STATE OF TEXAS
MEDICAID MANAGED CARE
STAR+PLUS PROGRAM RATE SETTING
STATE FISCAL YEAR 2007

Prepared for:
Texas Health and Human Services Commission

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I. Introduction

Rudd and Wisdom, Inc. has been retained by the Texas Health and Human Services Commission (HHSC) to develop the state fiscal year 2007 (FY2007, September 1, 2006 through August 31, 2007) premium rates for HMOs participating in the Texas Medicaid STAR+PLUS program. This report presents the rating methodology and assumptions used in developing the premium rates.

Rudd and Wisdom has provided actuarial services to the Texas Medicaid program for over 20 years. We have participated in the state's managed care rating process since its inception in 1993. This year, as in previous years, we have worked closely with HHSC in developing the FY2007 HMO premium rates.

Rudd and Wisdom has relied on the following data sources as provided by HHSC, the participating HMOs and the agency's External Quality Review Organization (EQRO):

- Monthly enrollment by risk group for each health plan. This includes historical enrollment since September 2003 and a projection of future enrollment through August 2007. These projections were prepared by HHSC System Forecasting staff.
- Claim lag reports by risk group for each health plan for the period September 2003 through March 2006. These reports include monthly paid claims by month of service.
- Financial Statistical Reports (FSR) for each participating HMO for FY2004, FY2005 and the first six months of FY2006. The FSR contains detailed information regarding monthly enrollment, revenue, incurred claims and administrative expenses, as reported by the HMO.
- Reports from the EQRO summarizing their analysis of the HMO's encounter data.
- Information regarding recent changes in covered services and provider reimbursement under the Medicaid plans.
- Information from the HMOs regarding current and projected payment rates for certain capitated services, such as vision services.
- Information from each of the health plans regarding out-of-network claims experience and provider reimbursement.
- FY2005 acuity risk adjustment analysis provided by the EQRO for each participating health plan.
- Information from the HMOs regarding current and projected reinsurance premium rates.
- Historical enrollment and claims experience data on Aged and Disabled and Blind client under the Medicaid Fee-for-Service (FFS) plan and Primary Care Case Management (PCCM) plan.

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

II. Overview of the Rate Setting Methodology

The actuarial model used to derive the FY2007 STAR+PLUS premium rates relies primarily on health plan financial experience. The historical claims experience for each HMO was analyzed and estimates for the base period (FY2005) were developed. These estimates were then projected forward to FY2007 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 FY2007 cost under the health plan. These projected total cost rates were determined separately for each risk group for each health plan. The results of this analysis were then combined for all HMOs in the service area in order to develop a set of community rates.

The STAR+PLUS program currently serves only Harris County. There is planned expansion for STAR+PLUS to other service areas during FY2007. At the time of expansion, there will also be significant changes to the STAR+PLUS program in Harris County. At that time the rates presented in this report will no longer be applicable and a new set of rates will apply. The post-expansion Harris County rates and the rates for the expansion areas are not included in this report.

The risk groups (or rating populations) used in this analysis are as follows:

- Medicaid-only, Other Community Care (OCC)
- Medicaid-only, Community-based Alternatives (CBA)
- Dual Eligible, OCC
- Dual Eligible, CBA

Dual eligible clients are those enrolled in both Medicare and Medicaid. CBA clients are those that qualify for nursing facility care. OCC clients are those that do not qualify for nursing facility care.

The acute care services used in the analysis include the following:

- Inpatient Hospital
- Outpatient Hospital
- Physician Services
- Other Professional Services
- Lab, X-ray and Radiology Services
- Medical Supplies
- Behavioral Health Services
- EPSDT Medical Services
- Family Planning and Genetics Services
- Comprehensive Care Program Services
- Vision Services
- Hearing Services
- Home Health Services
- Emergency Room Services
- Ambulance Services

The long-term care (LTC) services used in the analysis include the following:

- Adult Foster Care Services
- Assisted Living Services
- Residential Care Services
- Respite Care Services
- Minor Home Modification Services
- Emergency Response Services
- Personal Attendant Care Services
- Adult Day Care Services
- Nursing Services
- Physical Therapy Services
- Occupational Therapy Services
- Speech Therapy Services
- Home Delivered Meal Services
- Non-Emergency Transportation Services

Services specifically excluded from the analysis include:

- Prescription Drugs
- Dental and Orthodontia Services

After accumulating all of the information to be used in the rate setting process, a comparison of the various sources of claims data was performed to check for consistency. We compared (i) the claim lag reports provided by the HMOs, (ii) the claim amounts included in the FSRs and (iii) the claim amounts in the encounter data files as provided by the EQRO. There was satisfactory consistency between the three claims data sources for each of the health plans.

We projected the FY2007 cost for each HMO by estimating their base period (FY2005) average claims cost and then applying trend and other adjustment factors. (These adjustment factors are described in Section III). We added capitation expenses for services capitated by the HMO (such as care coordination and vision services), a net cost of reinsurance, a reasonable provision for administrative expenses and risk margin.

Care coordination is an integral STAR+PLUS service. HMOs must coordinate the client's acute and long-term care, including dual eligible client's Medicare services. All clients receiving long-term care services or who request it receive care coordination services from the HMO. Care coordination services include development of an individual plan of care with the client, family members and provider, and authorization of long-term care services for the client.

Attachment 2 presents a description and an example of the experience analysis for a sample HMO. This type of analysis was conducted on the experience of each participating STAR+PLUS HMO.

The analysis of base period claims experience for each health plan attempted to identify and adjust for any distortions in the data. Significant variations in experience, including the impact from unusually large individual claims, were investigated and adjustments were made if deemed appropriate.

HHSC utilizes a community rating methodology in setting the STAR+PLUS base premium rates. The base rates vary by risk group but are the same for each HMO. The community rates are developed by a weighted average of the projected FY2007 cost for each health plan. The weights used in this formula are the projected FY2007 number of members enrolled in each health plan by risk group. Attachment 3 presents the summary community rating exhibit along with a description of the analysis.

The base community rate for each risk group was adjusted to reflect the health status, or acuity, of the population enrolled in each health plan. The purpose of acuity risk adjustment is to recognize the anticipated cost differential between multiple health plans in a service area by analyzing the health status of their respective memberships. Additional information regarding risk adjustment is included in Section III below under Risk Adjustment and in Attachment 10.

III. Adjustment Factors

This section contains a description of the adjustment factors used in the FY2007 STAR+PLUS rate setting process.

Trend Factors

The rating methodology uses assumed trend factors to adjust the base period claims cost to the projection period. The cost trend factors used in this analysis are a combination of utilization and inflation components. The projected trend rate assumptions were developed by the actuary based on an analysis of recent experience under the HMO plans. The trend assumptions vary by type of service (acute care and LTC) and projection year (FY2006 and FY2007) but are the same for each risk group and health plan.

