STATE OF TEXAS
MEDICAID MANAGED CARE
STAR HEALTH PROGRAM RATE SETTING
STATE FISCAL YEAR 2015

Prepared for:
Texas Health and Human Services Commission
V1.20

Prepared by:
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I. Introduction

Rudd and Wisdom, Inc. has been retained by the Texas Health and Human Services Commission (HHSC) to develop a fiscal year 2015 (FY2015, September 2014 through August 2015) premium rate for the STAR Health program. STAR Health is the managed health care program for Foster Care clients in Texas that was implemented April 1, 2008. This report presents the rating methodology and assumptions used in developing the FY2015 premium rate.

Rudd and Wisdom has provided actuarial services to the Texas Medicaid program for over 25 years. We have participated in the state's managed care rating process since its inception in 1993. We have worked closely with HHSC staff in developing the FY2015 STAR Health premium rate.

Rudd and Wisdom has relied on the following data sources as provided by HHSC and Bankers Reserve Life Insurance Company of Wisconsin, the underwriting carrier for the STAR Health program (the carrier):

- Monthly Foster Care enrollment for the period September 2010 through March 2014 with a projection through August 2015. These enrollment figures were provided by HHSC System Forecasting staff.

- Claim lag reports provided by the carrier for the period September 2010 through February 2014. These reports include monthly paid claims by month of service.

- Information provided by the carrier on high volume claimants during the experience period.

- Information from the carrier regarding current and projected payment rates for certain capitated services, such as mental health, dental and vision.

- Financial Statistical Reports (FSR) from the carrier for FY2011, FY2012, FY2013 and the first six months of FY2014. The FSR contains detailed information regarding monthly enrollment, revenue, incurred claims and administrative expenses, as reported by the HMO.

- Information from the carrier regarding current and projected reinsurance premium rates.

- Information from both HHSC and the carrier regarding recent changes in covered services and provider reimbursement under the Medicaid program.

- Information provided by HHSC regarding the expected impact of FY2014 and FY2015 Medicaid provider reimbursement rate changes.

- Information provided by HHSC regarding FY2013 health plan claims cost by type of service for certain services. This information was obtained from the encounter database.

- Information provided by the carrier regarding the administrative costs for Foster Care clients under the STAR Health plan.

- Current (FY2014) STAR Health premium rate.

Although the above data was reviewed for reasonableness, Rudd and Wisdom did not audit the data.

II. Overview of the Rate Setting Methodology

This report details the development of the medical component of the total premium rate. Information regarding the carve-in of prescription drugs into the STAR Health program can be found in the report titled State of Texas Medicaid Managed Care Rate Setting Pharmacy Carve-in State Fiscal Year 2015.

The actuarial model used to derive the FY2015 STAR Health premium rate relies primarily on health plan financial experience. The historical claims experience for the program was analyzed and estimates for the base period (FY2013, September 1, 2012 through August 31, 2013) were developed. These estimates were then projected forward to FY2015 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 FY2015 cost under the plan.

Only one health plan provides services under the STAR Health program. The health plan is reimbursed using a single premium rate which does not vary by age, gender or area. The STAR Health program covers the entire state of Texas. 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
- Dental and Orthodontia Services
- Prescription Drugs

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 HMOs, (ii) the claim amounts reported in the FSRs and (iii) the claim amounts in the encounter data files. There was satisfactory consistency between the three claims data sources.

We projected the FY2015 cost by estimating base period average claims cost and then applying trend and other adjustment factors. These adjustment factors are described in Section III of this

report. We added capitation expenses for services capitated by the carrier (such as radiology and dental services), a net cost of reinsurance, a reasonable provision for administrative expenses, taxes and risk margin.

The analysis of base period claims experience 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 and adjustments were made if deemed appropriate.

Attachment 1 to this report provides a description of the calculation of the FY2015 STAR Health premium rate. Attachment 2 contains a summary of recent program incurred claims experience. Attachment 3 details the calculation of the rate adjustment factor for provider rate changes.

III. Adjustment Factors

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

Trend Factors

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 for Foster Care clients and the actuary's professional judgment regarding future cost increases. The annual trend assumptions used in the rating analysis were 1.3% for FY2014 and 3.2% for FY2015.

