STATE OF TEXAS
MEDICAID MANAGED CARE
STAR HEALTH PROGRAM RATE SETTING
STATE FISCAL YEAR 2016

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 2016 (FY2016, September 2015 through August 2016) premium rate for the STAR Health program. STAR Health is the managed health care program for Foster Care clients in Texas that was implemented April 1, 2008. This report presents the rating methodology and assumptions used in developing the FY2016 premium rate.

Rudd and Wisdom has provided actuarial services to the Texas Medicaid program for over 25 years. We have participated in the state's managed care rating process since its inception in 1993. We have worked closely with HHSC staff in developing the FY2016 STAR Health premium rate.

Rudd and Wisdom has relied on the following data sources as provided by HHSC and Superior HealthPlan Network (Superior), the managed care plan who manages the STAR Health program.

- Monthly Foster Care enrollment for the period September 2011 through February 2015 with a projection through August 2016. These enrollment figures were provided by HHSC System Forecasting staff.

- Claim lag reports provided by the carrier for the period September 2011 through February 2015. These reports include monthly paid claims by month of service.

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

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

- Financial Statistical Reports (FSR) from the carrier for FY2012, FY2013, FY2014 and the first six months of FY2015. The FSR contains detailed information regarding monthly enrollment, revenue, incurred claims and administrative expenses, as reported by the HMO.

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

- 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 FY2015 and FY2016 Medicaid provider reimbursement rate changes.

- Information provided by HHSC regarding FY2014 health plan claims cost by type of service for certain services. This information was obtained from the encounter database.

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

- Current (FY2015) STAR Health premium rate.

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 Superior, (ii) the claim amounts reported in the FSRs and (iii) the claim amounts in the encounter data files. There was satisfactory consistency between the three claims data sources. Although the above data was reviewed for reasonableness, Rudd and Wisdom did not audit the data.

In addition, to the review for reasonableness performed by Rudd and Wisdom HHSC employs the Institute for Child Health Policy (ICHP) as an External Quality Review Organization. ICHP reviews the detail encounter data and provides certification of the data quality. Below is an excerpt from their data certification report:

Based on an administrative review, the EQRO considers the required data elements for STAR Health 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.*

II. Overview of the Rate Setting Methodology

This report details the development of the medical component of the total premium rate. Information regarding the carve-in of prescription drugs into the STAR Health program can be found in the report titled State of Texas Medicaid Managed Care Rate Setting Pharmacy Carve-in State Fiscal Year 2016.

The actuarial model used to derive the FY2016 STAR Health premium rate relies primarily on health plan financial experience. The historical claims experience for the program was analyzed and estimates for the base period (FY2014, September 1, 2013 through August 31, 2014) were developed. These estimates were then projected forward to FY2016 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 FY2016 cost under the plan.

Only one health plan provides services under the STAR Health program. The health plan is reimbursed using a single premium rate which does not vary by age, gender or area. The STAR Health program covers the entire state of Texas. The services used in the analysis include the following:

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

We projected the FY2016 cost by estimating base period average claims cost and then applying trend and other adjustment factors. These adjustment factors are described in Section III of this report. We added capitation expenses for services capitated by Superior (such as radiology and dental services), a net cost of reinsurance, a reasonable provision for administrative expenses, taxes and risk margin.

The analysis of base period claims experience attempted to identify and adjust for any distortions in the data. Significant variations in experience, including the impact from unusually large individual claims, were investigated however no adjustments were deemed necessary.

Attachment 1 to this report provides a description of the calculation of the FY2016 STAR Health premium rate. Attachment 2 contains a summary of recent program incurred claims experience. Attachment 3 details the calculation of the rate adjustment factor for provider rate changes. Attachment 4 details the calculation of the Community First Choice (CFC) component of the premium which is eligible for an enhanced federal match rate.

III. Adjustment Factors

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

Trend Factors

The rating methodology uses assumed trend factors to adjust the base period claims cost to the projection period. The cost trend factors used in this analysis are a combination of utilization and inflation components. The projected trend rate assumptions were developed by the actuary based on an analysis of recent experience for Foster Care clients and the actuary's professional judgment regarding future cost increases. All historical trends have been calculated as the average cost per member per month during a specified time period (monthly, quarterly or annually) compared to the same time period from the prior year. For example the FY2014 trend has been calculated as the change in average cost per member per month during the period September 1, 2013 through August 31, 2014 (FY2014) compared to the average cost per member per month during the period September 1, 2012 through August 31, 2013 (FY2013). The experience trends for all time periods were adjusted to remove the impact of various provider reimbursement changes and other revisions that have impacted the program.

