin

No changes applicable to this section.

Section V. Summary

The tables in this section are replaced in their entirety with the following mid-year rates effective March 1, 2020 through August 31, 2020.

Health Plan	Medicaid Only OCC	Medicaid Only HCBS	Dual Eligible OCC	Dual Eligible HCBS
Monthly Premium Rates				
Amerigroup - Bexar	$1,496.00	$5,287.31	$425.36	$2,100.21
Molina - Bexar	1,571.96	4,616.09	428.54	2,054.87
Superior - Bexar	1,626.22	5,089.71	459.37	2,186.37
Molina - Dallas	1,585.68	4,199.81	434.83	1,917.28
Superior - Dallas	1,485.62	4,803.02	390.81	1,970.25
Amerigroup - El Paso	1,642.52	4,709.65	553.39	2,154.71
Molina - El Paso	1,818.14	5,156.51	639.71	2,256.24
Amerigroup - Harris	1,725.32	6,063.58	384.86	2,374.86
Molina - Harris	1,530.48	5,460.68	383.23	2,327.82
United - Harris	1,943.77	5,797.42	452.25	2,344.80
Health Spring - Hidalgo	1,898.09	5,346.55	1,027.72	2,638.34
Molina - Hidalgo	1,889.07	5,232.42	925.59	2,571.62
Superior - Hidalgo	2,148.26	5,508.91	1,161.04	2,621.76
Amerigroup - Jefferson	1,355.24	5,340.81	319.08	1,886.51
Molina - Jefferson	1,459.46	4,476.55	301.57	1,763.20
United - Jefferson	1,670.31	4,710.77	232.20	1,601.02
Amerigroup - Lubbock	1,508.03	4,214.77	185.11	1,539.45
Superior - Lubbock	1,475.10	4,478.22	188.02	1,671.85
Superior - Nueces	1,683.70	4,674.85	590.28	2,214.00
United - Nueces	1,910.25	4,852.82	495.37	2,171.77
Amerigroup - Tarrant	1,600.39	5,191.19	354.97	1,916.98
Health Spring - Tarrant	1,495.31	5,144.14	293.33	1,946.01
Amerigroup - Travis	1,490.79	5,698.49	391.25	2,059.89
United - Travis	1,539.82	5,707.35	212.68	2,032.47
Superior - MRSA Central	1,460.14	4,820.29	252.07	1,859.35
United - MRSA Central	1,425.93	5,174.17	262.40	1,979.29
Health Spring - MRSA Northeast	1,341.13	5,002.66	257.98	1,900.99
United - MRSA Northeast	1,520.78	5,086.32	284.55	1,680.28
Amerigroup - MRSA West	1,415.51	5,316.69	304.37	1,751.10
Superior - MRSA West	1,475.39	4,754.43	283.81	1,693.92