The trend analysis included a review of HMO claims experience data through March 31, 2006. Based on this information, estimates of monthly incurred claims were made through January 2006. The claims cost and trend experience was reviewed separately by risk group and type of service.

The FY2006 trend assumptions by risk group were developed using the weighted average HMO trend for the period September 1, 2005 through January 31, 2006 (the first five months of FY2006). The FY2007 trend assumptions were developed based on an average of the HMO experience trends for the most recent three years (FY2004 through FY2006).

Attachment 4 is a summary of the cost trend analysis. The chart below presents the assumed annual trend rates for FY2006 and FY2007. Note that these trend assumptions apply to all risk groups.

	FY2006	FY2007
Acute Care	5.6%	8.0%
Long Term Care	3.0%	3.0%

Provider Reimbursement Adjustment

There are several provider reimbursement changes that impact the cost of acute care services in the STAR+PLUS program. Effective September 1, 2006 ESRD clients who are receiving 1915(c) services will be included in STAR+PLUS. This change is estimated to increase the program's average claims cost by 0.3%. Effective March 1, 2006, a Medicaid provider reimbursement increase was implemented for Nurse Practitioners, Clinical Nurse Specialists, Certified Nurse Midwifes, and Certified Registered Nurse Anesthetists. This change is estimated to increase the average cost by 0.06%. There was also an increase in the amount paid to nursing facilities. Attachment 5 presents the estimated cost impact from these revisions.

For LTC services, there was a 13.5% increase in the amount paid nursing facilities and a 1.1% increase in the amount paid on all other services. Exhibit C of Attachment 5 presents the estimated cost impact of these changes.

Benefit Change Factors

Effective September 1, 2006, the State restored several services and covered providers that were reduced or eliminated in FY2004. These revisions impact adult clients only. The rate setting process includes adjustments for the estimated cost impact of these revisions. Attachment 6 presents the estimated cost impact from these revisions.

Out-of-Network Adjustment

Effective September 1, 2006, the state will implement a change in the rules regarding STAR+PLUS HMO reimbursement to out-of-network providers. Currently, HMOs are allowed to pay out-of-network providers a discounted Medicaid fee-for-service (FFS) rate using a discount of up to 12%. Beginning September 1, 2006, the maximum discount will be 3%. Attachment 7 presents the estimated cost impact from this revision.

Nursing Facility Adjustment

Effective September 1, 2006 the state will no longer pay a premium to the HMO on behalf of STAR+PLUS clients in a nursing home even though the health plan will continue to be financially responsible for those clients. As a result, an adjustment to the premium is required in order to properly compensate the HMO for these services. Attachment 8 presents the estimated cost impact from this adjustment.

Investment Income Adjustment

An investment income credit was included in the rating process to account for the income expected to be generated between the time the health plan receives the premium from HHSC and the time they pay claims. This revision is new for FY2007. We have assumed that the value of this timing (or cash flow) difference is 0.25% of premium. Attachment 9 presents our analysis and estimate of the value of this revision.

Risk Adjustment

Several risk adjustment techniques are employed in the rate setting methodology. Premium rates are established separately by risk group in order to recognize the inherent demographic variation in the cost of delivering care. In addition, the rating methodology includes a health status adjustment.

The base community rate in each service area was adjusted to reflect the health status, or acuity, of the population enrolled in each health plan. The purpose of acuity risk adjustment is to recognize the anticipated cost differential between multiple health plans in a service area by analyzing the health status of their respective memberships. The risk analysis was performed by the University of Florida's Institute for Child Health Policy (ICHP). The methodology used to incorporate the acuity risk adjustment is the Chronic Illness and Disability Payment System (CDPS). This adjustment applies to acute care services only. Additional information regarding acuity risk adjustment is included in Attachment 10.

Although the results of the risk adjustment analysis were reviewed for reasonableness, Rudd and Wisdom did not audit the risk adjustment data or the results of ICHP's analysis.

IV. Administrative Fees and Risk Margin

The rating methodology includes an explicit provision for administrative services. The amount allocated for administrative expenses is $12.6275 per member per month plus 7.5% of gross premium. This amount is intended to provide for all administrative-related services performed by the HMO.

The administrative fee amounts were determined based on a review of (i) the administrative fee provision included in Medicaid HMO premium rates in other states, (ii) the reported administrative expenses of the STAR+PLUS HMOs and (iii) the fees paid for similar services for other large Texas health plans.

The premium rates also include a risk margin equal to 2.0% of gross premium.

V. Summary

The chart below presents the results of the FY2007 STAR+PLUS rating analysis.

Health Plan	Medicaid Only OCC	Medicaid Only CBA	Dual Eligible OCC	Dual Eligible CBA
Monthly Premium Rates				
Americaid – Harris	824.76	3,812.97	144.74	1,303.83
Evercare – Harris	846.38	3,578.44	144.74	1,303.83

The above premium rates include provision for 1915(b)(3) waiver services. The STAR+PLUS HMOs cover annual adult well-checks and adult inpatient hospital days in excess of thirty. The chart below presents the amount included in the FY2007 STAR+PLUS HMO premium rates for 1915(b)(3) waiver services.

Health Plan	Medicaid Only OCC	Medicaid Only CBA
Monthly Premium Rates for 1915(b)(3) Services		
Americaid – Harris	7.97	40.82
Evercare – Harris	8.17	38.31

Attachment 1 presents additional information regarding the FY2007 rates including a comparison to current (FY2006) rates.

VI. Actuarial Certification of FY2007 STAR+PLUS HMO Premium Rates

I, David G. Wilkes, am a principal with the firm of Rudd and Wisdom, Inc., Consulting Actuaries (Rudd and Wisdom). I am a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries. I meet the Academy's qualification standards for rendering this opinion.

Rudd and Wisdom has been retained by the Texas Health and Human Services Commission (HHSC) to assist in the development of their state fiscal year 2007 (FY2007) managed care rate-setting methodology, assumptions and resulting premium rates and to provide the actuarial certification required under Centers for Medicare and Medicaid Services (CMS) requirements 42 CFR 438.6(c).

I certify that the FY2007 HMO premium rates developed by HHSC and Rudd and Wisdom satisfy the following:

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

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

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

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

VII. Attachments

Attachment 1

Summary of FY2007 STAR+PLUS Rating Analysis

The attached exhibit presents summary information regarding the FY2007 rates. Included on the exhibit are current (FY2006) premium rates, projected FY2007 enrollment, FY2007 premium rates and a comparison of FY2006 and FY2007 rates.