The FY2015 trend assumption was developed from two components: (i) the actual estimated trend for the period September 2014 through December 2014 and (ii) the projected trend for the period January 2015 through August 2015. The actual estimated trend during the period September 2014 through December 2014 was 1.2%. The projected trend for the period January 2015 through August 2015 was calculated as the average trend during FY2012, FY2013, FY2014 and the first four months of FY2015 and equaled 2.2%. The actual trend during the first four months and the projected trend during the final eight months of FY2015 were then blended together to develop the FY2015 trend assumption of 1.9%.

The FY2016 trend assumption was calculated as the average trend during FY2012, FY2013, FY2014 and the first four months of FY2015 and equals 2.2%.

Provider Reimbursement Adjustment

Medicaid provider reimbursement changes were provided for the following services: children's hospital inpatient reimbursement revisions, safety net and trauma hospital inpatient reimbursement revisions, potentially preventable readmission reimbursement reductions, potentially preventable complication reimbursement reductions, rural hospital reimbursement increases, therapy reimbursement reductions and personal care services (PCS) reimbursement increases.

Effective September 1, 2014 behavioral health targeted case management services became capitated services under the STAR Health Program. Previously these services were carved out of STAR Health and paid on a fee-for-service basis.

Prior to September 1, 2015 HHSC has required all managed care organizations to incorporate Electronic Visit Verification (EVV) into their management duties for Personal Assistance Services (PAS), Personal Care Services (PCS) and Private Duty Nursing (PDN).

The rating adjustments for these provider reimbursement changes were calculated by applying actual health plan encounter data to the old and new reimbursement basis and the resulting impact determined. Attachment 3 presents a summary of the derivation of these adjustment factors.

Community First Choice Initiative

Effective June 1, 2015 Texas has provided 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 will 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.

The implementation of CFC will not significantly impact the utilization of attendant care services, the reimbursement for attendant care services or the number of individuals eligible for attendant care services within the STAR Health program. As a result no adjustment is necessary to the monthly capitation rate.

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 4.

IV. Administrative Fees, Taxes and Risk Margin

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

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

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

The premium rate also includes provisions for premium tax (1.75% of premium), maintenance tax ($0.07 pmpm) and a risk margin (2.0% of premium).

The capitation rates included in this document do not include provision for the Affordable Care Act (ACA) Health Insurance Providers Fee. HHSC will develop and implement a procedure for reimbursing Superior for (i) the ACA Health Insurance Providers Fee, (ii) any applicable federal income tax impact resulting from payment of the ACA Health Insurance Providers Fee and (iii) any applicable state premium tax impact resulting from payment of the ACA Health Insurance Providers Fee. Such reimbursement will be provided based on a CMS-approved methodology.

V. Summary

The FY2016 premium rate for the STAR Health program including prescription drugs is $921.62 per member per month. The total premium rate is made up of the total medical component of $761.46 and the prescription drug component of $160.16. This report details the derivation of the medical component of the rate. Further information regarding the prescription drug component of the premium rate can be found in the report titled State of Texas Medicaid Managed Care Rate Setting Pharmacy Carve-in State Fiscal Year 2016. This rate will be effective for the period September 1, 2015 through August 31, 2016. Attachment 1 shows the derivation of the medical component of the premium rate.

As noted in Section III., Texas is eligible for an enhanced match rate for CFC services. CFC services of $3.40 are a component of the total rate. Further information regarding the calculation of this amount can be found in Attachment 4.

VI. Actuarial Certification of FY2016 STAR Health Premium Rate

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

Rudd and Wisdom has been retained by the Texas Health and Human Services Commission (HHSC) to assist in the development of the STAR Health premium rate for the period September 1, 2015 through August 31, 2016 and to provide the actuarial certification required under Centers for Medicare and Medicaid Services (CMS) requirements 42 CFR 438.6(c).

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

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

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

(c) The premium rate is actuarially sound as defined in the regulations.