Health Plan	Medicaid Only NF	Dual Eligible NF	IDD Over 21	MBCCP
Monthly Premium Rates				
Amerigroup - Bexar	$8,155.72	$5,145.78	$971.12	$3,001.81
Molina - Bexar	8,175.47	5,145.78	828.18	2,727.19
Superior - Bexar	8,395.75	5,145.78	1,200.53	3,103.69
Molina - Dallas	8,714.09	5,246.81	840.50	3,514.27
Superior - Dallas	9,619.23	5,246.81	899.70	3,194.85
Amerigroup - El Paso	8,763.12	4,712.62	1,436.02	2,482.04
Molina - El Paso	8,829.18	4,712.62	1,562.67	1,948.57
Amerigroup - Harris	8,869.63	5,058.75	1,047.71	2,934.39
Molina - Harris	8,733.02	5,058.75	926.90	2,930.03
United - Harris	8,856.93	5,058.75	1,174.48	3,302.97
Health Spring - Hidalgo	9,441.27	5,517.52	991.40	2,683.08
Molina - Hidalgo	9,072.84	5,517.52	1,030.20	2,864.69
Superior - Hidalgo	10,066.66	5,517.52	1,346.08	3,086.95
Amerigroup - Jefferson	7,802.28	4,652.82	1,092.07	3,009.80
Molina - Jefferson	8,033.86	4,652.82	1,096.62	2,736.87
United - Jefferson	7,875.82	4,652.82	1,123.38	3,234.70
Amerigroup - Lubbock	8,094.13	5,234.24	971.79	2,850.73
Superior - Lubbock	7,812.34	5,234.24	1,052.04	3,194.38
Superior - Nueces	7,965.86	5,132.87	998.21	3,191.94
United - Nueces	7,699.83	5,132.87	1,104.38	2,911.07
Amerigroup - Tarrant	8,313.43	4,984.17	965.18	3,247.62
Health Spring - Tarrant	7,901.35	4,984.17	756.38	2,705.30
Amerigroup - Travis	8,382.04	5,263.11	1,012.02	2,666.49
United - Travis	8,249.82	5,263.11	1,146.90	3,179.70
Superior - MRSA Central	7,484.45	4,843.96	1,006.49	4,141.54
United - MRSA Central	7,496.29	4,843.96	977.15	3,875.68
Health Spring - MRSA Northeast	8,617.89	5,018.26	933.83	3,741.02
United - MRSA Northeast	8,298.68	5,018.26	1,020.03	3,207.66
Amerigroup - MRSA West	8,241.18	5,007.54	1,020.88	2,518.60
Superior - MRSA West	7,973.49	5,007.54	1,101.42	2,880.42

Section VI. Actuarial Certification of FY2020 STAR+PLUS Premium Rate

We, Evan L. Dial, Khiem D. Ngo and David G. Wilkes are principals with the firm of Rudd and Wisdom, Inc., Consulting Actuaries (Rudd and Wisdom). We are Fellows of the Society of Actuaries and members of the American Academy of Actuaries. We meet the Academy's qualification standards for rendering this opinion.

Rudd and Wisdom has been retained by the Texas Health and Human Services Commission (HHSC) to assist in the development of the STAR+PLUS premium rates for the period March 1, 2020 through August 31, 2020 and to provide the actuarial certification required under Centers for Medicare and Medicaid Services (CMS) requirements 42 CFR 438.4.

We certify that the amended FY2020 premium rates developed by HHSC and Rudd and Wisdom satisfy the following:

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

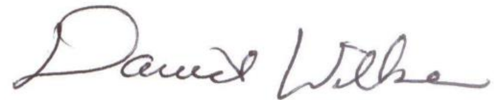
(b) The premium rates are appropriate for the populations and services covered under the managed care contract; and

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

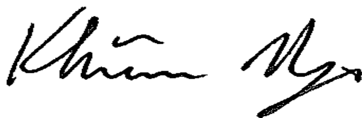
We have relied on historical experience data and program information provided to us by HHSC. We have reviewed the data for reasonableness but have not audited the data.

Please note that actual health plan contractor experience will differ from these projections. Rudd and Wisdom has developed these rates on behalf of the State to demonstrate compliance with the CMS requirements under 42 CFR 438.3(c), 438.3(e), 438.4, 438.5, 438.6 and 438.7. Any health plan contracting with the State should analyze its own projected premium needs before deciding whether to contract with the State.

Evan L. Dial, F.S.A., M.A.A.A.



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



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

Section VII. Attachments

The following sections indicate any revisions applicable to each of the attachments in the original actuarial report dated July 9, 2019.

Attachment 1 - *Summary of FY2020 STAR+PLUS Rating Analysis*

Exhibit A Revised. This exhibit presents summary information regarding the FY2020 rates. Included on the exhibit are current (September 1, 2019 – February 29, 2020) premium rates split between medical (acute care and long-term care), prescription drug, NAIP, QIPP and UHRIP rates; March 1, 2020 through August 31, 2020 premium rates split between medical (acute care and long-term care), prescription drug, NAIP, QIPP and UHRIP rates and a comparison of September 1, 2019 and March 1, 2020 premium rates.