Attachment 1

FY2007 STAR+Plus Rating
Summary

	Medicaid Only OCC	Medicaid Only CBA	Dual Eligible OCC	Dual Eligible CBA	Total
Projected FY2007 Recipient Months					
Americaid	141,332	8,399	130,034	16,755	296,521
Evercare	142,132	5,293	213,730	18,321	379,475
Total	283,464	13,692	343,764	35,076	675,996
FY2006 Premium Rate					
Americaid	820.17	3,151.61	168.36	1,291.10	626.98
Evercare	778.80	3,037.76	168.36	1,291.10	491.22
Total	799.43	3,107.60	168.36	1,291.10	550.77
Projected FY2007 Premium Based on FY2006 Premium Rates					
Americaid	115,916,525	26,471,499	21,892,471	21,632,967	185,913,462
Evercare	110,692,156	16,077,778	35,983,637	23,653,656	186,407,227
Total	226,608,681	42,549,277	57,876,107	45,286,624	372,320,689
FY2007 Rates Based on Individual Plan Experience					
Americaid	752.95	3,829.42	174.31	1,358.39	620.56
Evercare	917.79	3,552.31	126.75	1,253.93	525.23
Total	835.60	3,722.30	144.74	1,303.83	567.04
Percentage Increase					
Americaid	-8.2 %	21.5 %	3.5 %	5.2 %	-1.0 %
Evercare	17.8 %	16.9 %	-24.7 %	-2.9 %	6.9 %
Total	4.5 %	19.8 %	-14.0 %	1.0 %	3.0 %
FY2007 Premium - Individual Plan Experience					
Americaid	106,416,156	32,164,636	22,666,398	22,760,506	184,007,697
Evercare	130,446,388	18,801,106	27,090,615	22,972,616	199,310,723
Total	236,862,544	50,965,741	49,757,013	45,733,122	383,318,420
FY2007 Community Rate					
Acute Care	745.07	2,571.67	0.00	0.00	
LTC	90.53	1,150.64	144.74	1,303.83	
Total	835.60	3,722.31	144.74	1,303.83	
FY2007 Risk Adjusted Factors					
Americaid	0.985	1.033			
Evercare	1.014	0.942			
FY2007 Preliminary Risk Adjusted Rate					
Americaid	824.42	3,807.31	144.74	1,303.83	
Evercare	846.03	3,573.13	144.74	1,303.83	
Total	835.26	3,716.78	144.74	1,303.83	

FY2007 STAR+Plus Rating
Summary

	Medicaid Only OCC	Medicaid Only CBA	Dual Eligible OCC	Dual Eligible CBA	Total
FY2007 Risk Adjusted Rate					
Americaid	824.76	3,812.97	144.74	1,303.83	638.27
Evercare	846.38	3,578.44	144.74	1,303.83	511.39
Total	835.60	3,722.31	144.74	1,303.83	567.04
Percentage Increase					
Americaid	0.6 %	21.0 %	-14.0 %	1.0 %	1.8 %
Evercare	8.7 %	17.8 %	-14.0 %	1.0 %	4.1 %
Total	4.5 %	19.8 %	-14.0 %	1.0 %	3.0 %
FY2007 Premium - Risk Adjusted Rate					
Americaid	116,565,241	32,026,498	18,821,075	21,846,264	189,259,078
Evercare	120,297,415	18,939,404	30,935,326	23,886,877	194,059,022
Total	236,862,656	50,965,902	49,756,401	45,733,141	383,318,100

Attachment 2

Individual HMO Experience Analysis

The following exhibits present a summary of the experience analysis performed for each participating HMO. These exhibits use hypothetical experience data from a sample HMO. The actual analysis is based on experience data provided by each HMO. This data was checked for reasonableness by comparing to other data sources provided by HHSC, the EQRO and the HMO. Below is a brief description of each of the exhibits contained in this attachment.

Exhibit A. This exhibit shows monthly enrollment and earned premium by risk group for the period September 2003 through March 2006. All of this information was provided by HHSC.

Exhibit B. This exhibit shows a sample of a claim lag report for one risk group. This report includes claim amounts by payment month and month of service. We analyzed claims experience for the period September 2003 through January 2006 separately by risk group and type of service (acute care and LTC).

Exhibit C. This exhibit shows the calculation of estimated monthly incurred claims for one risk group. The report includes the following information: (i) monthly enrollment, (ii) claim amounts incurred in that month and paid through March 31, 2006, (iii) estimated proportion of that month's incurred claims paid through March 31, 2006 (completion factor), (iv) estimated incurred claims, (v) estimated incurred claims per member per month (pmpm) and (vi) the ratio of this month's incurred claims pmpm to the same statistic from one year ago (trend factor). The assumed completion factors and estimated incurred claims were derived based on the actual historical claims payment pattern of the HMO. This analysis was performed separately by risk group and type of service (acute care and LTC).

Exhibit D. This exhibit is a summary of the sample HMO's projected FY2007 cost based on the HMO's actual experience for two risk groups. The top of the exhibit shows summary base period (FY2005) enrollment, premium and claims experience. Next are projected FY2007 enrollment and premium based on current (FY2006) rates. Trend assumptions (separate for acute care and LTC) for FY2006 and FY2007 are used to project the average base period claims cost to FY2007. Following that are several adjustment factors. Combining these factors results in projected FY2007 incurred claims.

In addition to incurred claims, provision is also made for services that are capitated by the HMO, such as vision services. The cost of reinsurance is also considered. In developing the cost of reinsurance, an assumption is made regarding how much the HMO is expected to receive in reinsurance recoveries (reimbursements from the reinsurance company for large claims). We have assumed that the net cost of reinsurance (reinsurance premium less reinsurance recoveries) is the minimum of (a) the actual reinsurance premium rate and (b) $1.50 pmpm.

A provision for administrative expenses is included in the amount of $12.6275 pmpm and 7.5% of gross premium. A risk margin is also included at 2.0% of gross premium.

At the bottom of Exhibit D is a summary of the projected FY2007 cost based on the above assumptions along with the resulting rate change.

Sample HMO
Enrollment and Premium Experience

Month	Members Medicaid Only OCC	Medicaid Only CBA	Dual Eligible OCC	Dual Eligible CBA	Total Members
Sep-03	10,485	238	13,118	786	24,627
Oct-03	10,493	249	13,278	811	24,831
Nov-03	10,666	252	13,409	816	25,143
Dec-03	10,722	254	13,345	820	25,141
Jan-04	10,714	256	13,416	827	25,213
Feb-04	10,823	265	13,646	831	25,565
Mar-04	10,816	271	13,454	859	25,400
Apr-04	10,862	269	13,503	876	25,510
May-04	10,870	274	13,485	897	25,526
Jun-04	11,067	301	13,368	911	25,647
Jul-04	11,041	293	13,471	931	25,736
Aug-04	11,008	306	13,449	1,000	25,763
Sep-04	10,941	314	13,447	1,024	25,726
Oct-04	10,936	325	13,401	1,048	25,710
Nov-04	11,144	331	13,472	1,068	26,015
Dec-04	10,990	351	13,253	1,075	25,669
Jan-05	11,035	362	13,364	1,092	25,853
Feb-05	11,193	372	13,448	1,103	26,116
Mar-05	11,212	378	13,457	1,104	26,151
Apr-05	11,257	405	13,480	1,117	26,259
May-05	11,268	408	13,518	1,107	26,301
Jun-05	11,330	426	13,554	1,116	26,426
Jul-05	11,312	433	13,532	1,118	26,395
Aug-05	11,358	438	13,558	1,127	26,481
Sep-05	11,365	439	13,710	1,155	26,669
Oct-05	11,400	436	13,737	1,167	26,740
Nov-05	11,503	431	13,752	1,180	26,866
Dec-05	11,473	432	13,489	1,183	26,577
Jan-06	11,614	432	13,741	1,199	26,986
Feb-06	11,699	427	13,757	1,195	27,078
Mar-06	11,664	431	13,708	1,188	26,991
FY2004	129,567	3,228	160,942	10,365	304,102
FY2005	133,976	4,543	161,484	13,099	313,102
FY2006	80,718	3,028	95,894	8,267	187,907

