STATE OF TEXAS
MEDICAID MANAGED CARE
STAR HEALTH PROGRAM RATE SETTING
STATE FISCAL YEAR 2025

Prepared for:
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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 2025 (FY2025, September 2024 through August 2025) premium rate for the STAR Health program. STAR Health is a managed health care program for Foster Care clients in Texas implemented on April 1, 2008. A single managed care organization, Superior Health Plan (Superior), covers this population in all 254 counties (statewide). This report presents the rating methodology and assumptions used in developing the FY2025 premium rate.

Rudd and Wisdom has provided actuarial services to the Texas Medicaid program for over 35 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 FY2025 STAR Health premium rate.

Rudd and Wisdom has relied on the following data sources as provided by HHSC, Superior, the managed care organization (MCO) that administers the STAR Health program and the agency's External Quality Review Organization (EQRO):

- Monthly STAR Health enrollment for the period September 2012 through March 2024 with a projection through August 2025. These enrollment figures were provided by HHS Forecasting staff.

- Detailed, member-level enrollment data for FY2022, FY2023 and FY2024. This information is used to identify members that were disenrolled as a result of the PHE unwind process and those members that newly joined the program.

- Detailed MCO encounter data for FY2023. The encounter data is a dataset that includes detail claim information for every claim incurred during FY2023 and paid through November 30, 2023. The dataset includes but is not limited to (1) individual member information – date of birth, risk group, MCO; (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 provided by Superior for the period September 2020 through March 2024. These reports include monthly paid claim amounts by month of service. These reports summarize the detail encounter data.

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

- Information from both HHSC and Superior regarding COVID-19 related claims paid on a non-risk basis during the period March 2020 through August 2023.

- Financial Statistical Reports (FSR) from the MCO for FY2021, FY2022, FY2023 and the first six months of FY2024. The FSR contains detailed information regarding monthly enrollment, revenue, incurred claims and administrative expenses, as reported by the HMO. These reports are prepared by the MCO and are audited by an external audit organization. An MCO 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 MCO's encounter claims data.

- Information from Superior regarding current and projected reinsurance premium rates.

- Information from Superior regarding current and projected payment rates for certain capitated services, such as dental and radiology.

    - Subcapitated services make up approximately 2.7% of total plan cost and are primarily dental services. Information about these arrangements was provided by Superior and verified with the audited FSRs. These items were reviewed for reasonableness by comparing the reported expense amounts to those expenses in other programs along with the historical dental expenditures within the STAR Health program.

- Information from both HHSC and Superior regarding historical service coordination expenditures and enhanced requirements for FY2025.

    - Service Coordination expenses make up approximately 6.4% of total plan cost and are separate from the included administrative allowance. Information about service coordination expenses was provided by the MCO and verified with the FSRs. Effective September 1, 2023, the service coordination requirements in the STAR Health program increased significantly. This increase has been reflected in the assumed service coordination expense of $100.00 per member per month included in the rate development.

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

- Information provided by HHSC regarding the expected impact of FY2023, FY2024 and FY2025 Medicaid provider reimbursement rate changes.

- Information provided by HHSC regarding FY2023 MCO claims cost by type of service for certain services. This information was obtained from the encounter database.

- Current (FY2024) STAR Health premium rate.

All data requested by the actuary was provided by HHSC and the participating MCO. Although the above data was reviewed for reasonableness, Rudd and Wisdom did not audit the data. Further discussion of the base data development and review is included in Section II.

II. Base Period Data

The actuarial model used to derive the FY2025 STAR Health premium rate relies primarily on historical MCO experience. The historical claims experience for the program was analyzed and estimates for the base period were developed. The base period for the medical, prescription drug and non-emergency medical transportation (NEMT) components of the rate was defined as FY2023 (September 1, 2022 through August 31, 2023). Estimates of the base period include an estimate of incurred but unpaid claims (IBNR). Given that there are seven months of runout beyond the base period, the IBNR estimates for medical and prescription drug are immaterial. The IBNR estimate is based on claims paid through March 2024 and represents the following percentage of claims by type of service:

- Medical – ~0.00%
- Prescription Drug – ~0.00%
- NEMT – 0.10%

The rating analysis primarily relies on the three data sources: i) Financial Statistical Report (FSR), ii) MCO Supplemental Data and iii) Encounter Data.

- Financial Statistical Report – The FSR provides high-level, summary information of paid claims, subcapitated expenses, reinsurance expenses and administrative costs. The FSRs are used to determine the experience rebate for each MCO and the allowability (or not) of expenses which impact the calculation of the FSR-reported net income for experience rebate purposes. As a result, the MCOs are required to only report "allowable" expenses on the FSRs. The FSRs are subject to audit by an external auditor.

- MCO Supplemental Data – The MCO supplemental data provides HHSC-specified data such as subcapitated expenses by type of service, claim lag data by type of service, other medical expenses and large claimant information. All expense items such as claim lag, capitation, direct service expense, etc. are reconciled to the FSR by risk group for each MCO to ensure the accuracy and consistency of the data sources. MCOs are asked to explain any material difference between the two data sources and if necessary, provide revised supplemental data. Once all issues have been resolved, Rudd and Wisdom aggregates the information from the MCO Supplemental Data into a "Data Book" and provides all information to the MCOs in order to confirm the accuracy. The Data Book is used to determine base year data used in the rating analysis.

- Encounter Data – The detail encounter data provides claims data at the most granular level including information for individual claims such as provider, procedure code, diagnostic information, etc. The encounter data is primarily used to develop rating adjustment factors for various provider reimbursement and benefit revisions. For each rating adjustment, the applicable base period encounter data is repriced using the FFS reimbursement in place during the base period, the FFS reimbursement that will be in place during the rating period and the applicable percentage change determined.

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. ICHP performs four types of analyses:

- Volume analysis based on service category
- Data validity and completeness analysis
- Pharmacy encounter analysis
- Consistency analysis between encounter data and FSRs provided by the MCO by service area (SA)

Below is an excerpt from their data certification report:

The EQRO considers the required data elements for all MCO-SA combinations in all programs 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.*

The ICHP encounter data to FSR reconciliation is done at an aggregate level by Medicaid program, service area and MCO. In addition to ICHP's encounter data to FSR comparison, Rudd and Wisdom performs a similar analysis by risk group to review for reasonableness. Risk group codes are added to the encounter data by mapping Medicaid ID from the encounter data to the eligibility files.

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. The comparison includes (i) the claim lag reports provided by the MCOs in the supplemental data request, (ii) the claim amounts reported in the FSRs and (iii) the claim amounts included in the encounter data files. The three data sources are compared to ensure consistent results such that the three are considered interchangeable in aggregate. 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.

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 of high quality and we have no concerns over the availability or applicability to the FY2025 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 Health program, the rate development is based exclusively on managed care data.

III. Overview of the Rate Setting Methodology

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

Only one MCO provides services under the STAR Health program. The MCO is paid 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
- Early and Periodic Screening, Diagnosis and Treatment (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
- Non-Emergency Medical Transportation Services
- COVID-19 related expenses for testing, treatments and vaccines

Examples of services specifically excluded from the analysis include:

- Texas Health Steps environmental lead investigation (ELI)
- Early Childhood Intervention (ECI) Case Management
- ECI Specialized Skills Training
- Texas School Health and Related Services (SHARS)
- HHSC Blind Children's Vocational Discovery and Development Program
- Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation)
- Certain high cost carve-out prescription drugs
- Hemostatic drugs
- Applied Behavioral Analysis (ABA) services

All expenses related to these, any other non-capitated services and any value-added services have been excluded from the FY2025 rating analysis.

Claim payments associated with the American Rescue Plan Act (ARPA), which temporarily increased the reimbursement for certain services during the period March 2022 through August 2022, have been removed from the historical data since the reimbursement increase did not continue beyond August 31, 2022.

We projected the FY2025 cost by estimating base period average claims cost and then applying trend and other adjustment factors including various programmatic, reimbursement, benefit and policy-related adjustment factors. These adjustment factors are described in Section IV of this report. We added capitation expenses for services capitated by Superior (such as radiology and dental services), a net cost of reinsurance, a reasonable provision for administrative expenses, service coordination expenses, taxes and risk margin in order to project the total FY2025 cost under the plan.

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; however, no adjustments were deemed necessary.

Attachment 1 to this report provides a description of the calculation of the FY2025 STAR Health premium rate. Attachment 2 contains a summary of recent program incurred claims experience. Attachment 3 summarizes the development of the trend assumptions. Attachment 4 details the calculation of the rate adjustment factors for provider rate changes. Attachment 5 details the calculation of the Public Health Emergency (PHE) unwinding on FY2025 program costs. Attachment 6 details the calculation of the Community First Choice (CFC) component of the premium which is eligible for an enhanced federal match rate. Attachment 7 provides information on in-lieu of services (ILOS). Attachment 8 provides the required index summarizing the applicable sections from the 2024-2025 Medicaid Managed Care Rate Development Guide.

IV. Adjustment Factors

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

Trend Factors - Medical

The rating methodology uses assumed medical trend factors to adjust the base period claims cost to the rating period. The medical trend factor used in this analysis is a combination of utilization and inflation components. The projected trend rate assumptions were developed by the actuary based on an analysis of historical experience for STAR Health clients and the actuary's professional judgment regarding future cost increases. 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 previous year. For example, the FY2018 trend has been calculated as the change in average cost per member per month during the period September 1, 2017 through August 31, 2018 (FY2018) compared to the average cost per member per month during the period September 1, 2016 through August 31, 2017 (FY2017). The experience trends for all time periods were adjusted to remove the impact of various provider reimbursement changes and other changes that have materially impacted the program.

The trend assumption was calculated as the average trend during FY2018, FY2019 and the first six months of FY2020 and equals 7.7%. STAR Health trends after February 2020 were evaluated but not considered due to the significant impact the COVID-19 pandemic had on average expenditures and enrollment. During the PHE, the STAR Health program experienced significant membership growth and abnormally low trends that are not indicative of future cost growth as the PHE unwinding process has begun. Once the PHE ended, the enrollment has declined significantly in the STAR Health program resulting in large increases in average cost and abnormally large trends. It is expected that as the PHE-related disenrollments are complete and enrollment stabilizes that future STAR Health trends will return to the pre-PHE averages experienced within the program.

Trend Factors – Rx

The rating methodology uses assumed pharmacy trend factors to adjust the base period claims cost to the rating period. The trend assumptions were developed by the actuary based on an analysis of historical pharmacy claims experience for STAR Health clients and the actuary's professional judgment regarding anticipated future cost changes.

The trend analysis included a review of STAR Health utilization and cost experience data paid through March 31, 2024. Incurred monthly utilization (days supply per member) and cost per service (plan payments per days supply) statistics were developed through February 2024. From this experience, the average annual utilization and cost per service were determined for each of the six 12-month periods ending February 2024.

Due to the impact on healthcare utilization and cost from the COVID-19 pandemic and the PHE, experience after February 2020 was deemed unusable for purposes of developing trend projections.

As a result, we have used the four 12-month periods ending February 2020 in our trend analysis in order to exclude pandemic-related experience.

Certain drugs and drug categories are excluded from the pharmacy trend analysis. Direct-acting antivirals (DAA) used for the treatment of the Hepatitis C virus and the drug Orkambi were carved into the managed care contract effective September 1, 2018, but they were excluded from the trend analysis due to their extraordinary one-time impact on recent trends. Please note that i) effective March 1, 2021, Hepatitis C DAAs were carved out of the managed care arrangement due to significant changes to the prior authorization criteria for these medications and ii) effective September 1, 2024, Hepatitis C DAAs will be carved back into managed care. In addition to these drugs, experience for the anti-viral and progestational agent drug classes was removed from our trend analysis. Anti-viral was removed due to the significant variation in the intensity of flu season from year to year. Progestational agent was removed due to its one-time distortion of pharmacy trends for pregnant women. Hemostatic agents were also excluded from the pharmacy trend analysis. Effective September 1, 2020, hemophilia medications were carved out of the managed care arrangement. Please note that while excluded from the pharmacy trend analysis, the historical managed care claims for all carve-in drugs were included in the base period experience used in developing the pharmacy component of the rates.