Exhibit B Revised. This exhibit presents a comparison of the projected expenditures under the current (September 1, 2019 through February 29, 2020) premium rates and the March 1, 2020 through August 31, 2020 premium rates. The projection is split by each component.

The reasons for the rate changes shown in Exhibit A Revised are due solely to the revisions in the QIPP program as described above. There are no other changes to the premium rates effective March 1, 2020.

Attachment 2 - *Individual Health Plan Experience Analysis*

No changes applicable to this section.

Attachment 3 - *Community Experience Analysis*

No changes applicable to this section.

Attachment 4 - *Trend Analysis*

No changes applicable to this section.

Attachment 5 - *Provider Reimbursement and Benefit Revisions Effective During FY2018, FY2019 and FY2020*

No changes applicable to this section.

Attachment 6 – *Acuity Risk Adjustment – Acute Care*

There have been no changes to this section.

Attachment 7 – *Acuity Risk Adjustment – Long Term Care*

There have been no changes to this section.

Attachment 8 – *Network Access Improvement Program (NAIP)*

There have been no changes to this section.

Attachment 9 – *Quality Incentive Payment Program (QIPP)*

Effective March 1, 2020 the distribution of Medicaid days and funding for the QIPP has been adjusted due to changes in the nursing facility provider community resulting from provider type changes, mergers and terminations triggering a revision to the QIPP add-on amounts included in the capitation rates. Exhibit B Revised presents a summary of the QIPP add-on amounts effective during the period March 1, 2020 through August 31, 2020. There have been no other changes to the QIPP program.

Attachment 10 – *Uniform Hospital Rate Increase Program*

There have been no changes to this section.

Attachment 11– *Community First Choice Initiative (CFC)*

There have been no changes to this section.

Attachment 12– *Pay for Quality Program*

There have been no changes to this section.

Attachment 13– *FY2020 STAR+PLUS Rate Certification Index*

FY2020 STAR+PLUS Rate Certification Index

The index below includes the pages of the original report and this amendment letter that correspond to the applicable sections of the 2019-2020 Medicaid Managed Care Rate Development Guide, dated March 2019.

Section I. Medicaid Managed Care Rates

1. General Information

Rate Development Standards

i. Rates are for the period March 1, 2020 through August 31, 2020.

ii. (a) The certification letter is on page 5 of the amendment letter.

(b) The final capitation rates are shown on pages 3 and 4 of the amendment letter.

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

(ii) The rates included in this amendment are for the period March 1, 2020 through August 31, 2020.

(iii) See page 1 of the original report.

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

(v) Pages 236-240 (NAIP), 241-252 (QIPP), 253-268 (UHRIP) and 276-278 (P4Q) of the original report. Changes to the QIPP program are detailed on page 1 of the amendment letter

(vi) Not applicable.

iii. Acknowledged.

iv. Acknowledged.

v. Acknowledged.

vi. Acknowledged.

vii. Acknowledged.

viii. Acknowledged.

ix. Acknowledged.

A. Appropriate Documentation

i. Acknowledged

ii. Acknowledged.

iii. See pages 269 through 275 of the original report.

iv. (a) See pages 16 through 37 of the amendment letter.

(b) Not applicable. All rating adjustment factors have been included in 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 original report.

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

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

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

(d) Not applicable.

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

(b) See page 4 of the original report.

(c) No errors found in the data.

(d) See pages 178 through 212 of the original report.

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

3. Projected benefit Costs and Trends

A. Rate Development Standards

i. Acknowledged.

ii. Acknowledged.

iii. Acknowledged.

iv. Acknowledged.

v. See page 179 and pages 199 through 202 of the original report.

B. Appropriate Documentation

i. See pages 3 and 4 and Attachment 1 Revised pages 16 through 37 of the amendment letter.

ii. (a) See Attachment 3 pages 50 through 155 of the original report.

(b) There have been no significant changes in the development of the benefit cost since the last certification.