Sample HMO
Enrollment and Premium Experience

Month	Premium Medicaid Only OCC	Medicaid Only CBA	Dual Eligible OCC	Dual Eligible CBA	Total
Sep-03	7,221,229	849,819	2,001,151	1,181,625	11,253,825
Oct-03	7,226,739	889,097	2,025,559	1,219,209	11,360,603
Nov-03	7,345,888	899,809	2,045,543	1,226,725	11,517,965
Dec-03	7,384,456	906,950	2,035,780	1,232,739	11,559,925
Jan-04	7,378,946	914,092	2,046,611	1,243,262	11,582,911
Feb-04	7,454,017	946,228	2,081,697	1,249,276	11,731,217
Mar-04	7,449,196	967,652	2,052,408	1,291,369	11,760,624
Apr-04	7,480,877	960,510	2,059,883	1,316,926	11,818,195
May-04	7,486,386	978,364	2,057,137	1,348,496	11,870,383
Jun-04	7,622,064	1,074,772	2,039,288	1,369,543	12,105,667
Jul-04	7,604,158	1,046,206	2,055,001	1,399,610	12,104,974
Aug-04	7,581,430	1,092,625	2,051,645	1,503,340	12,229,040
Sep-04	8,057,390	1,062,994	2,087,378	1,348,936	12,556,697
Oct-04	8,053,708	1,100,232	2,080,237	1,380,551	12,614,729
Nov-04	8,206,887	1,120,544	2,091,259	1,406,898	12,825,588
Dec-04	8,093,476	1,188,251	2,057,263	1,416,119	12,755,109
Jan-05	8,126,615	1,225,489	2,074,494	1,438,513	12,865,112
Feb-05	8,242,973	1,259,343	2,087,533	1,453,004	13,042,853
Mar-05	8,256,965	1,279,655	2,088,930	1,454,321	13,079,871
Apr-05	8,290,105	1,371,059	2,092,500	1,471,446	13,225,111
May-05	8,298,206	1,381,215	2,098,399	1,458,273	13,236,093
Jun-05	8,343,865	1,442,151	2,103,987	1,470,129	13,360,132
Jul-05	8,330,609	1,465,848	2,100,572	1,472,764	13,369,793
Aug-05	8,364,486	1,482,775	2,104,608	1,484,620	13,436,488
Sep-05	9,086,090	1,358,569	2,308,216	1,491,221	14,244,095
Oct-05	9,114,072	1,349,285	2,312,761	1,506,714	14,282,832
Nov-05	9,196,418	1,333,811	2,315,287	1,523,498	14,369,015
Dec-05	9,172,434	1,336,906	2,271,008	1,527,371	14,307,719
Jan-06	9,285,161	1,336,906	2,313,435	1,548,029	14,483,530
Feb-06	9,353,117	1,321,433	2,316,129	1,542,865	14,533,542
Mar-06	9,325,135	1,333,811	2,307,879	1,533,827	14,500,652
FY2004	89,235,384	11,526,123	24,551,702	15,582,119	140,895,328
FY2005	98,665,285	15,379,554	25,067,161	17,255,575	156,367,576
FY2006	64,532,427	9,370,721	16,144,714	10,673,524	100,721,386

Sample HMO
Enrollment and Premium Experience

	Adjusted Premium (using current rates)				
Month	Medicaid Only OCC	Medicaid Only CBA	Dual Eligible OCC	Dual Eligible CBA	Total
Sep-03	8,382,548	736,536	2,208,546	1,014,805	12,342,435
Oct-03	8,388,944	770,578	2,235,484	1,047,082	12,442,088
Nov-03	8,527,254	779,862	2,257,539	1,053,538	12,618,192
Dec-03	8,572,025	786,051	2,246,764	1,058,702	12,663,542
Jan-04	8,565,629	792,241	2,258,718	1,067,740	12,684,327
Feb-04	8,652,772	820,093	2,297,441	1,072,904	12,843,210
Mar-04	8,647,176	838,661	2,265,115	1,109,055	12,860,007
Apr-04	8,683,952	832,472	2,273,365	1,131,004	12,920,792
May-04	8,690,348	847,945	2,270,335	1,158,117	12,966,744
Jun-04	8,847,845	931,502	2,250,636	1,176,192	13,206,175
Jul-04	8,827,059	906,744	2,267,978	1,202,014	13,203,795
Aug-04	8,800,676	946,975	2,264,274	1,291,100	13,303,025
Sep-04	8,747,111	971,733	2,263,937	1,322,086	13,304,867
Oct-04	8,743,113	1,005,774	2,256,192	1,353,073	13,358,153
Nov-04	8,909,405	1,024,342	2,268,146	1,378,895	13,580,788
Dec-04	8,786,285	1,086,236	2,231,275	1,387,933	13,491,729
Jan-05	8,822,262	1,120,278	2,249,963	1,409,881	13,602,384
Feb-05	8,948,580	1,151,225	2,264,105	1,424,083	13,787,993
Mar-05	8,963,770	1,169,793	2,265,621	1,425,374	13,824,558
Apr-05	8,999,746	1,253,349	2,269,493	1,442,159	13,964,747
May-05	9,008,541	1,262,634	2,275,890	1,429,248	13,976,312
Jun-05	9,058,108	1,318,338	2,281,951	1,440,868	14,099,265
Jul-05	9,043,718	1,340,001	2,278,248	1,443,450	14,105,416
Aug-05	9,080,494	1,355,474	2,282,625	1,455,070	14,173,663
Sep-05	9,086,090	1,358,569	2,308,216	1,491,221	14,244,095
Oct-05	9,114,072	1,349,285	2,312,761	1,506,714	14,282,832
Nov-05	9,196,418	1,333,811	2,315,287	1,523,498	14,369,015
Dec-05	9,172,434	1,336,906	2,271,008	1,527,371	14,307,719
Jan-06	9,285,161	1,336,906	2,313,435	1,548,029	14,483,530
Feb-06	9,353,117	1,321,433	2,316,129	1,542,865	14,533,542
Mar-06	9,325,135	1,333,811	2,307,879	1,533,827	14,500,652
FY2004	103,586,225	9,989,659	27,096,195	13,382,252	154,054,331
FY2005	107,111,132	14,059,177	27,187,446	16,912,119	165,269,874
FY2006	64,532,427	9,370,721	16,144,714	10,673,524	100,721,386