The STAR Health pharmacy annual trend assumption was developed using the following formula. The utilization and unit cost trend assumptions were set equal to one-sixth of the experience trend rate for the 12-month period ending February 2018 plus two-sixths of the experience trend rate for the 12-month period ending February 2019 plus three-sixths of the experience trend rate for the 12-month period ending February 2020. The final cost trend assumptions were then determined by combining the assumed utilization and unit cost trends into a single trend assumption.

The preferred drug list (PDL) changes implemented in recent years have had a material impact on pharmacy trends. As a result, recent pharmacy experience trends will tend to understate the expected underlying trend. In order to correct for this understatement, we developed adjustment factors to restate pharmacy experience for the three most recent 12-month periods ending February 2020 assuming that the PDL changes had not been implemented. The PDL trend adjustment factors were developed by comparing (i) the actual cost after PDL change and (ii) the expected cost had the PDL change not been implemented.

Attachment 3 – Exhibit B presents the resulting pharmacy trend assumptions used for the STAR Health program. We selected a prospective pharmacy trend assumption of 1.6% per annum.

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

Trend Factors – NEMT

The rating methodology uses assumed trend factors to adjust the base period claims cost to the rating period. Due to the impact on NEMT utilization and cost from the COVID-19 pandemic and the PHE, experience after February 2020 was deemed unusable for purposes of developing trend

projections. The NEMT trend factors used in this analysis are a combination of utilization and inflation components. The NEMT trend factors were developed using a combination of i) actual statewide NEMT trend experience for all Medicaid managed care programs and ii) the industry trend from the Consumer Price Index published by the Bureau of Labor Statistics for transportation services. The annual trend assumption of 3.30% was used in the rating analysis to project historical experience forward to the rating period. Attachment 3 – Exhibit C presents a summary of the NEMT trend analysis.

Provider Reimbursement Adjustments

Medicaid provider reimbursement changes were recognized for the following: inpatient hospital, potentially preventable readmissions (PPR), potentially preventable complications (PPC), clinical lab, dental anesthesia, non-invasive perinatal screening, prescribed pediatric extended care centers, private duty nursing, ground ambulance, attendant care, rural hospital outpatient services, birth and women's health related surgeries, evaluation and management services, ambulatory surgical centers and biomarker testing.

The rating adjustments for these provider reimbursement changes were calculated by applying actual MCO encounter data to the old and new reimbursement basis and the resulting impact determined. Attachment 4 presents a summary of the derivation of these adjustment factors.

Potentially Preventable Readmission Quality Improvement

Effective September 1, 2019, HHSC began utilizing an adjustment to the base period data that analyzes inefficiencies and potentially preventable expenses that unnecessarily increase managed care costs. This analysis was performed using the 3M™ PPR methodology which is a computerized algorithm to identify readmissions with a plausible clinical relationship to the care rendered during or immediately following a prior hospital admission. An expected reduction of PPR events of 10% has been applied for FY2025. Attachment 4 presents a summary of the derivation of the adjustment factor.

Readmissions are an indicator of quality of care because they may reflect poor clinical care and poor coordination of services either during hospitalization or in the immediate post discharge period. A potentially preventable readmission is a readmission (return hospitalization within the specified readmission time interval) that is clinically related to the initial hospital admission. HHSC expects the MCOs to provide their members with timely access to appropriate care at the proper level by coordinating care across the entire continuum of the health care spectrum. Preventable readmissions should be avoided through high-quality outpatient care, thus improving efficiency of the managed care programs.

Driscoll Children's Hospital Rio Grande Valley

During the summer of 2024 Driscoll Rio Grande Valley, a new children's hospital, will open in the Hidalgo SDA. This hospital has been built on the grounds of an existing non-children's hospital and will assume the care for all non-maternity related hospital services for children that were previously provided at the existing hospital. The shift from the current hospital to Driscoll

Children's Hospital Rio Grande Valley will result in a reimbursement increase as the Medicaid fee-for-service reimbursement to the children's hospital is much larger than the existing facility. Attachment 4 presents a summary of the derivation of the adjustment factor.

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. Attachment 4 presents a summary of the derivation of this adjustment factor.

Federally Qualified Health Center (FQHC) Wrap Payment Removal

Effective September 1, 2017, MCOs were no longer required to reimburse FQHCs the full encounter rate. The MCOs 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 by HHSC up to their full encounter rate outside of the capitation rate. The rating adjustment was calculated by collecting the FQHC wrap payments paid by the MCOs during the base period. Attachment 4 presents a summary of the derivation of this adjustment factor.

Insulin Price Adjustment

Effective January 1, 2024, the three pharmaceutical manufacturers Eli Lilly, Novo Nordisk and Sanofi reduced the list price for certain insulins by as much as 70%. The base period unit cost for the impacted insulins were repriced assuming the unit cost is the same as for the periods January 2024 through March 2024. Attachment 4 includes additional information regarding the application of the insulin price adjustment factor.

Makena Formulary Adjustment

Effective April 7, 2023, Makena and its generic equivalent hydroxyprogesterone were removed from the formulary. The rating adjustment was determined by removing the base period experience for Makena and its generic equivalent hydroxyprogesterone. Attachment 4 includes additional information regarding the application of the Makena formulary adjustment factor.

AMP Cap Removal

Prior to January 1, 2024, there was a rebate cap that prevented Medicaid programs from receiving rebate payments that exceed the Average Manufacturer Price (AMP) for a drug. Effective January 1, 2024, a provision in the American Rescue Plan Act of 2021 removed the cap. Pharmacy

manufacturers reduced the list price for Symbicort, Advair and Victoza in response to legislation to prevent paying rebates that exceeded the gross cost. The base period unit cost for the impacted drugs were repriced assuming the unit cost is the same as for the periods January 2024 through March 2024. Attachment 4 includes additional information regarding the application of the AMP-Cap removal adjustment factor.

Latuda Preferred Drug List Change

Effective January 25, 2024, the brand drug Latuda changed from preferred to non-preferred status. Utilization shifted from the higher gross cost brand name Latuda to the lower gross cost generic equivalent. Attachment 4 includes additional information regarding the application of the Latuda PDL change adjustment factor.

Hepatitis C Carve-In Adjustment

HHSC currently excludes Hepatitis C Direct Acting Antiviral (DAA) 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 Hepatitis C DAA drugs. Effective September 1, 2024, Hepatitis C DAA drugs will be carved-in and added to capitated services. Attachment 4 includes additional information regarding the application of the Hepatitis C carve-in adjustment factor.

NEMT Adjustment

Effective January 1, 2024, reimbursement for Individual Transportation Participant (ITP) service increased to $0.67 per mile. The base period claims cost for ITP service has been adjusted to reflect this change. Attachment 4 includes additional information regarding the application of the ITP adjustment factor.

Public Health Emergency (PHE) Related Cost Adjustment

Beginning in March 2020 and continuing into 2023, the PHE had a significant impact on average STAR Health expenditures and enrollment. Average enrollment during the FY2023 base period is twice as large as the expected enrollment during the FY2025 rating period. The PHE officially ended May 11, 2023 and the PHE unwind process has begun with disenrollments in the STAR Health program beginning in October 2023. The majority of STAR Health disenrollment occurred during the last three months of 2023 and the entire unwinding process will be complete prior to September 1, 2024. Given the significant disenrollment in the STAR Health program, the average cost during the FY2025 rating period will increase significantly as the disenrollment process has disproportionally impacted the lower cost members. A rate adjustment was calculated in order to estimate the impact of the PHE unwinding process and the associated disenrollment on average cost in FY2025. Attachment 5 presents a summary of the derivation of this adjustment factor.

Service Coordination

STAR Health members and their families receive help with coordinating care. The MCO provides

service coordination which requires the MCO to work with the member, the member's family and the member's doctors and other providers to help the member get the medical care and long-term services and supports they need. The service coordinators partner with health care providers and the members' families to ensure care is holistically integrated and coordinated. They find ways to avoid preventable hospital admissions, readmissions, and emergency room visits, resulting in shared savings to benefit both the providers and MCO, and most importantly the members themselves. Service coordination expenses were included in the rate development based on the amounts reported by the MCO in their audited FSRs along with information from HHSC and the MCO regarding increased requirements effective September 1, 2023. The enhanced service coordination requirements will be most comparable to the STAR Kids service coordination model which is expected to significantly increase the service coordination expense for the STAR Health program. The service coordination expense included in the FY2025 STAR Health rate development is $100.00 per member per month.

Community First Choice Initiative

Effective June 1, 2015, Texas began providing CFC services to individuals who:

- have a physical or intellectual disability,
- meet categorical coverage requirements for Medicaid or meet financial eligibility for home and community-based services, and
- meet an institutional level of care.

The CFC services include:

- Help with activities of daily living and health-related tasks through hands-on assistance, supervision or cueing.
- Services to help the individual learn how to care for themselves.
- Backup systems or ways to ensure continuity of services and supports.
- Training on how to select, manage and dismiss attendants.

As a result of CFC, Texas is eligible for an enhanced federal match rate on all CFC eligible services. The calculation of the CFC portion of the rate is detailed in Attachment 6.

COVID-19

COVID-19 and the associated Public Health Emergency (PHE) have had an unprecedented impact on the historical enrollment and claims data beginning March 2020 and continuing through the FY2023 base period. Significant enrollment growth has resulted in reductions in average cost which vary by program and risk group. During FY2020 through FY2023, HHSC addressed the additional risk associated with the PHE with multiple approaches including paying COVID-19 related expenditures on a non-risk basis, adjusting the base period used in rate development and revising the experience rebate structure.

With the expiration of the PHE on May 11, 2023 and the commencement of the PHE unwinding

process, the Medicaid programs are returning to enrollment and average cost patterns that are in line with historical pre-PHE norms. In our opinion, the pre-PHE base period, March 2019 through February 2020, which was used for the FY2022 and FY2023 rate developments is outdated for use in developing FY2025 rates. As a result, the base period has been updated to FY2023 which aligns with managed care regulations. Given that this data was during the latter stages of the PHE, it must be adjusted to reflect the impact of the PHE unwinding process and the associated disenrollments. The PHE Related Cost adjustments described above and included in Attachment 5 have been developed based on an extensive review of program-specific data and information about the PHE unwinding process including disenrollment by member. The PHE-related cost adjustment is intended to adjust the base period for observed changes in the enrollment, acuity and average cost for each program.

Effective September 1, 2023, all COVID-19 related expenses for testing, treatments and vaccines transitioned to being covered under the capitation rate with no further non-risk payments. Given the historical information available regarding COVID-19 and the stabilization of the monthly cost patterns, we believe the FY2023 base period data is a reasonable basis for projecting future expenses. The FY2023 base period includes claims experience for all COVID-19 related expenses and no further adjustment is needed to account for the carve-in of COVID-19 related expenses. While we cannot predict future COVID-19 outbreaks or variants just like we cannot predict higher or lower than average flu seasons, we believe the FY2023 data demonstrates sufficient consistency to be an appropriate basis for rate development.

Given the adjustments to the base period, utilizing FY2023 data, and transitioning COVID-19 services into the capitation rate, HHSC reverted the experience rebate structure to its original structure effective September 1, 2023. No further changes are applicable to FY2025.