Provider Reimbursement Adjustment

Medicaid provider reimbursement changes were provided for the following services: APR DRG implementation, Potentially Preventable Readmission reimbursement reductions, Potentially Preventable Complication reimbursement reductions, 10% reimbursement reduction for inpatient outlier reimbursement, revisions to the therapy fee schedule, outpatient facility reimbursement reductions, outpatient imaging reimbursement reductions, ambulance reimbursement reductions, revisions to emergency room reimbursement provisions for non emergent services, reduction of Medicaid reimbursement in excess of Medicare. Effective September 1, 2014 behavioral health targeted case management services will become capitated services under the STAR Health Program. Previously these services were carved out of STAR Health and paid on a fee-for-service basis. Effective September 1, 2014 HHSC will require all managed care organizations to incorporate Electronic Visit Verification (EVV) into their management duties for Personal Assistance Services (PAS), Personal Care Services (PCS) and Private Duty Nursing (PDN).

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 3 presents a summary of the derivation of these adjustment factors.

IV. Administrative Fees and Risk Margin

The rating methodology includes an explicit provision for administrative services. The amount allocated for administrative expenses is $24.00 pmpm plus 5.75% of gross premium. This amount is intended to provide for all administrative-related services performed by the carrier.

The administrative fee includes provision for new services provided under STAR Health that were not previously provided under the FFS plan. These services include the following:

- A dedicated organizational structure for Foster Care clients
- Additional mandatory staffing
- An expanded provider network
- A dedicated member services help line
- A Nurse Line
- Creation of a Foster Care Medical Advisory Committee
- Increased training for staff and providers
- CME credit for physicians
- Creation of a new pre-appeals process
- Coordination with the Department of Family and Protective Services and the court system
- Health Passport (an electronic medical record that is available to multiple parties online)
- Electronic Visit Verification for PAS, PCS and PDN services

The premium rate also includes provisions for premium tax (1.75% of premium), maintenance tax ($0.065 pmpm) and a risk margin (2.0% of premium).

V. Summary

The FY2015 premium rate for the STAR Health program including prescription drugs is $925.11 per member per month. The total premium rate is made up of the total medical component of $765.50 and the prescription drug component of $159.61. This report details the derivation of the medical component of the rate. Further information regarding the prescription drug component of the premium rate can be found in the report titled State of Texas Medicaid Managed Care Rate Setting Pharmacy Carve-in State Fiscal Year 2015. This rate will be effective for the period September 1, 2014 through August 31, 2015. Attachment 1 shows the derivation of the medical component of the premium rate.

VI. Actuarial Certification of FY2015 STAR Health Premium Rate

I, Evan L. Dial, am a principal with the firm of Rudd and Wisdom, Inc., Consulting Actuaries (Rudd and Wisdom). I am a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries. I 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 Health premium rate for the period September 1, 2014 through August 31, 2015 and to provide the actuarial certification required under Centers for Medicare and Medicaid Services (CMS) requirements 42 CFR 438.6(c).

I certify that the STAR Health premium rate developed by HHSC and Rudd and Wisdom satisfies the following:

(a) The premium rate has been developed in accordance with generally accepted actuarial principals and practices;

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

(c) The premium rate is 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 this rate on behalf of the State to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c). 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.

VII. Attachments

Attachment 1

Summary of FY2015 STAR Health Rating Analysis

The attached exhibit presents summary information regarding the FY2015 STAR Health rate development. Included on the exhibit are base period (FY2013) experience, projected FY2015 enrollment, trend and provider reimbursement adjustment factors, assumed capitation rates, reinsurance and administrative costs.

The actuarial model used to derive the FY2015 STAR Health premium rate relies primarily on health plan financial experience. The historical claims experience for the program was analyzed and estimates for the base period were developed. These estimates were then projected forward to FY2015 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 FY2015 cost under the plan.

Only one health plan provides services through the STAR Health program. The health plan is reimbursed using a single premium rate which does not vary by age, gender or area.

The information presented in Attachment 1 does not include the prescription drug portion of the total premium rate. Further information regarding the prescription drug component of the premium rate can be found in the report titled State of Texas Medicaid Managed Care Rate Setting Pharmacy Carve-in State Fiscal Year 2015.