Sample HMO
Claims Lag Report

Month Incurred	Month Paid Sep-03	Oct-03	Nov-03	Dec-03	Jan-04	Feb-04	Mar-04	Apr-04	May-04	Jun-04	Jul-04	Aug-04	Sep-04	Oct-04	Nov-04
Medicaid Only, Other Community Care, Acute Care															
Sep-03	162696	2262709	1052186	278503	164305	205226	43395	42199	103263	208720	17692	52953	129075	-9473	1959
Oct-03		410595	2047787	1051102	515114	308367	191090	306378	120917	155362	41676	-27769	9918	24135	-19660
Nov-03			317543	1980695	967444	546656	396393	102138	120608	65529	30433	53989	527	-32203	17034
Dec-03				424078	1454816	1123778	672056	203554	163418	56716	89310	34238	29552	20668	20975
Jan-04					244396	1849358	1786296	523668	201500	218521	93458	22567	160550	21221	1411
Feb-04						192534	2098723	1282781	455901	133222	53236	36249	26456	38739	16439
Mar-04							366877	2378514	1360679	380031	415521	99104	38607	32936	6419
Apr-04								278143	2245656	1236512	710071	296831	174104	29833	46207
May-04									211135	2069122	1808023	486846	339073	80212	31683
Jun-04										96848	2552693	1180272	797675	251387	85247
Jul-04											297433	2164121	2130030	407194	254970
Aug-04												132447	2561646	1557211	719133
Sep-04													266610	2226588	1590978
Oct-04														205712	2347824
Nov-04															132362
Dec-04															
Jan-05															
Feb-05															
Mar-05															
Apr-05															
May-05															
Jun-05															
Jul-05															
Aug-05															
Sep-05															
Oct-05															
Nov-05															
Dec-05															
Jan-06															
Feb-06															
Mar-06															
Total	162696	2673304	3417516	3734378	3346075	4225919	5554830	5117375	4983077	4620583	6109546	4531848	6663823	4854160	5252981

Sample HMO
Estimated Claims Experience

Medicaid Only, Other Community Care, Acute Care

Month	Members	Inc & Pd Claims	Completion Factor	Est Incurred Claims	Incurred pmpm	Trend Factor
Sep-03	10,485	4,730,410	1.000	4,730,410	451.16	
Oct-03	10,493	5,172,167	1.000	5,172,167	492.92	
Nov-03	10,666	4,605,594	1.000	4,605,594	431.80	
Dec-03	10,722	4,399,253	1.000	4,399,253	410.30	
Jan-04	10,714	5,212,957	1.000	5,212,957	486.56	
Feb-04	10,823	4,408,592	1.000	4,408,592	407.34	
Mar-04	10,816	5,285,874	1.000	5,285,874	488.71	
Apr-04	10,862	5,313,912	1.000	5,313,912	489.22	
May-04	10,870	5,642,978	1.000	5,642,978	519.13	
Jun-04	11,067	5,223,920	1.000	5,223,920	472.03	
Jul-04	11,041	5,770,652	1.000	5,770,652	522.66	
Aug-04	11,008	5,871,349	1.000	5,871,349	533.37	
Sep-04	10,941	5,625,157	0.999	5,630,788	514.65	1.141
Oct-04	10,936	5,817,714	0.998	5,829,373	533.04	1.081
Nov-04	11,144	5,598,167	0.997	5,615,012	503.86	1.167
Dec-04	10,990	5,421,686	0.996	5,443,460	495.31	1.207
Jan-05	11,035	6,030,450	0.995	6,060,754	549.23	1.129
Feb-05	11,193	5,485,245	0.992	5,529,481	494.01	1.213
Mar-05	11,212	6,757,209	0.990	6,825,464	608.76	1.246
Apr-05	11,257	6,444,250	0.989	6,515,925	578.83	1.183
May-05	11,268	6,069,264	0.985	6,161,689	546.83	1.053
Jun-05	11,330	6,093,828	0.980	6,218,192	548.83	1.163
Jul-05	11,312	6,135,431	0.974	6,299,210	556.86	1.065
Aug-05	11,358	6,351,839	0.967	6,568,603	578.32	1.084
Sep-05	11,365	6,395,296	0.961	6,654,835	585.56	1.138
Oct-05	11,400	6,011,081	0.948	6,340,803	556.21	1.043
Nov-05	11,503	5,634,745	0.921	6,118,073	531.87	1.056
Dec-05	11,473	5,319,475	0.873	6,093,328	531.10	1.072
Jan-06	11,614	5,437,741	0.830	6,551,495	564.10	1.027
Feb-06	11,699					
Mar-06	11,664					
9/03-11/03	31,644			14,508,171	458.48	
12/03-2/04	32,259			14,020,802	434.63	
3/04-5/04	32,548			16,242,764	499.04	
6/04-8/04	33,116			16,865,921	509.30	
9/04-11/04	33,021			17,075,173	517.10	1.128
12/04-2/05	33,218			17,033,694	512.79	1.180
3/05-5/05	33,737			19,503,078	578.09	1.158
6/05-8/05	34,000			19,086,005	561.35	1.102
9/05-11/05	34,268			19,113,710	557.77	1.079
FY2004	129,567			61,637,658	475.72	
FY2005	133,976			72,697,950	542.62	1.141
FY2006	57,355			31,758,533	553.72	1.067

Sample HMO
STAR+PLUS Experienced-based Renewal Rating

	Medicaid Only, OCC		Medicaid Only, CBA	
	Amount	per Member per Month	Amount	per Member per Month
FY2005 Experience Period				
Member Months	133,976		4,543	
Premium Revenue	98,665,285	736.44	15,379,554	3,385.33
Adjusted Premium	107,111,132	799.48	14,059,177	3,094.69
Estimated FY2005 Incurred Claims				
Acute Care	72,697,950	542.62	8,688,668	1,912.54
Long Term Care	7,876,449	58.79	4,743,464	1,044.13
Projected FY2007 Member Months	140,000		6,000	
Projected FY2007 Premium at Current Rates	111,927,200	799.48	18,568,140	3,094.69
Annual Cost Trend Assumptions				
Acute Care				
FY2006	5.6 %		5.6 %	
FY2007	8.0 %		8.0 %	
Long Term Care				
FY2006	3.0 %		3.0 %	
FY2007	3.0 %		3.0 %	
Provider Reimbursement Change				
Acute Care		1.0038		1.0038
Long Term Care		1.0113		1.0113
Benefit Change Factor (pmpm)		2.73		6.51
Out-of-Network Adjustment		1.003		1.003
4 Month Nursing Facility Adjustment		1.0007		1.0000
Projected FY2007 Incurred Claims				
Acute Care	87,732,400	626.66	13,222,080	2,203.68
LTC	8,836,800	63.12	6,721,380	1,120.23
Total	96,569,200	689.78	19,943,460	3,323.91
Capitation Expenses	5,000,000	35.71	200,000	33.33
Net Reinsurance Cost	250,000	1.79	10,000	1.67
Administrative Expenses				
Fixed Amount	1,767,850	12.6275	75,765	12.6275
Percentage of Premium	0	7.5 %	0	7.5 %
Total	1,767,850		75,765	
Risk Margin	0	2.0 %	0	2.0 %
Investment Income Adjustment		0.9975		0.9975
Projected Total Cost	114,174,677	815.53	22,296,853	3,716.14
Experience Rate Increase		2.0 %		20.1 %