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%

V. Administrative Fees, Taxes and Risk Margin

The rating methodology includes an explicit provision for administrative services. The amount allocated for administrative expenses in the medical premium rate is $9.00 pmpm plus 5.25% of gross premium. The amount allocated for administrative expenses in the prescription drug premium rate is $1.60 pmpm. The amount allocated for administrative expenses in the NEMT premium rate is $0.175 pmpm plus 22% of gross premium. These amounts are intended to provide for all administrative-related services performed by the MCO.

The administrative fee amounts were determined based on a review of the administrative expenses of the MCO as reported in their audited Financial Statistical Reports (FSRs). The table below summarizes the reported administrative expenses for the past five fiscal years for the STAR Health program. The table includes actual reported expenses along with estimated inflation adjusted expenses.

	Administrative Expense less Service Coordination			
	Actual	Actual - Enrollment Adjusted	Average Annual ECI	Inflation Adjusted
FY2020	50.77	61.62	4.0%	74.83
FY2021	53.94	76.01	3.9%	88.66
FY2022	54.18	80.00	3.5%	88.70
FY2023	53.14	80.48	3.1%	85.55
FY2024	57.56	64.96	2.1%	66.33
Average				
FY20-FY24	53.92	72.61		80.81
FY20-FY23	53.36	78.83		87.64

The actual administrative expenses reported by year were adjusted for the significant change in enrollment by assuming that 50% of the actual administrative cost is fixed and the remainder is variable and will change with the enrollment. The significant decline in enrollment will lead to an increase in the average cost of the fixed component of the administrative cost while the variable component will remain unchanged. In addition, the enrollment adjusted average administrative expense was adjusted for inflation by applying the annual growth in the Employee Cost Index (ECI) as reported by the US Bureau of Labor and Statistics. Based on this analysis, the expected range of administrative costs for FY2025 was deemed to be $80-90.

Based on the administrative fee formula included in the rate development, the average administrative expense included in the capitation rate (medical, pharmacy and NEMT components combined) is $88.16 which is in line with the range of historical average cost excluding service coordination. The FY2024 average administrative cost appears to be an outlier and is attributable to the significant changes in enrollment in the STAR Health program during a portion of the year.

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. For informational purposes,

the $9 fixed component of the medical administrative expense formula breaks down into two categories:

- Quality Improvement - $2.00
- General Administration - $7.00

The quality improvement amount is in addition to the service coordination expenses noted on pages 11 and 12 and includes services such as disease management, health information technology and wellness service among other items.

The premium rate also includes provisions for premium tax (1.75% of premium), maintenance tax ($0.071 pmpm) and a risk margin (1.5% of premium). The premium tax and maintenance tax are based on Texas Department of Insurance requirements.

VI. Summary

The FY2025 total premium rate for the STAR Health program is $1,556.08 per member per month. The total premium rate is made up of the total medical component of $1,458.89, the prescription drug component of $93.58 and the NEMT component of $3.61. This rate will be effective for the period September 1, 2024 through August 31, 2025. Attachment 1 shows the derivation of the premium rate for each component.

A single rate cell or risk group has been deemed appropriate for STAR Health because the program is served by a single managed care plan and the overall demographics of the program have not varied significantly from year to year with the exception of the recent PHE. Any normal changes in the acuity of the population are captured in the trend assumption as these ongoing changes are reflected in the historical claims experience which is used to develop the rating trend assumptions. Further changes in the acuity have been captured in the PHE Related Cost Adjustment factor described in Attachment 5.

As noted in Section IV, Texas is eligible for an enhanced match rate for CFC services. CFC services of $3.05 pmpm are a component of the total rate. Further information regarding the calculation of this amount can be found in Attachment 6.

The implied medical loss ratio based on the FY2025 rate development and assumptions detailed in this report is 91% which exceeds the 85% minimum as required per 42 CFR 438.4(b)(9). The premium rates have been calculated such that they are adequate to cover all reasonable expenses projected under the STAR Health program for FY2025.

The medical loss ratios have varied significantly in recent years due to the unprecedented volatility associated with the PHE and the unwinding process. The medical loss ratio for FY2023 was 63% due to the unexpected continuation of the PHE and the large enrollment growth experienced in the STAR Health program. Through the first six months of FY2024 the medical loss ratio has increased to 92% due to the large number of disenrollments and the significant increase in average cost. The medical loss ratio is expected to continue increasing throughout the remainder of FY2024. While the FY2025 rates are not calculated based solely on the loss ratios of prior years, they have been calculated based on the actual expenditures that generated these loss ratios adjusted for expected changes in enrollment, reimbursement and program policy.

VII. Actuarial Certification of FY2025 STAR Health Premium Rate

We, Evan L. Dial, Dustin J. Kim, Khiem D. Ngo and David G. Wilkes are with the firm Rudd and Wisdom, Inc., Consulting Actuaries. All are Fellows of the Society of Actuaries (FSAs), members of the American Academy of Actuaries and 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, 2024 through August 31, 2025 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 Health premium rate developed by HHSC and Rudd and Wisdom satisfies the following:

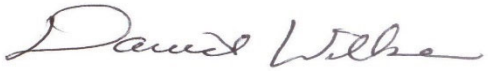
(a) The premium rate has been developed in accordance with generally accepted actuarial principles and practices;
(b) The premium rate is appropriate for the populations and services covered under the managed care contract; and
(c) The premium is actuarially sound as defined in the regulations.

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.

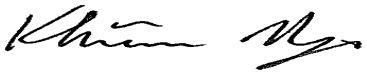
The assumptions, methodologies and factors used in developing the certified capitation rates are based on valid rate development standards and represent actual cost differences in providing covered services to the covered populations, and these differences do not vary with the rate of FFP associated with the covered populations. All rates have been developed based on the actual managed care experience of the covered populations. Any services subject to varying FFP have been separately identified and documented throughout this report.

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.

Dustin J. Kim, F.S.A., M.A.A.A.

VIII. Attachments

Attachment 1

Summary of FY2025 STAR Health Rating Analysis

Exhibit A presents summary information regarding the FY2025 STAR Health medical rate development. Included on the exhibit are base period (FY2023) experience, projected FY2025 enrollment, trend and provider reimbursement adjustment factors, assumed capitation rates, reinsurance and administrative costs.

The actuarial model used to derive the FY2025 STAR Health premium rate relies primarily on historical MCO 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 FY2025 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 FY2025 cost under the plan.

Reinsurance is provided through an affiliate of Superior. Therefore, the net cost of reinsurance has been set at $0.00. Any reinsurance premium paid to this affiliated provider is assumed to be offset by reinsurance recoveries.

Exhibit B presents summary information regarding the FY2025 STAR Health prescription drug rate development. Included on the exhibit are base period (FY2023) experience, projected FY2025 enrollment, trend and provider reimbursement adjustment factors and administrative costs.

Exhibit C presents summary information regarding the FY2025 STAR Health NEMT rate development. Included on the exhibit are base period (FY2023) experience, projected FY2025 enrollment, trend and provider reimbursement adjustment factors and administrative costs.

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

Exhibit D presents a comparison of the projected expenditures under the current (FY2024) premium rates and the FY2025 premium rates. The projection is split by medical, pharmacy and NEMT.

The primary cost driver behind the rate increase is the significant change in enrollment beginning October 2023 and the resulting impact on the overall acuity of the STAR Health population. Average enrollment has decreased by over 50% resulting in a significant increase in the average cost for the remaining members as evident by the large PHE-related cost adjustment detailed in Attachment 5.

FY2025 STAR Health Rating Analysis
Rate Development for the STAR Health Program - Medical

	Rating Period FY2025 Total	PMPM
Base Period Used in Rating	FY2023	
Base Period Experience		
Member Months	564,402	
Estimated Incurred Claims	304,085,228	538.77
Projected FY2025 Rating Period Experience		
Member Months	278,162	
Assumed Annual Trend Rate		7.70 %
Provider Reimbursement Adjustment		-0.10 %
Hospital Reimbursement Adjustment		0.01 %
PHE Related Cost Adjustment		87.83 %
Projected Incurred Claims	326,219,721	1,172.77
Capitation Expenses		
Dental Services	11,602,146	41.71
PCP	0	0.00
Settlements and Miscellaneous Expenses	3,154,360	11.34
Total	14,756,506	53.05
Service Coordination	27,816,223	100.00
Reinsurance Expenses		
Gross Premium	0	0.00
Projected Reinsurance Recoveries	0	0.00
Net Reinsurance Cost	0	0.00
Administrative Expenses		
Fixed Amount	2,503,460	9.00
Percentage of Premium	21,304,925	5.25 %
Total	23,808,385	85.59
Premium Tax	7,101,642	1.75 %
Maintenance Tax pmpm	19,703	0.07
Risk Margin	6,087,121	1.50 %
Projected Premium	405,808,089	$ 1,458.89

FY2025 STAR Health Rating Analysis
Rate Development for the STAR Health Program - Prescription Drug

	Rating Period FY2025 Total	PMPM
Base Period Used in Rating	FY2023	
Base Period Experience		
Member Months	564,402	
Estimated Incurred Claims	34,798,469	61.66
Other Costs/Refunds	-22,576	-0.04
Total Cost	34,775,893	61.62
Projected FY2025 Rating Period Experience		
Member Months	278,162	
Assumed Annual Trend Rate		1.60 %
PHE Related Cost Adjustment		49.18 %
Insulin Price Adjustment		-0.94 %
Makena Adjustment		-0.01 %
Latuda Adjustments		-5.01 %
Hep C carve-in		0.07 %
AMP-Cap Removal Adjustment		-0.44 %
Projected Incurred Claims	24,740,444	88.94
Administrative Expenses	445,060	1.60
Premium Tax	455,532	1.75 %
Risk Margin	390,456	1.50 %
Projected Premium	26,030,421	$ 93.58

FY2025 STAR Health Rating Analysis
Rate Development for the STAR Health Program - NEMT

	Rating Period FY2025 Total	PMPM
Base Period Used in Rating	FY2023	
Base Period Experience		
Member Months	564,402	
Estimated Incurred Claims	699,522	1.24
Projected FY2025 Rating Period Experience		
Member Months	278,162	
Assumed Annual Trend Rate		3.30 %
PHE Related Cost Adjustment		87.83 %
Mileage Reimbursement Adjustment		1.70 %
Projected Incurred Claims	702,745	2.53
Administrative Expenses		
Fixed Amount	48,678	0.175
Percentage of Premium	220,916	22.00%
Total	269,595	0.97
Premium Tax	17,573	1.75 %
Risk Margin	15,062	1.50 %
Projected Premium	1,004,166	$ 3.61

FY2025 STAR Health Rating Analysis

	Projected PMPM		Projected FY2025 Premium		
	Current Rates	FY2025 Rates	Current Rates	FY2025 Rates	% Rate Change
Medical	1,076.02	1,458.89	299,308,118	405,808,089	35.6%
Pharmacy	90.85	93.58	25,271,038	26,030,421	3.0%
NEMT	2.36	3.61	656,463	1,004,166	53.0%
Total	1,169.23	1,556.08	325,235,619	432,842,676	33.1%

Attachment 2

STAR Health Incurred Claims Experience

The attached exhibit presents a summary of STAR Health incurred claims experience by type of service during the base period used in the rate setting analysis. For each month during the experience period the exhibits show enrollment, claims incurred during the month and paid through March 31, 2024 and estimated incurred claims.