(c) All recoupments and recoveries resulting from overpayments to providers have been netted out of the claim payments used in the rate development. MCOs are required to adjust encounter data to remove all overpayments and correct the submitted information. Any provider recoveries not adjust for in the submitted encounter data are excluded from the base period as a negative add-on payment.

iii. (a) See Attachment 4 pages 156 through 177 of the original report.

(b) See Attachment 4 pages 156 through 177 of the original report.

(c) See Attachment 4 pages 156 through 177 of the original report.

(d) See Attachment 4 pages 156 through 177 of the original report.

(e) Not applicable.

iv. Not applicable.

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

- The MCO may provide inpatient services for acute psychiatric conditions in a free-standing psychiatric hospital in lieu of an acute care inpatient hospital setting.
- The MCO may provide substance use disorder treatment services in a chemical dependency treatment facility in lieu of an acute care inpatient hospital setting.

- For individuals between the ages of 21 and 64, services are provided in IMDs only in lieu of an acute care hospital setting. IMD services for individuals under age 21 and age 65 and over are covered pursuant to the Texas state plan.

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

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

(b) All claims paid during retroactive enrollment periods are included in the base period data used to develop the FY2020 premium rate.

(c) All enrollment data during retroactive enrollment periods are included in the base period data used to develop the FY2020 premium rate.

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

vii. See Attachment 5 pages 178 through 212 of the original report.

viii. See Attachment 5 pages 178 through 212 of the original report.

4. Special Contract Provisions Related to Payment

A. Incentive Arrangements

i. Rate Development Standards

Acknowledged.

ii. Appropriate Documentation

See Attachment 12 pages 276 through 278 of the original report.

B. Withhold Arrangements

i. Rate Development Standards

Acknowledged.

ii. Appropriate Documentation

See Attachment 12 pages 276 through 278 of the original report.

C. Risk-Sharing Arrangements

i. Rate Development Standards

Not applicable.

ii. Appropriate Documentation

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

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

D. Delivery System and Provider Payment Initiatives

i. Rate Development Standards

Acknowledged.

ii. Appropriate Documentation

(a) See Attachment 9 pages 241 through 252 and Attachment 10 pages 253 through 268 of the original report and the revisions included in the amendment letter for a description of the QIPP and UHRIP programs. See Attachment 1 Revised page 37 of the amendment letter for the estimated value of these programs.

E. Pass-Through Payments

i. Rate Development Standards

Acknowledged.

ii. Appropriate Documentation

(a) See Attachment 8 pages 236 through 240 of the original report.

(b) See Attachment 8 pages 236 through 240 of the original report.

5. Projected Non-Benefit Costs

A. Rate Development Standards

i. Acknowledged.

ii. Acknowledged.

iii. Acknowledged.

iv. Acknowledged.

B. Appropriate Documentation

i. See page 15 of the original report.

ii. See page 15 of the original report.

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

(b) Not applicable.

(c) Not applicable.

(d) See page 15 of the original report.

(e) See Attachment 1 Revised pages 16 through 37 of the amendment letter.

(f) See page 15 of the original report

6. Risk Adjustment and Acuity Adjustments

A. Rate Development Standards

i. Acknowledged.

ii. Acknowledged.

iii. Acknowledged.

B. Appropriate Documentation

i. See Attachments 6 and 7 pages 213 through 235 of the original report.

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

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

iv. See Attachments 6 and 7 pages 213 through 235 of the original report.

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

1. Managed Long-Term Services and Supports

A. Acknowledged.

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

C. Appropriate Documentation

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

(b) Rate cells are specified on page 5 of the original report. Description of the rate setting methodology is included in Attachment 3 pages 50 through 155 of the original report. All trend analysis and other adjustment factors follow the same methodology as described throughout the report.

(c) Not applicable.

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

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

ii. The development of the administrative cost is described on page 15 of the original report. Service coordination expenditures are based on the amounts reported by the MCO as discussed on page 2 of the original report.

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