Attachment 3

Community Experience Analysis

The following exhibit presents a summary of the STAR+PLUS experience analysis performed for the Harris County area. HHSC utilizes an adjusted community rating methodology in setting the STAR+PLUS premium rates. The base community rates vary by risk group but are the same for each HMO. The community rates are developed by a weighted average of the projected FY2007 cost for each HMO. The weights used in this formula are the projected number of FY2007 members enrolled in each health plan.

These attached exhibit shows projected FY2007 experience for the Harris County service area. These amounts were derived by summing amounts from each individual STAR+PLUS HMO in the service area. The experience analysis for individual HMOs is described in Attachment 2. The top portion of the exhibit shows summary base period (FY2005) experience. Following that is projected FY2007 enrollment, premium and incurred claims experience.

In addition to incurred claims, provision is also made for services that are capitated by the HMOs, such as vision services. The cost of reinsurance is also considered. In developing the cost of reinsurance we make an assumption regarding how much the HMO is expected to receive in reinsurance recoveries (reimbursements from the reinsurance company for large claims). We have assumed that the net cost of reinsurance (reinsurance premium less reinsurance recoveries) is the minimum of (a) the actual reinsurance premium rate and (b) $1.50 pmpm.

A provision for administrative expenses is included in the amount of $12.6275 pmpm and 7.5% of gross premium. A risk margin is also included at 2.0% of gross premium.

Near the bottom of the exhibit is a summary of the projected FY2007 cost based on these assumptions.

FY2007 STAR+PLUS Rating Summary
Harris SDA Total

	Medicaid Only - OCC		Medicaid Only - CBA		Dual Eligible - OCC		Dual Eligible - CBA		Total	
	Amount	pmpm	Amount	pmpm	Amount	pmpm	Amount	pmpm	Amount	pmpm
FY2005 Experience Period										
Member Months	279,716		10,420		329,782		28,372		648,290	
Premium Revenue	205,908,825	736.14	35,423,885	3,399.61	51,192,060	155.23	41,242,958	1,453.65	333,767,727	514.84
Adjusted Premium	223,535,043	799.15	32,395,875	3,109.01	55,522,098	168.36	36,631,089	1,291.10	348,084,105	536.93
Estimated FY2005 Incurred Claims										
Acute Care	157,476,243	562.99	20,906,632	2,006.39	0	0.00	0	0.00	178,382,875	275.16
Long Term Care	17,352,199	62.04	9,914,214	951.46	31,804,470	96.44	30,497,203	1,074.90	89,568,086	138.16
Proj. FY2007 Member Months	287,767		12,792		349,549		30,932		681,040	
Projected FY2007 Premium										
At Current Rates	230,064,049	799.48	39,586,699	3,094.69	58,850,051	168.36	39,935,917	1,291.10	368,436,716	540.99
Annual Cost Trend Assump.										
Acute Care										
FY2006	5.6 %		5.6 %		5.6 %		5.6 %			
FY2007	8.0 %		8.0 %		8.0 %		8.0 %			
Long Term Care										
FY2006	3.0 %		3.0 %		3.0 %		3.0 %			
FY2007	3.0 %		3.0 %		3.0 %		3.0 %			
Provider Reimbursement Change										
Acute Care (1)		1.003		1.003		1.000		1.000		
Long Term Care (2)		1.012		1.012		1.013		1.014		
Benefit Change Factor (pmpm) (3)		5.15		7.31		0.00		0.00		
Out-of-Network Adjustment (3)		1.014		1.009		1.000		1.000		
4-Month Nursing Facility Adjust.		1.0011		1.0000		1.0031		1.0000		
Projected Incurred Claims										
Acute Care	189,765,006	659.44	29,730,998	2,324.22	0	0.00	0	0.00	219,496,005	322.30
LTC	19,184,310	66.67	13,065,762	1,021.42	36,354,648	104.00	35,752,562	1,155.86	104,357,282	153.23
Total	208,949,316	726.11	42,796,760	3,345.64	36,354,648	104.00	35,752,562	1,155.86	323,853,286	475.53

FY2007 STAR+PLUS Rating Summary
Harris SDA Total

	Medicaid Only - OCC		Medicaid Only - CBA		Dual Eligible - OCC		Dual Eligible - CBA		Total	
	Amount	pmpm	Amount	pmpm	Amount	pmpm	Amount	pmpm	Amount	pmpm
Capitation Expenses	5,360,942	18.63	229,449	17.94	5,135,068	14.69	446,685	14.44	11,172,144	16.40
Net Reinsurance Expenses	215,217	0.75	11,771	0.92	0	0.00	0	0.00	226,987	0.33
Administrative Expenses										
Fixed Amount	3,633,779	12.6275	161,529	12.6275	4,413,929	12.6275	390,590	12.6275	8,599,826	12.6275
Percentage of Premium	18,034,297	7.50 %	3,571,120	7.50 %	3,794,659	7.50 %	3,024,726	7.50 %	28,424,802	7.50 %
Total	21,668,077		3,732,648		8,208,588		3,415,316		37,024,629	54.36
Risk Margin	4,809,146	2.00 %	952,299	2.00 %	1,011,909	2.00 %	806,594	2.00 %	7,579,947	2.00 %
Investment Income Adjustment		0.9975		0.9975		0.9975		0.9975		
Projected Total Cost	240,457,300	835.60	47,614,928	3,722.30	50,595,453	144.74	40,329,682	1,303.83	378,997,363	556.50

(1) Applies to Acute Care claims only
(2) Includes increases for NFs, Nursing Homes, NPs, CNs, CNMs, and CRNAs and ESRD clients
(3) Includes increases for NFs, Nursing Homes, and all other LTC services

Attachment 4

Trend Analysis

The rating methodology uses assumed trend factors to adjust the base period claims cost to the projection period. The cost trend factors used in this analysis are a combination of utilization and inflation components. The projected trend rate assumptions were developed by the actuary based on an analysis of recent experience under the HMO plans. A trend assumptions vary by type of service (acute care and LTC) and projection year (FY2006 and FY2007) but are the same for each risk group and health plan.