FY2025 STAR Health Rating Analysis
Estimated STAR Health Incurred Claims

Month	Number of Members	Professional Claims Incurred and Paid	Completion Factor	Estimated Incurred Claims	Estimated Incurred pmpm	Trend Factor
Sep-20	37,527	8,214,035	1.0000	8,214,035	218.88	
Oct-20	38,684	8,340,884	1.0000	8,340,884	215.62	
Nov-20	39,718	7,630,349	1.0000	7,630,349	192.11	
Dec-20	40,633	7,942,850	1.0000	7,942,850	195.48	
Jan-21	41,538	7,992,185	1.0000	7,992,185	192.41	
Feb-21	42,375	6,981,523	1.0000	6,981,523	164.76	
Mar-21	43,222	9,044,353	1.0000	9,044,353	209.25	
Apr-21	43,343	8,720,545	1.0000	8,720,545	201.20	
May-21	43,881	8,271,210	1.0000	8,271,210	188.49	
Jun-21	44,478	8,545,295	1.0000	8,545,295	192.12	
Jul-21	44,902	8,386,541	1.0000	8,386,541	186.77	
Aug-21	45,414	8,461,058	1.0000	8,461,058	186.31	
Sep-21	45,610	8,416,591	1.0000	8,416,591	184.53	0.843
Oct-21	45,531	8,283,895	1.0000	8,283,895	181.94	0.844
Nov-21	44,932	7,704,794	1.0000	7,704,794	171.48	0.893
Dec-21	44,852	7,421,275	1.0000	7,421,275	165.46	0.846
Jan-22	44,830	7,501,756	1.0000	7,501,756	167.34	0.870
Feb-22	44,873	7,177,543	1.0000	7,177,543	159.95	0.971
Mar-22	44,977	8,398,130	1.0000	8,398,130	186.72	0.892
Apr-22	45,235	7,911,497	1.0000	7,911,497	174.90	0.869
May-22	45,468	7,863,178	1.0000	7,863,178	172.94	0.917
Jun-22	45,627	7,801,658	1.0000	7,801,658	170.99	0.890
Jul-22	45,729	7,153,685	1.0000	7,153,685	156.44	0.838
Aug-22	45,552	8,158,134	1.0000	8,158,134	179.09	0.961
Sep-22	46,340	7,858,904	1.0000	7,858,904	169.59	0.919
Oct-22	46,576	7,838,948	1.0000	7,838,948	168.30	0.925
Nov-22	46,742	7,416,489	1.0000	7,416,489	158.67	0.925
Dec-22	46,864	7,034,896	1.0000	7,034,896	150.11	0.907
Jan-23	46,730	7,640,689	1.0000	7,640,689	163.51	0.977
Feb-23	46,738	7,242,695	1.0000	7,242,695	154.96	0.969
Mar-23	46,901	8,037,383	1.0000	8,037,383	171.37	0.918
Apr-23	47,227	7,309,963	1.0000	7,309,963	154.78	0.885
May-23	47,511	7,897,429	1.0000	7,897,429	166.22	0.961
Jun-23	47,548	7,536,686	1.0000	7,536,686	158.51	0.927
Jul-23	47,621	7,227,570	1.0000	7,227,570	151.77	0.970
Aug-23	47,604	7,993,526	1.0000	7,993,526	167.92	0.938
FY2021	505,715			98,530,828	194.83	
FY2022	543,216			93,792,136	172.66	0.886
FY2023	564,402			91,035,178	161.29	0.934

FY2025 STAR Health Rating Analysis
Estimated STAR Health Incurred Claims

		Emergency Room				
Month	Number of Members	Claims Incurred and Paid	Completion Factor	Estimated Incurred Claims	Estimated Incurred pmpm	Trend Factor
Sep-20	37,527	553,430	1.0000	553,430	14.75	
Oct-20	38,684	634,421	1.0000	634,421	16.40	
Nov-20	39,718	617,806	1.0000	617,806	15.55	
Dec-20	40,633	594,244	1.0000	594,244	14.62	
Jan-21	41,538	612,535	1.0000	612,535	14.75	
Feb-21	42,375	520,057	1.0000	520,057	12.27	
Mar-21	43,222	696,633	1.0000	696,633	16.12	
Apr-21	43,343	800,758	1.0000	800,758	18.47	
May-21	43,881	863,310	1.0000	863,310	19.67	
Jun-21	44,478	798,859	1.0000	798,859	17.96	
Jul-21	44,902	833,712	1.0000	833,712	18.57	
Aug-21	45,414	801,478	1.0000	801,478	17.65	
Sep-21	45,610	873,449	1.0000	873,449	19.15	1.299
Oct-21	45,531	867,573	1.0000	867,573	19.05	1.162
Nov-21	44,932	887,407	1.0000	887,407	19.75	1.270
Dec-21	44,852	826,382	1.0000	826,382	18.42	1.260
Jan-22	44,830	773,049	1.0000	773,049	17.24	1.169
Feb-22	44,873	687,722	1.0000	687,722	15.33	1.249
Mar-22	44,977	818,593	1.0000	818,593	18.20	1.129
Apr-22	45,235	805,631	1.0000	805,631	17.81	0.964
May-22	45,468	860,883	1.0000	860,883	18.93	0.962
Jun-22	45,627	725,449	1.0000	725,449	15.90	0.885
Jul-22	45,729	812,074	1.0000	812,074	17.76	0.956
Aug-22	45,552	911,351	1.0000	911,351	20.01	1.134
Sep-22	46,340	1,040,955	1.0000	1,040,955	22.46	1.173
Oct-22	46,576	1,088,509	1.0000	1,088,509	23.37	1.227
Nov-22	46,742	1,077,800	1.0000	1,077,800	23.06	1.168
Dec-22	46,864	918,724	1.0000	918,724	19.60	1.064
Jan-23	46,730	885,199	1.0000	885,199	18.94	1.099
Feb-23	46,738	787,356	1.0000	787,356	16.85	1.099
Mar-23	46,901	908,111	1.0000	908,111	19.36	1.064
Apr-23	47,227	964,009	1.0000	964,009	20.41	1.146
May-23	47,511	1,066,276	1.0000	1,066,276	22.44	1.185
Jun-23	47,548	813,691	1.0000	813,691	17.11	1.076
Jul-23	47,621	869,859	1.0000	869,859	18.27	1.029
Aug-23	47,604	1,008,554	1.0000	1,008,554	21.19	1.059
FY2021	505,715			8,327,243	16.47	
FY2022	543,216			9,849,563	18.13	1.101
FY2023	564,402			11,429,044	20.25	1.117

FY2025 STAR Health Rating Analysis
Estimated STAR Health Incurred Claims

Month	Number of Members	Outpatient Claims Incurred and Paid	Outpatient Completion Factor	Outpatient Estimated Incurred Claims	Outpatient Estimated Incurred pmpm	Outpatient Trend Factor
Sep-20	37,527	1,424,160	1.0000	1,424,160	37.95	
Oct-20	38,684	1,458,219	1.0000	1,458,219	37.70	
Nov-20	39,718	1,245,354	1.0000	1,245,354	31.35	
Dec-20	40,633	1,287,307	1.0000	1,287,307	31.68	
Jan-21	41,538	1,426,075	1.0000	1,426,075	34.33	
Feb-21	42,375	1,189,564	1.0000	1,189,564	28.07	
Mar-21	43,222	1,741,523	1.0000	1,741,523	40.29	
Apr-21	43,343	1,648,169	1.0000	1,648,169	38.03	
May-21	43,881	1,490,552	1.0000	1,490,552	33.97	
Jun-21	44,478	1,629,917	1.0000	1,629,917	36.65	
Jul-21	44,902	1,576,652	1.0000	1,576,652	35.11	
Aug-21	45,414	1,518,512	1.0000	1,518,512	33.44	
Sep-21	45,610	1,546,399	1.0000	1,546,399	33.90	0.893
Oct-21	45,531	1,612,035	1.0000	1,612,035	35.41	0.939
Nov-21	44,932	1,434,431	1.0000	1,434,431	31.92	1.018
Dec-21	44,852	1,555,201	1.0000	1,555,201	34.67	1.094
Jan-22	44,830	1,458,264	1.0000	1,458,264	32.53	0.947
Feb-22	44,873	1,333,537	1.0000	1,333,537	29.72	1.059
Mar-22	44,977	1,627,766	1.0000	1,627,766	36.19	0.898
Apr-22	45,235	1,416,069	1.0000	1,416,069	31.30	0.823
May-22	45,468	1,409,087	1.0000	1,409,087	30.99	0.912
Jun-22	45,627	1,512,567	1.0000	1,512,567	33.15	0.905
Jul-22	45,729	1,529,281	1.0000	1,529,281	33.44	0.952
Aug-22	45,552	1,749,267	1.0000	1,749,267	38.40	1.148
Sep-22	46,340	1,628,068	1.0000	1,628,068	35.13	1.036
Oct-22	46,576	1,486,902	1.0000	1,486,902	31.92	0.902
Nov-22	46,742	1,441,024	1.0000	1,441,024	30.83	0.966
Dec-22	46,864	1,398,939	1.0000	1,398,939	29.85	0.861
Jan-23	46,730	1,608,807	1.0000	1,608,807	34.43	1.058
Feb-23	46,738	1,553,043	1.0000	1,553,043	33.23	1.118
Mar-23	46,901	1,852,551	1.0000	1,852,551	39.50	1.091
Apr-23	47,227	1,823,556	1.0000	1,823,556	38.61	1.233
May-23	47,511	1,908,849	1.0000	1,908,849	40.18	1.296
Jun-23	47,548	1,957,574	1.0000	1,957,574	41.17	1.242
Jul-23	47,621	1,809,493	1.0000	1,809,493	38.00	1.136
Aug-23	47,604	2,242,856	1.0000	2,242,856	47.11	1.227
FY2021	505,715			17,636,005	34.87	
FY2022	543,216			18,183,905	33.47	0.960
FY2023	564,402			20,711,662	36.70	1.096

FY2025 STAR Health Rating Analysis
Estimated STAR Health Incurred Claims

Month	Number of Members	Inpatient Claims Incurred and Paid	Completion Factor	Estimated Incurred Claims	Estimated Incurred pmpm	Trend Factor
Sep-20	37,527	5,051,490	1.0000	5,051,490	134.61	
Oct-20	38,684	5,719,705	1.0000	5,719,705	147.86	
Nov-20	39,718	6,310,210	1.0000	6,310,210	158.88	
Dec-20	40,633	7,887,436	1.0000	7,887,436	194.11	
Jan-21	41,538	5,048,222	1.0000	5,048,222	121.53	
Feb-21	42,375	5,430,534	1.0000	5,430,534	128.15	
Mar-21	43,222	6,775,824	1.0000	6,775,824	156.77	
Apr-21	43,343	5,108,038	1.0000	5,108,038	117.85	
May-21	43,881	7,143,403	1.0000	7,143,403	162.79	
Jun-21	44,478	6,567,045	1.0000	6,567,045	147.65	
Jul-21	44,902	7,133,077	1.0000	7,133,077	158.86	
Aug-21	45,414	5,949,866	1.0000	5,949,866	131.01	
Sep-21	45,610	5,767,513	1.0000	5,767,513	126.45	0.939
Oct-21	45,531	6,366,066	1.0000	6,366,066	139.82	0.946
Nov-21	44,932	5,609,613	1.0000	5,609,613	124.85	0.786
Dec-21	44,852	5,373,936	1.0000	5,373,936	119.81	0.617
Jan-22	44,830	5,702,338	1.0000	5,702,338	127.20	1.047
Feb-22	44,873	4,886,492	1.0000	4,886,492	108.90	0.850
Mar-22	44,977	5,581,626	1.0000	5,581,626	124.10	0.792
Apr-22	45,235	5,903,718	1.0000	5,903,718	130.51	1.107
May-22	45,468	5,713,483	1.0000	5,713,483	125.66	0.772
Jun-22	45,627	5,461,195	1.0000	5,461,195	119.69	0.811
Jul-22	45,729	4,679,936	1.0000	4,679,936	102.34	0.644
Aug-22	45,552	4,939,944	1.0000	4,939,944	108.45	0.828
Sep-22	46,340	6,083,240	1.0000	6,083,240	131.27	1.038
Oct-22	46,576	6,179,055	1.0000	6,179,055	132.67	0.949
Nov-22	46,742	6,083,053	1.0000	6,083,053	130.14	1.042
Dec-22	46,864	4,391,821	1.0000	4,391,821	93.71	0.782
Jan-23	46,730	5,754,399	1.0000	5,754,399	123.14	0.968
Feb-23	46,738	5,062,116	1.0000	5,062,116	108.31	0.995
Mar-23	46,901	6,564,716	1.0000	6,564,716	139.97	1.128
Apr-23	47,227	4,496,229	1.0000	4,496,229	95.20	0.729
May-23	47,511	4,549,513	1.0000	4,549,513	95.76	0.762
Jun-23	47,548	4,442,317	1.0000	4,442,317	93.43	0.781
Jul-23	47,621	3,942,024	1.0000	3,942,024	82.78	0.809
Aug-23	47,604	4,923,780	1.0000	4,923,780	103.43	0.954
FY2021	505,715			74,124,850	146.57	
FY2022	543,216			65,985,862	121.47	0.829
FY2023	564,402			62,472,264	110.69	0.911