FY2015 STAR Health Rating Analysis
Rate Development for the STAR Health Program

	Rating Period FY2015
Base Period Used in Rating	FY2013
Base Period Experience	
Member Months	363,516
Estimated Incurred Claims	217,140,095
Estimated Incurred Claims pmpm	$ 597.33
Projected Rating Period Experience	
Member Months	400,350
Assumed Annual FFS Claims Cost Trend Rate	
- FY2014	1.3 %
- FY2015	3.2 %
Provider Reimbursement Adjustment	-0.98 %
Hospital Reimbursement Adjustment	0.64 %
Projected Incurred Claims pmpm	$ 622.30
Projected Incurred Claims	249,137,632
Capitation Expenses	
Laboratory	$ 0.03
Behavioral Health	$ 0.00
Vision Services	$ 0.00
Dental Services	$ 43.29
Radiology	$ 2.40
Settlements and Miscellaneous Expenses	$ 0.69
Total	$ 46.41
Reinsurance Expenses	
Gross Premium	$ 0.04
Projected Reinsurance Recoveries	$ 0.04
Net Reinsurance Cost	$ 0.00
Administrative Expenses	
Fixed Amount	$ 24.00
Percentage of Premium	5.75 %
Premium Tax	1.75 %
Maintenance Tax pmpm	$ 0.0650
Risk Charge	2.0 %
Premium Rate pmpm	$ 765.50
Percentage Increase	-5.6 %

Attachment 2

STAR Health Incurred Claims Experience

The attached exhibit presents a summary of STAR Health incurred claims experience during the base period used in the rate setting analysis. For each month during the experience period the exhibit shows enrollment, claims incurred during the month and paid through February 28, 2014 and estimated incurred claims.

FY2015 STAR Health Rating Analysis
Estimated STAR Health Incurred Claims (excluding dental and prescription drugs)

Month	Number of Members	Claims Incurred and Paid	Completion Factor	Estimated Incurred Claims	Estimated Incurred pmpm	Trend Factor
Sep-10	31,311	17,609,127	1.0000	17,609,127	562.39	
Oct-10	31,490	17,294,342	1.0000	17,294,342	549.20	
Nov-10	31,641	17,507,724	1.0000	17,507,724	553.32	
Dec-10	31,483	17,058,069	1.0000	17,058,069	541.82	
Jan-11	31,402	18,548,113	1.0000	18,548,113	590.67	
Feb-11	31,695	16,654,904	1.0000	16,654,904	525.47	
Mar-11	32,013	18,681,530	1.0000	18,681,530	583.56	
Apr-11	32,024	19,710,019	1.0000	19,710,019	615.48	
May-11	32,213	18,671,387	1.0000	18,671,387	579.62	
Jun-11	32,539	18,063,022	1.0000	18,063,022	555.12	
Jul-11	32,116	17,570,291	1.0000	17,570,291	547.09	
Aug-11	32,076	18,430,319	1.0000	18,430,319	574.58	
Sep-11	31,641	17,131,773	1.0000	17,131,773	541.44	0.963
Oct-11	31,273	17,591,875	1.0000	17,591,875	562.53	1.024
Nov-11	31,681	17,341,377	1.0000	17,341,377	547.37	0.989
Dec-11	31,475	16,887,957	1.0000	16,887,957	536.55	0.990
Jan-12	31,003	17,903,582	1.0000	17,903,582	577.48	0.978
Feb-12	30,913	17,661,388	1.0000	17,661,388	571.33	1.087
Mar-12	31,021	19,083,934	1.0000	19,083,934	615.19	1.054
Apr-12	31,153	17,632,152	1.0000	17,632,152	565.99	0.920
May-12	31,127	19,287,793	1.0000	19,287,793	619.65	1.069
Jun-12	31,105	18,475,881	1.0000	18,475,881	593.98	1.070
Jul-12	30,948	19,332,128	1.0000	19,332,128	624.66	1.142
Aug-12	30,707	19,324,637	1.0000	19,324,637	629.32	1.095
Sep-12	30,752	18,226,153	1.0000	18,226,153	592.68	1.095
Oct-12	30,604	19,305,273	1.0000	19,305,273	630.81	1.121
Nov-12	30,378	18,101,141	1.0000	18,101,141	595.86	1.089
Dec-12	29,927	16,229,089	0.9997	16,233,836	542.45	1.011
Jan-13	29,731	18,940,343	0.9997	18,945,891	637.24	1.103
Feb-13	29,944	17,212,662	0.9993	17,224,119	575.21	1.007
Mar-13	29,920	18,095,865	0.9991	18,112,557	605.37	0.984
Apr-13	30,032	18,914,557	0.9987	18,938,516	630.61	1.114
May-13	30,286	18,320,709	0.9987	18,345,401	605.74	0.978
Jun-13	30,527	17,869,544	0.9981	17,904,000	586.50	0.987
Jul-13	30,606	18,031,158	0.9971	18,083,515	590.85	0.946
Aug-13	30,809	17,613,850	0.9940	17,719,694	575.15	0.914
Sep-13	30,708	17,713,749	0.9916	17,863,600	581.73	0.982
Oct-13	30,938	18,771,649	0.9851	19,056,470	615.96	0.976
Nov-13	30,886	16,989,438	0.9733	17,456,125	565.18	0.949
Dec-13	30,455	15,597,115	0.9452	16,502,140	541.86	0.999
FY2011	382,003			215,798,848	564.91	
FY2012	374,047			217,654,478	581.89	1.030
FY2013	363,516			217,140,095	597.33	1.027
9/12-12/12	121,661			71,866,403	590.71	
9/13-12/13	122,987			70,878,335	576.31	0.976

Attachment 3

Provider Reimbursement Adjustments

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 (FY2013) and before the end of FY2015.