The trend analysis included a review of HMO claims experience data through March 31, 2006. Based on this information, estimates of monthly incurred claims were made through January 2006. The claims cost and trend experience was reviewed separately by risk group and type of service.

The FY2006 trend assumptions by risk group were developed using the weighted average HMO trend for the period September 1, 2005 through January 31, 2006 (the first five months of FY2006). The FY2007 trend assumptions were developed based on an average of the HMO experience trends for the most recent three years (FY2004 through FY2006). The attached exhibit presents a summary of the cost trend analysis.

FY2007 STAR+Plus Rating Analysis
Analysis of HMO Cost Trends

	Acute Care			Long Term Care		
	Americaid	Evercare	Total	Americaid	Evercare	Total
FY2004						
Medicaid-only, OCC	1.075	1.189	1.136	0.867	0.735	0.788
Medicaid-only, CBA	0.873	1.400	0.968	0.863	0.749	0.817
Dual Eligible, OCC	n/a	n/a	n/a	0.943	1.120	1.029
Dual Eligible, CBA	n/a	n/a	n/a	0.883	0.923	0.903
Total	1.090	1.222	1.157	0.966	1.023	0.996
FY2005						
Medicaid-only, OCC	1.020	1.065	1.042	0.917	1.183	1.056
Medicaid-only, CBA	1.015	1.112	1.061	0.870	0.979	0.908
Dual Eligible, OCC	n/a	n/a	n/a	1.009	0.959	0.983
Dual Eligible, CBA	n/a	n/a	n/a	0.988	1.018	1.009
Total	1.059	1.064	1.064	1.018	1.017	1.019
FY2006						
Medicaid-only, OCC	0.972	1.151	1.064	1.256	1.068	1.140
Medicaid-only, CBA	0.904	0.868	0.888	0.951	0.958	0.960
Dual Eligible, OCC	n/a	n/a	n/a	1.022	1.096	1.062
Dual Eligible, CBA	n/a	n/a	n/a	0.849	0.982	0.915
Total	0.973	1.133	1.056	0.969	1.045	1.010
Weighted Average						
Medicaid-only, OCC	1.014	1.120	1.069	1.026	1.053	1.032
Medicaid-only, CBA	0.948	1.084	0.982	0.897	0.926	0.908
Dual Eligible, OCC	n/a	n/a	n/a	1.000	1.039	1.020
Dual Eligible, CBA	n/a	n/a	n/a	0.919	0.986	0.955
Total	1.035	1.120	1.080	0.990	1.028	1.011

Attachment 5

Provider Reimbursement Adjustment

There are several provider reimbursement changes that impact the cost of acute care services in the STAR+PLUS program. Effective September 1, 2006 ESRD clients who are receiving 1915(c) services will be included in STAR+PLUS. This change is estimated to increase the program's average claims cost by 0.3%. The attached Exhibit A presents the estimated cost impact from this revision.

Effective March 1, 2006, a Medicaid provider reimbursement increase was implemented for Nurse Practitioners, Clinical Nurse Specialists, Certified Nurse Midwifes, and Certified Registered Nurse Anesthetists. This change is estimated to increase the average cost by 0.06%. The attached Exhibit B presents the estimated cost impact from this revision. There was also an increase in the amount paid to nursing facilities. The attached Exhibit C presents the estimated cost impact from this revision.

For LTC services, there was a 13.5% increase in the amount paid nursing facilities and a 1.1% increase in the amount paid on all other services. Attached Exhibit C presents the estimated cost impact of these changes.

FY2007 STAR+PLUS Rating
Adjustment for Change in Treatment of End Stage Renal Disease (ESRD) Clients (1)

Number of ESRD clients receiving 1915(c) Nursing Facility Waiver services (2)	20
Estimated monthly cost for these clients (3)	$ 3,000
Estimated additional annual cost	$ 720,000
Projected FY2007 STAR+PLUS Experience	
Member Months	681,040
Incurred Claims (Acute Care)	$ 220,260,000
Incurred Claims pmpm	$ 323.42
Adjusted FY2007 STAR+PLUS Experience with ESRD	
Member Months	681,060
Incurred Claims (Acute Care)	$ 220,980,000
Incurred Claims pmpm	$ 324.46
Adjustment Factor	1.003

Footnotes:
(1) Effective 9/1/2006, ESRD clients who are receiving 1915(c) services will be included in STAR+PLUS.

FY2007 STAR+PLUS Rating
Estimated Impact of Increase in Reimbursement for NPs, CNSs CNMs and CRNAs (1)

Risk Group	FY2004 Incurred Claims (2)	FY2004 Impacted Providers (3)	Adjustment Amount (4)	Adjustment Factor (5)
TANF Children Age 1+	57,695,863			
TANF Children Age <1	13,396,981			
TANF Adults	56,013,394			
Pregnant Women	250,777,125			
Newborns	263,140,215			
Expansion Children Age 1+	152,385,626			
Expansion Children Age <1	50,696,870			
Federal Mandate Children	117,541,308			
Total	961,647,382	7,388,080	608,430	1.0006

Notes:
(1) Effective 9/1/2006, the reimbursement factor for these providers is being increased from .85 to .92.
(2) FY2004 incurred FFS claims for all STAR HMOs for all services.
(3) FY2004 incurred FFS claims for all STAR HMOs for all services provided by NPs, CNSs CNMs and CRNAs.
(4) Equals FY2004 claims for all services provided by NPs, CNSs CNMs and CRNAs times .07/.85.
(5) Equals Adjustment Amount divided by FY2004 total incurred claims.

FY2007 STAR+PLUS Rating
Nursing Facility Comparison
Total - All Plans

	FY2005 Experience
Acute Care	
Nursing Facility	332,276
Non-Nursing Facility	175,335,341
Total	175,667,617
% Nursing Facility	0.19 %
Long Term Care	
Nursing Facility	1,244,458
Non-Nursing Facility	85,061,853
Total	86,306,310
% Nursing Facility	1.44 %
Total	
Nursing Facility	1,576,734
Non-Nursing Facility	260,397,194
Total	261,973,928
% Nursing Facility	0.60 %

Nursing Facility

	Acute Care	LTC		% Increase
Increase	13.50%	13.50%	NF	11.75%
% of LTC	0.19%	1.44%	LTC - NF	1.75%
Adjustment Factor	1.0003	1.0019	LTC - all other	1.10%
Total Adjustment Factor	1.0003	1.0128		

Attachment 6

Benefit Change Factors

Effective September 1, 2006, the State restored several services and covered providers that were reduced or eliminated in FY2004. These revisions impact adult clients only. The rate setting process includes adjustments for the estimated cost impact of these revisions. The attached exhibit presents the estimated cost impact from these revisions.