FY2025 STAR Health Rating Analysis
Estimated STAR Health Incurred Claims

		Vision				
Month	Number of Members	Claims Incurred and Paid	Completion Factor	Estimated Incurred Claims	Estimated Incurred pmpm	Trend Factor
Sep-20	37,527	102,858	1.0000	102,858	2.74	
Oct-20	38,684	90,604	1.0000	90,604	2.34	
Nov-20	39,718	90,304	1.0000	90,304	2.27	
Dec-20	40,633	76,536	1.0000	76,536	1.88	
Jan-21	41,538	86,465	1.0000	86,465	2.08	
Feb-21	42,375	70,253	1.0000	70,253	1.66	
Mar-21	43,222	106,387	1.0000	106,387	2.46	
Apr-21	43,343	80,792	1.0000	80,792	1.86	
May-21	43,881	76,393	1.0000	76,393	1.74	
Jun-21	44,478	81,102	1.0000	81,102	1.82	
Jul-21	44,902	86,809	1.0000	86,809	1.93	
Aug-21	45,414	95,519	1.0000	95,519	2.10	
Sep-21	45,610	83,592	1.0000	83,592	1.83	0.669
Oct-21	45,531	89,616	1.0000	89,616	1.97	0.840
Nov-21	44,932	81,562	1.0000	81,562	1.82	0.798
Dec-21	44,852	70,915	1.0000	70,915	1.58	0.839
Jan-22	44,830	70,385	1.0000	70,385	1.57	0.754
Feb-22	44,873	70,846	1.0000	70,846	1.58	0.952
Mar-22	44,977	95,118	1.0000	95,118	2.11	0.859
Apr-22	45,235	75,456	1.0000	75,456	1.67	0.895
May-22	45,468	67,263	1.0000	67,263	1.48	0.850
Jun-22	45,627	72,528	1.0000	72,528	1.59	0.872
Jul-22	45,729	73,105	1.0000	73,105	1.60	0.827
Aug-22	45,552	90,749	1.0000	90,749	1.99	0.947
Sep-22	46,340	91,681	1.0000	91,681	1.98	1.079
Oct-22	46,576	92,830	1.0000	92,830	1.99	1.013
Nov-22	46,742	88,238	1.0000	88,238	1.89	1.040
Dec-22	46,864	79,550	1.0000	79,550	1.70	1.074
Jan-23	46,730	91,134	1.0000	91,134	1.95	1.242
Feb-23	46,738	87,068	1.0000	87,068	1.86	1.180
Mar-23	46,901	94,355	1.0000	94,355	2.01	0.951
Apr-23	47,227	78,327	1.0000	78,327	1.66	0.994
May-23	47,511	95,518	1.0000	95,518	2.01	1.359
Jun-23	47,548	88,869	1.0000	88,869	1.87	1.176
Jul-23	47,621	93,119	1.0000	93,119	1.96	1.223
Aug-23	47,604	130,263	1.0000	130,263	2.74	1.374
FY2021	505,715			1,044,022	2.06	
FY2022	543,216			941,134	1.73	0.839
FY2023	564,402			1,110,951	1.97	1.136

FY2025 STAR Health Rating Analysis
Estimated STAR Health Incurred Claims

		Other - PDN, DME, Therapy				
Month	Number of Members	Claims Incurred and Paid	Completion Factor	Estimated Incurred Claims	Estimated Incurred pmpm	Trend Factor
Sep-20	37,527	8,845,259	1.0000	8,845,259	235.70	
Oct-20	38,684	9,335,528	1.0000	9,335,528	241.33	
Nov-20	39,718	8,708,769	1.0000	8,708,769	219.27	
Dec-20	40,633	9,164,688	1.0000	9,164,688	225.55	
Jan-21	41,538	8,951,244	1.0000	8,951,244	215.50	
Feb-21	42,375	7,817,124	1.0000	7,817,124	184.47	
Mar-21	43,222	9,422,076	1.0000	9,422,076	217.99	
Apr-21	43,343	9,025,815	1.0000	9,025,815	208.24	
May-21	43,881	9,058,202	1.0000	9,058,202	206.43	
Jun-21	44,478	9,247,737	1.0000	9,247,737	207.92	
Jul-21	44,902	9,475,139	1.0000	9,475,139	211.02	
Aug-21	45,414	9,159,681	1.0000	9,159,681	201.69	
Sep-21	45,610	9,000,884	1.0000	9,000,884	197.34	0.837
Oct-21	45,531	9,181,192	1.0000	9,181,192	201.65	0.836
Nov-21	44,932	8,965,097	1.0000	8,965,097	199.53	0.910
Dec-21	44,852	8,882,003	1.0000	8,882,003	198.03	0.878
Jan-22	44,830	8,380,730	1.0000	8,380,730	186.94	0.868
Feb-22	44,873	7,999,277	1.0000	7,999,277	178.26	0.966
Mar-22	44,977	9,217,816	1.0000	9,217,816	204.95	0.940
Apr-22	45,235	8,799,597	1.0000	8,799,597	194.53	0.934
May-22	45,468	9,252,942	1.0000	9,252,942	203.50	0.986
Jun-22	45,627	9,340,313	1.0000	9,340,313	204.71	0.985
Jul-22	45,729	9,625,388	1.0000	9,625,388	210.49	0.997
Aug-22	45,552	9,661,407	1.0000	9,661,407	212.10	1.052
Sep-22	46,340	9,331,172	1.0000	9,331,172	201.36	1.020
Oct-22	46,576	9,684,968	1.0000	9,684,968	207.94	1.031
Nov-22	46,742	9,476,793	1.0000	9,476,793	202.75	1.016
Dec-22	46,864	9,376,012	1.0000	9,376,012	200.07	1.010
Jan-23	46,730	9,444,467	1.0000	9,444,467	202.11	1.081
Feb-23	46,738	8,790,805	1.0000	8,790,805	188.09	1.055
Mar-23	46,901	9,826,856	1.0000	9,826,856	209.52	1.022
Apr-23	47,227	9,533,123	1.0000	9,533,123	201.86	1.038
May-23	47,511	10,203,060	1.0000	10,203,060	214.75	1.055
Jun-23	47,548	10,005,896	1.0000	10,005,896	210.44	1.028
Jul-23	47,621	10,355,802	1.0000	10,355,802	217.46	1.033
Aug-23	47,604	11,297,174	1.0000	11,297,174	237.32	1.119
FY2021	505,715			108,211,261	213.98	
FY2022	543,216			108,306,645	199.38	0.932
FY2023	564,402			117,326,128	207.88	1.043

FY2025 STAR Health Rating Analysis
Estimated STAR Health Incurred Claims

		Total - Medical				
Month	Number of Members	Claims Incurred and Paid	Completion Factor	Estimated Incurred Claims	Estimated Incurred pmpm	Trend Factor
Sep-20	37,527	24,191,232	1.0000	24,191,232	644.64	
Oct-20	38,684	25,579,360	1.0000	25,579,360	661.24	
Nov-20	39,718	24,602,792	1.0000	24,602,792	619.44	
Dec-20	40,633	26,953,061	1.0000	26,953,061	663.33	
Jan-21	41,538	24,116,726	1.0000	24,116,726	580.59	
Feb-21	42,375	22,009,056	1.0000	22,009,056	519.39	
Mar-21	43,222	27,786,796	1.0000	27,786,796	642.89	
Apr-21	43,343	25,384,118	1.0000	25,384,118	585.66	
May-21	43,881	26,903,071	1.0000	26,903,071	613.09	
Jun-21	44,478	26,869,954	1.0000	26,869,954	604.12	
Jul-21	44,902	27,491,930	1.0000	27,491,930	612.27	
Aug-21	45,414	25,986,114	1.0000	25,986,114	572.20	
Sep-21	45,610	25,688,427	1.0000	25,688,427	563.22	0.874
Oct-21	45,531	26,400,377	1.0000	26,400,377	579.83	0.877
Nov-21	44,932	24,682,904	1.0000	24,682,904	549.34	0.887
Dec-21	44,852	24,129,712	1.0000	24,129,712	537.99	0.811
Jan-22	44,830	23,886,523	1.0000	23,886,523	532.82	0.918
Feb-22	44,873	22,155,419	1.0000	22,155,419	493.74	0.951
Mar-22	44,977	25,739,049	1.0000	25,739,049	572.27	0.890
Apr-22	45,235	24,911,968	1.0000	24,911,968	550.72	0.940
May-22	45,468	25,166,836	1.0000	25,166,836	553.51	0.903
Jun-22	45,627	24,913,710	1.0000	24,913,710	546.03	0.904
Jul-22	45,729	23,873,468	1.0000	23,873,468	522.06	0.853
Aug-22	45,552	25,510,851	1.0000	25,510,851	560.04	0.979
Sep-22	46,340	26,034,021	1.0000	26,034,021	561.80	0.997
Oct-22	46,576	26,371,212	1.0000	26,371,212	566.20	0.976
Nov-22	46,742	25,583,398	1.0000	25,583,398	547.33	0.996
Dec-22	46,864	23,199,942	1.0000	23,199,942	495.05	0.920
Jan-23	46,730	25,424,695	1.0000	25,424,695	544.08	1.021
Feb-23	46,738	23,523,082	1.0000	23,523,082	503.30	1.019
Mar-23	46,901	27,283,972	1.0000	27,283,972	581.74	1.017
Apr-23	47,227	24,205,207	1.0000	24,205,207	512.53	0.931
May-23	47,511	25,720,645	1.0000	25,720,645	541.36	0.978
Jun-23	47,548	24,845,031	1.0000	24,845,031	522.53	0.957
Jul-23	47,621	24,297,867	1.0000	24,297,867	510.23	0.977
Aug-23	47,604	27,596,154	1.0000	27,596,154	579.70	1.035
FY2021	505,715			307,874,209	608.79	
FY2022	543,216			297,059,244	546.85	0.898
FY2023	564,402			304,085,228	538.77	0.985