The benefit and provider reimbursement changes recognized in the FY2015 rate setting are listed below. The rating adjustments for these provider reimbursement changes were calculated by applying actual health plan encounter data to the old and new reimbursement bases and the resulting impact determined. The attached exhibit presents a summary of the derivation of the adjustment factors.

- Effective 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 hospitals performance during the evaluation time period.

- Effective September 1, 2013 HHSC implemented an outpatient hospital reduction of 5.3%, which excludes clinical lab and outpatient imaging services. This reduction does not apply to children's hospitals, rural hospitals, or state-owned teaching hospitals.

- Effective September 1, 2013, HHSC implemented revisions to the therapy fee schedules. Reimbursement was reduced by 2.5% for Comprehensive Outpatient Rehabilitation Facilities/Outpatient Rehabilitation Facilities (CORFs/ORFs), 4% for independent therapist operating in an office setting, and 1.5% for therapy services provided inside the home.

- Effective September 1, 2013 HHSC reduced hospital imaging reimbursement to 125% of the amount reimbursed for imaging performed in a physician's office.

- Effective September 1, 2013 HHSC revised the reimbursement for non emergent services provided in an emergency room. These changes included the following:

    - Reimbursement is restricted when an individual returns to the emergency department within a 36 hour period.
    - Reimbursement is restricted for non-urgent visits in excess of 24 per year.
    - Non-urgent visits are reimbursed using a flat fee.

- Effective September 1, 2013 HHSC reduced ambulance reimbursement by 5%.

- Effective September 1, 2013 HHSC reduced any Medicaid rates that exceed Medicare reimbursement levels.

- Effective September 1, 2012 HHSC implemented the APR-DRG reimbursement system for all hospitals excluding rural, children's and state owned teaching facilities. Effective

FY2015 STAR Health Rating Analysis
Provider Reimbursement Adjustments
Estimates Based on FY2013 STAR Health Encounter Data

Provider Reimbursement Adjustment Factor

EVV	-952,634
5.3% Outpatient Reduction	-251,970
Therapy Reimbursement Reduction	-325,796
Emergent Room Reductions	
Non Emergent within 36 Hours	-22,329
Non Emergent Flat Fee	-185,607
5% Ambulance Reduction	-96,824
Outpatient Imaging Reduction	-333,291
Reduce Medicaid rates in excess of Medicare	-86,569
Targeted Case Management	119,792
Overall Provider Reimbursement Changes	-2,135,228
FY2013 Total Claims	217,140,095
Provider Reimbursement Adjustment	-0.98 %

Hospital Adjustment Factor

APR DRG Implementation	1,569,448
PPR Reduction	-7,571
PPC Reduction	-37,975
Outlier Reduction	-143,522
FY2013 Incurred Claims	217,140,095
Hospital Reimbursement Adjustment	0.64 %

September 1, 2013 HHSC transitioned all rural and children's facilities to the APR-DRG reimbursement system.

- Effective September 1, 2013 HHSC reduced the outlier portion of facility reimbursement by 10%. Children's hospitals are excluding from this reduction.

- 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 hospitals performance during the evaluation time period.

- Effective September 1, 2014 behavioral health targeted case management services will be capitated under the program. Prior to this time these services were paid on a fee-for-service basis.

- Effective September 1, 2014 HHSC will require all managed care organizations to incorporate EVV into their management duties for Personal Assistance Services (PAS), Personal Care Services (PCS) and Private Duty Nursing (PDN). Based on an analysis of the impact of EVV on these services in the fee-for-service program the following savings assumptions have been developed:
    - PAS: 4.0%
    - PCS: 4.0%
    - PDN: 3.5%

  The impact of additional administrative expenses from the introduction of EVV was considered and it has been determined that the administrative allowance included in the rates should be increased by $0.50 per member per month.

The attached exhibit presents a summary of the rating adjustment factors.