FY2007 STAR+PLUS Rating Analysis
Estimated Impact of Benefit Changes
Based on FY2003 Experience

Risk Group/	Member	Acute Care Cost Exclusions for Discontinued Services						Cost
Plan	Months	Chiropractic	Counseling	Hearing	Podiatry	Vision	Total	pmpm
Medicaid Only, OCC								
Amerigroup	121,503	2,696	90,678	331	106,476	131,588	331,770	2.73
Evercare	137,636	1,475	703,988	12,699	129,674	191,972	1,039,808	7.55
All	259,139	4,172	794,666	13,029	236,150	323,560	1,371,577	5.29
Medicaid Only, CBA								
Amerigroup	4,013	0	9,421	0	10,941	5,758	26,120	6.51
Evercare	2,449	0	12,650	0	4,857	3,497	21,004	8.58
All	6,462	0	22,071	0	15,798	9,255	47,124	7.29

Attachment 7

Out-of-Network Adjustment

Effective September 1, 2006, the state will implement a change in the rules regarding STAR+PLUS HMO reimbursement to out-of-network providers. Currently, HMOs are allowed to pay out-of-network providers a discounted Medicaid fee-for-service (FFS) rate using a discount of up to 12%. Beginning September 1, 2006, the maximum discount will be 3%.

The attached exhibit presents the estimated cost impact from this revision. The exhibit shows FY2005 in-network and out-of-network claims experience as reported by the HMOs. Based on this information, the FY2005 cost impact of the program change was estimated. The resulting percentage impact for each individual health plan was then used in the FY2007 rating analysis.

FY2007 STAR+PLUS Rating Analysis
Analysis of Out-of-Network Reimbursement
and the Cost Impact of the Proposed New Rule

	FY2005 Experience Cost			Out-of-Net	Current			
Health Plan	In-Net Claims	Out-of-Net Claims	Total Claims	as % of Total	Out-of-Net Reimb. (4)	New Rule (5)	Cost Impact	% of Total Claims
Americaid - Harris	73,711,106	13,328,042	87,039,148	15.31%	M-5%	M-3%	266,561	0.3%
Evercare - Harris	64,679,083	22,148,931	86,828,013	25.51%	M-12%	M-3%	1,993,404	2.3%
STAR+PLUS Total	138,390,188	35,476,973	173,867,161	20.40%			2,259,965	1.3%

Attachment 8

Four-Month Nursing Facility Adjustment

Effective September 1, 2006 the state will no longer pay a premium to the HMO on behalf of STAR+PLUS clients in a nursing home even though the health plan will continue to be financially responsible for those clients. As a result, an adjustment to the premium is required in order to properly compensate the HMO for these services. The attached exhibit presents the estimated cost impact from this adjustment.

FY2007 STAR+PLUS Rating Analysis
Four Month Nursing Facility Reimbursemnet Adjustment*

	Medicaid Only OCC	Medicaid Only CBA	Dual-eligibles OCC	Dual-eligibles CBA	Total
Americaid					
Total	137,593	6,521	124,351	13,269	281,734
NF	94	0	324	0	418
Adjustment	1.0007	1.0000	1.0026	1.0000	1.0015
Evercare					
Total	142,123	3,899	205,431	15,103	366,556
NF	214	0	739	0	953
Adjustment	1.0015	1.0000	1.0036	1.0000	1.0026
Total					
Total	279,716	10,420	329,782	28,372	648,290
NF	308	0	1,063	0	1,371
Adjustment	1.0011	1.0000	1.0032	1.0000	1.0021

*Effective 9/1/06, HHSC will no longer pay a premium for the STAR+PLUS clients in a nursing home.

Attachment 9

Investment Income Adjustment

An investment income credit was included in the rating process to account for the income expected to be generated by the HMO between the time they receive the premium from HHSC and the time they pay claims. This revision is new for FY2007. We have assumed that the value of this timing (or cash flow) difference is 0.25% of premium. The attached exhibit presents our analysis and estimate of the value of this revision.

FY2007 Rating
Investment Income Assumption

Program	Average Claims Lag (1)	FFS Claims/ Total (2)	Interest Rate (3)	Investment Income Factor (4)
STAR	1.54	0.820	3.5 %	0.37 %
STAR+PLUS	1.52	0.852	3.5 %	0.38 %
CHIP	1.20	0.714	3.5 %	0.25 %

Footnotes:
(1) The average time (in months) between the beginning of the month of claim incurral and payment date for all plans combined.
(2) Equals the ratio of projected FY2007 FFS claims to FY2007 premium for all plans combined.
(3) Assumed annual interest rate earned by the plan.
(4) Equals Average Claims Lag divided by 12 times FFS Claims/Total times Interest Rate.

Attachment 10

Acuity Risk Adjustment

The rate setting methodology incorporates a risk adjustment technique that is designed to adjust the base community rate in each service area to reflect the health status, or acuity, of the population enrolled in each health plan. The purpose of acuity risk adjustment is to recognize the anticipated cost differential between multiple health plans in a service area by analyzing the health status of their respective memberships. The risk analysis was performed by the University of Florida's Institute for Child Health Policy (ICHP). The methodology used to incorporate the risk adjustment is the Chronic Illness and Disability Payment System (CDPS). The attached exhibits (provided by ICHP) present a summary of the risk adjustment analysis. There is a separate exhibit for each risk group.

The column titled Case Mix on the chart is the risk adjustment factor. It is the ratio of the predicted average cost of the individual health plan's membership divided by the predicted average cost of the entire service area's membership. The risk adjustment factor is applied to the acute care portion of the community rate for each health plan and risk group.

TEXAS STAR+PLUS CDPS Health Plan Risk
Reporting Period: September 1, 2004 to August 31, 2005

Health Plan	Percent Affected	Actual PMPM Expenditures Based on Paid Amounts	Predicted PMPM Payment	Case Mix	Spend Ratio
CDPS					
Medicaid-Only, OCC	100.00	522.79	522.79	1.000	1.000
Evercare	50.82	592.46	530.16	1.014	1.118
Amerigroup	49.18	450.68	515.16	0.985	0.875

Note: CDPS results are based on information in enrollment and encounter datasets from September 1, 2004 to August 30, 2005. CDPS results were obtained for those enrollees who had been in the program for at least 3 months (age<1) and for those who had been in the program for at least 6 months (age=>1) (permitting one month lapse in enrollment within the 6 months period).

TEXAS STAR+PLUS CDPS Health Plan Risk

Reporting Period: September 1, 2004 to August 31, 2005

Health Plan	Percent Affected	Actual PMPM Expenditures Based on Paid Amounts	Predicted PMPM Payment	Case Mix	Spend Ratio
CDPS					
Medicaid-Only, CBA	100.00	1,910.07	1,910.07	1.000	1.000
Evercare	36.56	2,349.17	1,799.42	0.942	1.306
Amerigroup	63.44	1,658.93	1,973.35	1.033	0.841

Note: CDPS results are based on information in enrollment and encounter datasets from September 1, 2004 to August 30, 2005. CDPS results were obtained for those enrollees who had been in the program for at least 3 months (age<1) and for those who had been in the program for at least 6 months (age=>1) (permitting one month lapse in enrollment within the 6 months period).