FY2025 STAR Health Rating Analysis
Estimated STAR Health Incurred Claims

		Prescription Drug				
Month	Number of Members	Claims Incurred and Paid	Completion Factor	Estimated Incurred Claims	Estimated Incurred pmpm	Trend Factor
Sep-20	37,527	2,662,333	1.0000	2,662,333	70.94	
Oct-20	38,684	2,705,869	1.0000	2,705,869	69.95	
Nov-20	39,718	2,672,237	1.0000	2,672,237	67.28	
Dec-20	40,633	2,926,640	1.0000	2,926,640	72.03	
Jan-21	41,538	2,887,002	1.0000	2,887,002	69.50	
Feb-21	42,375	2,605,745	1.0000	2,605,745	61.49	
Mar-21	43,222	3,003,162	1.0000	3,003,162	69.48	
Apr-21	43,343	2,793,628	1.0000	2,793,628	64.45	
May-21	43,881	2,584,044	1.0000	2,584,044	58.89	
Jun-21	44,478	2,966,693	1.0000	2,966,693	66.70	
Jul-21	44,902	2,681,701	1.0000	2,681,701	59.72	
Aug-21	45,414	2,924,913	1.0000	2,924,913	64.41	
Sep-21	45,610	3,010,077	1.0000	3,010,077	66.00	0.930
Oct-21	45,531	2,911,112	1.0000	2,911,112	63.94	0.914
Nov-21	44,932	3,059,228	1.0000	3,059,228	68.09	1.012
Dec-21	44,852	3,010,999	1.0000	3,010,999	67.13	0.932
Jan-22	44,830	3,119,296	1.0000	3,119,296	69.58	1.001
Feb-22	44,873	2,636,608	1.0000	2,636,608	58.76	0.956
Mar-22	44,977	2,903,309	1.0000	2,903,309	64.55	0.929
Apr-22	45,235	2,837,455	1.0000	2,837,455	62.73	0.973
May-22	45,468	2,738,792	1.0000	2,738,792	60.24	1.023
Jun-22	45,627	2,862,523	1.0000	2,862,523	62.74	0.941
Jul-22	45,729	2,708,972	1.0000	2,708,972	59.24	0.992
Aug-22	45,552	3,219,061	1.0000	3,219,061	70.67	1.097
Sep-22	46,340	3,165,260	1.0000	3,165,260	68.31	1.035
Oct-22	46,576	3,096,771	1.0000	3,096,771	66.49	1.040
Nov-22	46,742	2,805,481	1.0000	2,805,481	60.02	0.882
Dec-22	46,864	2,749,598	1.0000	2,749,599	58.67	0.874
Jan-23	46,730	3,007,318	1.0000	3,007,323	64.36	0.925
Feb-23	46,738	2,691,289	1.0000	2,691,290	57.58	0.980
Mar-23	46,901	3,046,436	1.0000	3,046,437	64.95	1.006
Apr-23	47,227	2,775,740	1.0000	2,775,740	58.77	0.937
May-23	47,511	2,985,260	1.0000	2,985,260	62.83	1.043
Jun-23	47,548	2,747,365	1.0000	2,747,365	57.78	0.921
Jul-23	47,621	2,742,795	1.0000	2,742,795	57.60	0.972
Aug-23	47,604	2,985,149	1.0000	2,985,149	62.71	0.887
FY2021	505,715			33,413,967	66.07	
FY2022	543,216			35,017,432	64.46	0.976
FY2023	564,402			34,798,469	61.66	0.956

FY2025 STAR Health Rating Analysis
Estimated STAR Health Incurred Claims

Month	Number of Members	NEMT Claims Incurred and Paid	NEMT Completion Factor	NEMT Estimated Incurred Claims	NEMT Estimated Incurred pmpm	NEMT Trend Factor
Sep-20	37,527	0	1.0000	0	-	
Oct-20	38,684	0	1.0000	0	-	
Nov-20	39,718	0	1.0000	0	-	
Dec-20	40,633	0	1.0000	0	-	
Jan-21	41,538	0	1.0000	0	-	
Feb-21	42,375	0	1.0000	0	-	
Mar-21	43,222	0	1.0000	0	-	
Apr-21	43,343	0	1.0000	0	-	
May-21	43,881	0	1.0000	0	-	
Jun-21	44,478	20,784	1.0000	20,784	0.47	
Jul-21	44,902	25,309	1.0000	25,309	0.56	
Aug-21	45,414	23,638	1.0000	23,638	0.52	
Sep-21	45,610	30,558	1.0000	30,558	0.67	
Oct-21	45,531	30,503	1.0000	30,503	0.67	
Nov-21	44,932	29,501	1.0000	29,501	0.66	
Dec-21	44,852	40,011	1.0000	40,011	0.89	
Jan-22	44,830	28,114	1.0000	28,114	0.63	
Feb-22	44,873	33,543	1.0000	33,543	0.75	
Mar-22	44,977	40,634	1.0000	40,634	0.90	
Apr-22	45,235	36,148	1.0000	36,148	0.80	
May-22	45,468	46,583	1.0000	46,583	1.02	
Jun-22	45,627	56,799	1.0000	56,799	1.24	
Jul-22	45,729	57,740	1.0000	57,740	1.26	
Aug-22	45,552	60,245	1.0000	60,245	1.32	
Sep-22	46,340	69,400	1.0000	69,400	1.50	
Oct-22	46,576	59,474	1.0000	59,474	1.28	
Nov-22	46,742	54,456	1.0000	54,456	1.17	
Dec-22	46,864	47,887	1.0000	47,887	1.02	
Jan-23	46,730	62,710	1.0000	62,710	1.34	
Feb-23	46,738	61,492	1.0000	61,492	1.32	
Mar-23	46,901	44,107	1.0000	44,107	0.94	
Apr-23	47,227	50,269	1.0000	50,269	1.06	
May-23	47,511	67,189	1.0000	67,189	1.41	
Jun-23	47,548	52,443	1.0000	52,443	1.10	0.886
Jul-23	47,621	58,704	1.0000	58,704	1.23	0.976
Aug-23	47,604	70,709	0.9905	71,389	1.50	1.134
FY2021	505,715			69,731	0.14	
FY2022	543,216			490,380	0.90	6.547
FY2023	564,402			699,522	1.24	1.373

Attachment 3

STAR Health Trend Analysis

Medical

The FY2025 rating methodology uses assumed medical trend factors to adjust the base period claims cost to the rating period (FY2025). 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 plan. The trend assumption is established on a statewide basis.

The trend analysis included a review of MCO claims experience data through March 31, 2024. Based on this information, estimates of monthly incurred claims were made through December 31, 2023. The claims cost and trend experience were reviewed separately by type of service.

Exhibit A provides a summary of the FY2018, FY2019 and FY2020 trends by category of service. The FY2020 trend represents the trend during the period September 2019 through February 2020. 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 FY2019 trend is calculated as the average cost per member per month during FY2019 divided by the average cost per member per month during FY2018.

All trends have been adjusted to remove the impact of the various provider reimbursement changes that have impacted the cost of 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, on September 1, 2019, the standard dollar amounts on which children's and rural hospital reimbursement is determined were revised resulting in a significant reimbursement increase for these facilities. As a result, the FY2020 observed trends are adjusted to remove the impact of the increased cost associated with these services to ensure the average cost during FY2019 and FY2020 are based on comparable services and reimbursement levels and the underlying trend is calculated.

Trends beyond February 2020 have been analyzed but excluded from the trend analysis due to the significant distortion caused by the COVID-19 pandemic, the corresponding PHE declaration and the PHE unwind process. From March 2020 to September 2023, enrollment increased by over 50% while the average cost dropped by over 30%. Beginning October 2023, enrollment has declined by 53% and average cost has increased by over 85%. These patterns are not expected to continue into FY2025 and therefore the trends for this time period have not been assigned any credibility.

The trend assumptions were then developed from an average of the FY2018, FY2019 and September 2019 through February 2020 STAR Health trends. The weighting of each time period was based on the number of months within each time period.

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 cost trend in future periods.

Prescription Drug

The rating methodology uses assumed pharmacy trend factors to adjust the base period (FY2023) claims cost to the rating period (FY2025). The trend rate assumptions were developed by the actuary based on an analysis of recent pharmacy claims experience for STAR Health clients. The trend rate assumption is the same for all clients and all service areas.

The trend analysis included a review of STAR Health utilization and cost experience data paid through March 31, 2024. Incurred monthly utilization (days supply per member) and cost per service (plan payments per days supply) statistics were developed through February 2024. From this experience, the average annual utilization and cost per service were determined for each of the six 12-month periods ending February 2024.

Due to the impact on healthcare utilization and cost from the COVID-19 pandemic and the PHE, experience after February 2020 was deemed unusable for purposes of developing trend projections. As a result, we have used the four 12-month periods ending February 2020 in our trend analysis in order to exclude pandemic-related experience.

Certain drugs and drug categories are excluded from the pharmacy trend analysis. Direct-acting antivirals (DAA) used for the treatment of the Hepatitis C virus and the drug Orkambi were carved into the managed care contract effective September 1, 2018, but they were excluded from the trend analysis due to their extraordinary one-time impact on trends. Please note that i) effective March 1, 2021, Hepatitis C DAAs were carved out of the managed care arrangement due to significant changes to the prior authorization criteria for these medications and ii) effective September 1, 2024, Hepatitis C DAAs will be carved back into managed care. In addition to these drugs, experience for the anti-viral and progestational agent drug classes was removed from our trend analysis. Anti-viral was removed due to the significant variation in the intensity of flu season from year to year. Progestational agent was removed due to its one-time distortion of pharmacy trends for pregnant women. Hemostatic agents were also excluded from the pharmacy trend analysis. Effective September 1, 2020, hemophilia medications were carved out of the managed care arrangement. Please note that while excluded from the pharmacy trend analysis, the historical managed care claims for all carve-in drugs were included in the base period experience used in

developing the pharmacy component of the rates.

The STAR Health pharmacy annual trend assumption was developed using the following formula. The utilization and unit cost trend assumptions were set equal to one-sixth of the experience trend rate for the 12-month period ending February 2018 plus two-sixths of the experience trend rate for the 12-month period ending February 2019 plus three-sixths of the experience trend rate for the 12-month period ending February 2020. The final cost trend assumptions were then determined by combining the assumed utilization and unit cost trends into a single trend assumption.

The preferred drug list (PDL) changes implemented in recent years have had a material impact on pharmacy cost per service trends. As a result, recent pharmacy experience trends will tend to understate the expected underlying trend. In order to correct for this understatement, we developed adjustment factors to restate pharmacy experience for the three most recent 12-month periods ending February 2020 assuming that the PDL changes had not been implemented. The PDL trend adjustment factors were developed by comparing i) the actual cost after the PDL change and ii) the expected cost had the PDL change not been implemented.

Attachment 3 – Exhibit B presents the resulting pharmacy trend assumptions used for the STAR Health program. We selected a prospective pharmacy trend assumption of 1.6% per annum.

Please note that the MCO was 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.

NEMT

The rating methodology uses assumed trend factors to adjust the base period claims cost to the projection period. The NEMT trend factors used in this analysis are a combination of utilization and inflation components. The NEMT trend factor was developed using a combination of (i) actual statewide NEMT trend experience for all Medicaid managed care programs and (ii) the industry trend from the Consumer Price Index published by the Bureau of Labor Statistics for transportation services.

Effective June 1, 2021, NEMT services were provided by the Medicaid MCOs. Prior to this, NEMT services were provided by the managed transportation organizations (MTOs) under a risk-based contract. Due to the impact on NEMT utilization and cost from the COVID-19 pandemic and the PHE, experience after February 2020 was deemed unusable for purposes of developing trend projections. As a result, we have used NEMT experience provided by the MTOs for the three most recent 12-month period trends ending February 2020 in our trend analysis in order to exclude pandemic-related experience.

Statewide NEMT trend experience for all Medicaid managed care programs was used due to small sample size. The NEMT trend analysis only includes demand response service. Mileage reimbursement service was excluded since reimbursement is equal to the state's mileage reimbursement rate. All other NEMT services such as airfare, meals and lodging are excluded from the trend analysis due to low volume and variation from year to year. In addition, experience for

MTO Region 1 and MTO Region 10 changed MTO provider effective September 1, 2017 and experience for these regions was excluded from the trend analysis. The statewide NEMT trend assumptions were developed using an average of the three most recent 12-month period trends ending February 2020.

The industry trends include inflation and utilization components. The inflation component of the trend was developed using average trends for the past 10 years from the Consumer Price Index published by the Bureau of Labor Statistics for transportation services. The utilization component of the trend was selected by the actuary.

The selected NEMT trend was developed using an average of the statewide NEMT trend and the industry trend. The annual trend assumption of 3.30% was used in the rating analysis to project historical experience forward to the rating period. Attachment 3 – Exhibit C presents a summary of the NEMT trend analysis.

FY2025 STAR Health Rating Analysis
Trend Development - Medical

Historical Average Trend (1)	Professional	Outpatient - ER	Outpatient - Non ER	Inpatient	Vision	Other	Total
FY2018	4.4%	7.6%	10.0%	8.2%	5.8%	3.5%	5.2%
FY2019	6.0%	2.0%	4.5%	10.0%	0.0%	15.6%	9.3%
9/2019-2/2020	7.6%	7.9%	9.2%	13.6%	-8.2%	13.3%	9.7%

Trend Assumption (2)	7.7%

Footnotes:
(1) Trends have been adjusted to remove the impact of policy and reimbursement changes.
(2) Average trend during FY2018, FY2019 and first six months of FY2020.

FY2025 Prescription Drug Rating Analysis
STAR Health Pharmacy Trends

	All Members
Days Supply per Member per Month	
3/2015-2/2016	29.284
3/2016-2/2017	28.164
3/2017-2/2018	28.332
3/2018-2/2019	28.508
3/2019-2/2020	29.920
Incurred Claims per Days Supply	
3/2015-2/2016	4.623
3/2016-2/2017	4.547
3/2017-2/2018	3.828
3/2018-2/2019	3.410
3/2019-2/2020	3.000
PDL Adjustment Factors	
3/2017-2/2018	1.1669
3/2018-2/2019	1.3515
3/2019-2/2020	1.4774
Adjusted Incurred Claims per Days Supply	
3/2015-2/2016	4.623
3/2016-2/2017	4.547
3/2017-2/2018	4.467
3/2018-2/2019	4.609
3/2019-2/2020	4.432
Adjusted Incurred Claims per Member per Month	
3/2015-2/2016	135.38
3/2016-2/2017	128.05
3/2017-2/2018	126.55
3/2018-2/2019	131.38
3/2019-2/2020	132.60
Annual Trend in Days Supply per Member per Month	
3/2016-2/2017	-3.8 %
3/2017-2/2018	0.6 %
3/2018-2/2019	0.6 %
3/2019-2/2020	5.0 %
Use	2.8 %

FY2025 Prescription Drug Rating Analysis
STAR Health Pharmacy Trends

	All Members
Annual Trend in Adjusted Incurred Claims per Days Supply	
3/2016-2/2017	-1.7 %
3/2017-2/2018	-1.8 %
3/2018-2/2019	3.2 %
3/2019-2/2020	-3.8 %
Use	-1.2 %
Annual Trend in Adjusted Incurred Claims per Member per Month	
3/2016-2/2017	-5.4 %
3/2017-2/2018	-1.2 %
3/2018-2/2019	3.8 %
3/2019-2/2020	0.9 %
Use	1.6 %

FY2025 STAR Health Rating Analysis
Trend Development - NEMT

	Trend Assumption
NEMT Experience (1)	
3/2017-2/2018	2.54%
3/2018-2/2019	3.79%
3/2019-2/2020	4.02%
Average	3.50%
Industry (CPI)	
Inflation (2)	1.60%
Utilization (3)	1.50%
Total	3.10%
Selected (4)	**3.30%**

Notes:
(1) Trend analysis only includes demand response services.
Experience for MTO 1, MTO 10 and MTO 4 are excluded from trend analysis.
MTO 1 and MTO 10 switched organizations effective 9/1/2017. MTO 4 is FFS.
(2) Average CPI Transportation (CUSR0000SAT) monthly year-over-year trend for the past 10 years.
(3) Selected by the Actuary.
(4) Average Experience and Industry trend.

Attachment 4

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 beginning of the base period used in rate setting and before the end of FY2025.

The benefit and provider reimbursement changes recognized in the FY2025 rate setting are listed below. The rating adjustments for these provider reimbursement changes were calculated by applying actual MCO 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.

<u>Provider Reimbursement Adjustments</u>

- 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 MCO will only be responsible for reimbursing the FQHC an amount no less than the rate paid to non-FQHC providers providing similar services.

- Invalid clinician administered drugs 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.

- Effective September 1, 2024, HHSC will make revisions to the reimbursement for clinical lab services.

- Effective September 1, 2024, HHSC will make revisions to the reimbursement for dental anesthesia services.

- Effective July 1, 2023, HHSC expanded the non-invasive perinatal screening benefit.

- Effective June 1, 2023, HHSC made revisions to the reimbursement for Prescribed Pediatric Extended Care Centers.

- Effective September 1, 2023, HHSC made revisions to the reimbursement for private duty nursing services.

- Effective September 1, 2023, HHSC made revisions to the reimbursement for ground ambulance services.

- Effective September 1, 2023, HHSC made revisions to the reimbursement for attendant care services.

- Effective September 1, 2023, HHSC made revisions to the reimbursement for rural hospital outpatient services.

- Effective September 1, 2023, HHSC made revisions to the reimbursement for birth and women's health related surgery services.

- Effective September 1, 2023, HHSC made revisions to the reimbursement for evaluation and management services.

- Effective June 1, 2023, HHSC made revisions to the ambulatory surgical center fee schedule.

- Effective September 1, 2024, HHSC will make revisions to biomarker testing.

Hospital Reimbursement Adjustments

- As a result of annual evaluations, several hospitals have had their Standard Dollar Amount (SDA) revised between the base period and FY2025. In addition, increases were applied to the SDA applicable to rural hospital deliveries effective September 1, 2023.

- 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 period and can change from one fiscal year to the next. A new PPR reduction list will become effective September 1, 2024. As a result, the adjustment factors represent the restoration of those reductions that were in place during the base period net of those reductions that will be in place during FY2025.

- Beginning 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 period and can change from one fiscal year to the next. A new PPC reduction list will become effective September 1, 2024. As a result, the adjustment factors represent the restoration of those reductions that were in place during the base period net of those reductions that will be in place during FY2025.

- Effective September 1, 2019, HHSC began utilizing an adjustment to the base period data that analyzes inefficiencies and potentially preventable expenses that unnecessarily increase managed care costs. This analysis was performed using the 3M™ PPR methodology which is a computerized algorithm to identify readmissions with a plausible clinical relationship to the care rendered during or immediately following a prior hospital admission. An expected reduction of PPR events of 10% has been applied for FY2025. The 10% PPR adjustment is intended to be an incremental step in improving the quality and efficiency of the managed care programs. This assumption will be monitored as actual experience develops and reassessed in future rating periods.

- During the summer of 2024, a new children's hospital will be opening in the Hidalgo SDA, Driscoll Children's Hospital Rio Grande Valley. The children's hospital will be opening on

the site of an existing hospital and all non-maternity care for children will be shifted to the new facility. As a result, all pediatric hospital care will be shifted from the lower cost hospital to the higher cost children's hospital. The impact of this change was estimated by applying the increased reimbursement rates to the base period utilization for pediatric care provided at the existing facility.

Pharmacy Adjustments

- Effective January 1, 2024, the three pharmaceutical manufacturers Eli Lilly, Novo Nordisk and Sanofi reduced the list price for certain insulins by as much as 70%.

- Effective April 7, 2023, Makena and its generic equivalent hydroxyprogesterone were removed from the formulary.

- Effective January 25, 2024, the brand drug Latuda changed from preferred to non-preferred status.

- Effective September 1, 2024, Hepatitis C DAA drugs will be carved into managed care and added to capitated services.

- Effective January 1, 2024, a provision in the American Rescue Plan Act of 2021 removed the cap that prevented Medicaid programs from receiving rebate payments that exceed the Average Manufacturer Price (AMP) for a drug.

NEMT Adjustments

- Effective January 1, 2024, reimbursement for Individual Transportation Participant (ITP) service increased to $0.67 per mile. The base period claims cost for ITP service has been adjusted to reflect this change.

The attached exhibit presents a summary of the rating adjustment factors. With the exception of the FQHC adjustment factor, all adjustment factors were calculated by repricing the FY2023 base period encounter data with both the old and new reimbursement terms and comparing the relative difference. 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.

The FQHC adjustment was calculated by collecting the total FQHC wrap payments paid during the base period and removing these amounts from the base period.

The adjustments were calculated independently by both HHSC and the consulting actuary to ensure consistent results.

FY2025 STAR Health Rating Analysis
Provider Reimbursement Adjustments
Estimates Based on FY2023 STAR Health Encounter Data

Medical - Provider Reimbursement Adjustment Factor

Remove FQHC Wrap Payment	-4,996,813
Removal of Invalid CAD	-373
Clinical Lab Reimbursement Changes	-123,556
Dental Anesthesia Reimbursement Changes	424,585
Non-Invasive Perinatal Screening	10,737
Prescribed Pediatric Extended Care Centers	60,014
Private Duty Nursing	1,292,391
Ground Ambulance	136,415
Attendant Care	605,026
Rural Hospital Outpatient	442,281
Birth and Women's Health Related Surgeries	13,091
Evaluation and Management Services	1,298,324
Ambulatory Surgical Center	410,699
Biomarker Testing	132,377
Total Provider Reimbursement Changes	-294,801
FY2023 Total Claims	304,085,228
Provider Reimbursement Adjustment	-0.10 %

Medical - Hospital Reimbursement Adjustment Factor

Standard Dollar Amount Changes	102,526
PPR Reduction/Restoration	5,733
PPC Reduction/Restoration	120,653
PPR Efficiency Improvements	-801,962
Driscoll Rio Grande Valley	596,405
Total Hospital Reimbursement Changes	23,356
FY2023 Total Claims	304,085,228
Hospital Reimbursement Adjustment	0.01 %

Pharmacy Adjustment Factors

FY2023 Total Claims	34,798,469
Insulin Reimbursement Change	-325,738
Adjustment	-0.94 %
Makena Formulary Change	-3,026
Adjustment	-0.01 %
Latuda Formulary Change	-1,743,108
Adjustment	-5.01 %
Hepatitis C Carve-In	24,666
Adjustment	0.07 %
AMP-Cap Removal Adjustment	-151,643
Adjustment	-0.44 %

FY2025 STAR Health Rating Analysis
Provider Reimbursement Adjustments
Estimates Based on FY2023 STAR Health Encounter Data

NEMT Carve-in Adjustment Factors

FY2023 Total Claims	699,522
Impact of Mileage Reimbursement Change	11,892
Adjustment	1.70 %

Attachment 5

PHE Related Cost Adjustment

The COVID-19 pandemic and the resulting Public Health Emergency (PHE) had a significant impact on the STAR Health program. Beginning March 2020, enrollment grew by over 40% while the average cost for all services declined significantly. The enrollment growth was due to the continuous enrollment provision during the PHE included in the Families First Coronavirus Response Act (FFCRA), while the cost reductions are due to many factors including mandatory shutdowns, mask mandates, social distancing, other environmental factors as well as inherent differences in cost between historically eligible members and the continuously enrolled members eligible under the PHE.

With the expiration of the PHE on May 11, 2023, HHSC has begun the PHE unwind process, which is expected to span a twelve-month period. HHSC began disenrollments on June 1, 2023 and has prioritized members into three cohorts:

- Cohort 1 - Individuals likely to be ineligible
- Cohort 2 - Individuals likely to transfer to another HHSC program
- Cohort 3 - Individuals likely to remain eligible

Current Medicaid members are spread throughout these cohorts based on known eligibility information and type program/type of assistance but are not specific to Medicaid program. Each cohort contains members from any Medicaid program and the disenrollments and renewals are staggered throughout the twelve-month period with the majority occurring in the first six months. Based on the planned PHE unwinding process and detailed information regarding the specific Medicaid members within each cohort and their expected redetermination dates, HHS Forecasting has developed projected caseload forecasts for each Medicaid program by month, service delivery area, MCO and risk group through the end of FY2025.

Given that the FY2023 base period was heavily impacted by the PHE and the expected disenrollments that will occur prior to FY2025, it is necessary to calculate an adjustment factor to properly estimate the impact of the PHE unwind process. The PHE impact was not uniform across all Medicaid programs and the adjustment factors calculated are specific to the populations being rated based on historical program-specific experience.

<u>Medical and Pharmacy Adjustment</u>

In order to estimate the impact of the PHE unwind on the FY2025 medical and prescription drug average costs, we have analyzed the base period claims along with enrollment and disenrollment information through February 2024. Base period enrollment was divided into two categories: (1) members who were continuously enrolled in the program as a result of the PHE and (2) members who remained enrolled in the STAR Health program. Continuously enrolled members were defined as individuals enrolled in the STAR Health program as of September 2023 and disenrolled as of February 2024. The PHE adjustment was determined by comparing (1) the FY2023 base period PMPM average cost to (2) the FY2023 average cost excluding the members who were

continuously enrolled as a result of the PHE. This adjustment adjusts the FY2023 base period to eliminate those members that have been disenrolled from the program as a result of the PHE unwinding process. The attached exhibit presents a summary of the derivation of the adjustment factors.

The methodology described above assumes that all impacted members will unwind and be disenrolled prior to the FY2025 rating period. In other words, the calculated adjustment factors represent the full impact of the PHE.

NEMT Adjustment

NEMT services represent 0.24% of the total premiums for the STAR Health program. The PHE adjustment was not developed for NEMT services due to sample size. In order to increase credibility, we have assumed the PHE adjustment for NEMT services is the same as the PHE adjustment for medical services described above.

FY2025 STAR Health Rating Analysis
PHE Related Cost Adjustment

	Medical	Pharmacy
FY2023 PMPM - Actual (1)	542.01	61.42
FY2023 PMPM - Excluding Continuously Enrolled PHE Members (2)	1,018.07	91.62
PHE Adjustment Factor (3)	1.8783	1.4918

Notes:
(1) Equals FY2023 health plan fee-for-service claims PMPM for all services (from Encounter database).
(2) Projected FY2023 PMPM (excluding continuously enrolled PHE members). Includes 1% margin for pent-up demand, increased utilization and membership churn.
(3) PHE Adjustment = Projected FY2023 PMPM divided by Actual FY2023 PMPM. Minimum value 1.0.

Attachment 6

Community First Choice (CFC)

As a result of CFC, Texas is eligible for an enhanced federal match rate on all CFC eligible services. The calculation of the CFC portion of the rate is based on an estimation of the CFC eligible services included in the STAR Health premium rate.

Certain services such as personal care services are currently provided under the STAR Health program and are currently included in the STAR Health premium rate. These services are now eligible for the enhanced federal match rate and must be identified. This calculation involved the following steps:

a. Determine the percentage of all claim payments which are associated with the personal care services (PCS) for CFC eligible members. This information was compiled by collecting a list of CFC eligible members and collecting all PCS claims for these members during the base period.

b. The CFC eligible services included in the STAR Health premium rate are then determined as the current premium rate multiplied by the percentage of total claims provided for personal care services for CFC eligible members.

Based on this calculation, the projected CFC portion of the total premium rate which is eligible for the enhanced federal match is $3.05 per member per month.

FY2025 STAR Health Rating Analysis
CFC Enhanced Match Calculation

FY2023 Personal Care Services (1)	635,249
FY2023 Total Claims	304,085,228
PCS % of Total	0.2%
FY2025 Premium Rate	1,458.89
CFC Portion of Premium Rate (2)	3.05

Footnotes:
(1) Total PCS provided to CFC eligible members.
(2) PCS % of Total Claims multiplied by FY2025 Premium Rate.

Attachment 7

In Lieu of Services

The Texas Medicaid program stipulates the following provisions related to in lieu of services:

a) 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 or age 65 and over are covered pursuant to the Texas state plan.

b) The MCO may provide residential substance use disorder (SUD) treatment services delivered in a chemical dependency treatment facility in lieu of an acute care inpatient hospital setting.

c) Coordinated Specialty Care (CSC) in lieu of inpatient hospital services.

d) Partial Hospitalization Services in lieu of inpatient hospital services.

e) Intensive Outpatient Program (IOP) Services in lieu of inpatient hospital services.

The ILOS Cost Percentage has been estimated as follows:

1. Collect information on ILOS paid claims for items (b)-(e) above during the FY2023 base period. ILOS claims = $1,844,577
2. Divide #1 by total medical claims during the FY2023 base period. ILOS % of medical claims equals 0.5%.
3. Divide FY2025 projected medical claims by FY2025 total projected capitation equals 75.4%.
4. Multiply #3 by #2 = .754 * .005 = 0.4%

Based on this analysis, the ILOS cost percentage is 0.4% which is considered immaterial. The ILOSs were considered in the rate development in the same manner as all other services. No special consideration or different approaches were applied to the ILOSs in comparison to any other category of service.

Attachment 8

FY2025 STAR Health Rate Certification Index

The index below includes the pages of this report that correspond to the applicable sections of the 2024-2025 Medicaid Managed Care Rate Development Guide, dated January 2024.

Section I. Medicaid Managed Care Rates

1. General Information

A. Rate Development Standards

i. Rate ranges are not being utilized in this rate development.

ii. Rates are for the 12-month period September 1, 2024 through August 31, 2025 (FY2025).

iii. (a) The certification letter is on page 17 of the report.

(b) The final capitation rates are shown on page 16 of the report.

(c) (i) See pages 1 and 5 through 6 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) Not applicable. There are no special contract provisions related to payment within the STAR Health program.

(vi) Not applicable.

iv. Acknowledged.

v. Acknowledged.

vi. Acknowledged.

vii. Acknowledged.

viii. Not applicable.

ix. Not applicable.

x. Acknowledged.

xi. Acknowledged.

xii. See pages 5, 7, 11 through 13 and 48 through 50 for discussion on how COVID-19 and the PHE unwind process have been accounted for in the FY2025 rate development.

xiii. Acknowledged.

B. Appropriate Documentation

i. The actuary is certifying capitation rates. See pages 16 and 17 of the report.

ii. Acknowledged.

iii. Acknowledged – see page 16 of the report.

iv. Acknowledged.

v. Not applicable.

vi. Acknowledged.

vii. Acknowledged. See page 17 of the report.

viii. See pages 51 through 52 of the report.

ix. (a) See pages 19 through 23 of the report.

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

(c) FY2024 rates were not adjusted by a *de minimis* amount using the authority in 42 C.F.R 438.7(c)(3).

x. Not applicable. There are no known amendments at this time.

xi. (a) Texas Medicaid Managed Care data has been studied for all programs, risk groups and service delivery areas through February 2024 to study the impact of COVID and the PHE unwinding. See pages 48 through 50 of the report.

(b) See pages 12 through 13 and 48 through 50 of the report.

(c) Effective September 1, 2023, all COVID-19 expenses for testing, treatment and vaccines have been covered in the capitation rates.

(d) See pages 12 through 13 and 48 through 50 of the report. Similar to the prior rating period, we are making a prospective adjustment to the FY2025 capitation rates. In addition, the revised experience rebate provisions utilized during FY2022 and FY2023 were returned to their pre-PHE provisions for FY2024 and beyond.

2. Data

A. Rate Development Standards

i. (a) Acknowledged.

(b) Acknowledged.

(c) Acknowledged.

(d) Not applicable. Data from the three most recent, completed years has been utilized.

B. Appropriate Documentation

i. (a) See pages 1 through 4 of the report.

ii. (a) See pages 1 through 4 of the report.

(b) See pages 3 through 4 of the report.

(c) See pages 3 through 4 of the report.

(d) Not applicable.

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

(b) See page 3 of the report.

(c) No errors found in the data.

(d) See pages 42 through 47 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. See page 53 of the report.

v. Not applicable. STAR Health eligibility ends at age 21 and therefore the IMD regulation does not impact this population.

B. Appropriate Documentation

i. See pages 19 through 23 of the report.

ii. (a) See pages 19 through 23 of the 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 adjusted for in the submitted encounter data are excluded from the base period as a negative add-on payment.

iii. (a) See pages 34 through 41 of the report.

(b) See pages 34 through 41 of the report.

(c) See pages 34 through 41 of the report.

(d) See pages 34 through 41 of the report.

(e) Not applicable.

iv. Not applicable.

v. See page 53 of the report.

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 FY2025 premium rate.

(c) All enrollment data during retroactive enrollment periods are included in the base period data used to develop the FY2025 premium rate.

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

vii. See pages 42 through 47 of the report.

viii. See pages 42 through 47 of the report.

4. Special Contract Provisions Related to Payment

A. Incentive Arrangements

i. Rate Development Standards

Not applicable.

ii. Appropriate Documentation

Not applicable.

B. Withhold Arrangements

i. Rate Development Standards

Not applicable.

ii. Appropriate Documentation

Not applicable.

C. Risk-Sharing Arrangements

i. Rate Development Standards

Acknowledged.

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. State Directed Payments

i. Rate Development Standards

Not applicable.

ii. Appropriate Documentation

(a) Not applicable. No such arrangements exist in the STAR Health program.

(b) Confirmed.

(c) Confirmed.

E. Pass-Through Payments

i. Rate Development Standards

Not applicable.

ii. Appropriate Documentation

(a) Not applicable. No such arrangements exist in the STAR Health program.

5. Projected Non-Benefit Costs

A. Rate Development Standards

i. Acknowledged.

ii. Acknowledged.

B. Appropriate Documentation

i. See pages 14 through 15 of the report.

ii. See pages 14 through 15 of the report.

iii. See pages 14 through 15 of the report.

6. Risk Adjustment

A. Rate Development Standards

i. Acknowledged.

ii. Acknowledged.

B. Appropriate Documentation

i. Not applicable, risk adjustment is not applied to the STAR Health rate development.

ii. Not applicable, risk adjustment is not applied to the STAR Health rate development.

iii. Not applicable, risk adjustment is not applied to the STAR Health rate development.

7. Acuity Adjustments

A. Rate Development Standards

i. Acknowledged.

B. Appropriate Documentation

i. (a) See pages 11 and 48 through 50 of the report.

(b) The analysis is based on historical STAR Health program experience.

(c) See pages 48 through 50 of the report.

(d) See pages 48 through 50 of the report.

(e) The calculation is a one-time calculation performed due to the significant nature of the PHE unwind process.

(f) See pages 48 through 50 of the report.

(g) As detailed in pages 48 through 50 of the report, the adjustment has been calculated in accordance with generally accepted actuarial principles and practices.

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

Not applicable

Section III. New Adult Group Capitation Rates

Not applicable