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

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

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

VII. Attachments

Attachment 1

Summary of FY2016 STAR Health Rating Analysis

The attached exhibit presents summary information regarding the FY2016 STAR Health medical rate development. Included on the exhibit are base period (FY2014) experience, projected FY2016 enrollment, trend and provider reimbursement adjustment factors, assumed capitation rates, reinsurance and administrative costs.

The actuarial model used to derive the FY2016 STAR Health premium rate relies primarily on health plan financial experience. The historical claims experience for the program was analyzed and estimates for the base period were developed. These estimates were then projected forward to FY2016 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 FY2016 cost under the plan.

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

The information presented in Attachment 1 does not include the prescription drug portion of the total premium rate. Further information regarding the prescription drug component of the premium rate can be found in the report titled State of Texas Medicaid Managed Care Rate Setting Pharmacy Carve-in State Fiscal Year 2016.

FY2016 STAR Health Rating Analysis
Rate Development for the STAR Health Program

	Rating Period FY2016
Base Period Used in Rating	FY2014
Base Period Experience	
Member Months	368,716
Estimated Incurred Claims	221,530,039
Estimated Incurred Claims pmpm	$ 600.81
Projected Rating Period Experience	
Member Months	392,853
Assumed Annual Trend Rate	
- FY2015	1.9 %
- FY2016	2.2 %
Provider Reimbursement Adjustment	-1.67 %
Hospital Reimbursement Adjustment	0.45 %
Projected Incurred Claims pmpm	$ 618.02
Projected Incurred Claims	242,790,245
Capitation Expenses	
Laboratory	$ 0.03
Behavioral Health	$ 0.00
Vision Services	$ 0.00
Dental Services	$ 41.04
Radiology	$ 2.37
Settlements and Miscellaneous Expenses	$ 3.59
Total	$ 47.03
Reinsurance Expenses	
Gross Premium	$ 0.04
Projected Reinsurance Recoveries	$ 0.04
Net Reinsurance Cost	$ 0.00
Administrative Expenses	
Fixed Amount	$ 24.00
Percentage of Premium	5.75 %
Premium Tax	1.75 %
Maintenance Tax pmpm	$ 0.07
Risk Charge	2.0 %
Premium Rate pmpm	$ 761.46

Attachment 2

STAR Health Incurred Claims Experience

The attached exhibit presents a summary of STAR Health incurred claims experience during the base period used in the rate setting analysis. For each month during the experience period the exhibit shows enrollment, claims incurred during the month and paid through February 28, 2015 and estimated incurred claims.

FY2016 STAR Health Rating Analysis
Estimated STAR Health Incurred Claims (excluding dental and prescription drugs)

Month	Number of Members	Claims Incurred and Paid	Completion Factor	Estimated Incurred Claims	Estimated Incurred pmpm	Trend Factor
Sep-11	31,641	17,131,773	1.0000	17,131,773	541.44	
Oct-11	31,273	17,591,875	1.0000	17,591,875	562.53	
Nov-11	31,681	17,341,377	1.0000	17,341,377	547.37	
Dec-11	31,475	16,887,957	1.0000	16,887,957	536.55	
Jan-12	31,003	17,903,582	1.0000	17,903,582	577.48	
Feb-12	30,913	17,661,388	1.0000	17,661,388	571.33	
Mar-12	31,021	19,083,934	1.0000	19,083,934	615.19	
Apr-12	31,153	17,632,152	1.0000	17,632,152	565.99	
May-12	31,127	19,287,793	1.0000	19,287,793	619.65	
Jun-12	31,105	18,475,881	1.0000	18,475,881	593.98	
Jul-12	30,948	19,332,128	1.0000	19,332,128	624.66	
Aug-12	30,707	19,324,637	1.0000	19,324,637	629.32	
Sep-12	30,752	18,473,870	1.0000	18,473,870	600.74	1.110
Oct-12	30,604	19,464,786	1.0000	19,464,786	636.02	1.131
Nov-12	30,378	18,085,592	1.0000	18,085,592	595.35	1.088
Dec-12	29,927	16,328,290	1.0000	16,328,290	545.60	1.017
Jan-13	29,731	18,917,177	1.0000	18,917,177	636.28	1.102
Feb-13	29,944	17,289,297	1.0000	17,289,297	577.39	1.011
Mar-13	29,920	18,232,614	1.0000	18,232,614	609.38	0.991
Apr-13	30,032	18,959,601	1.0000	18,959,601	631.31	1.115
May-13	30,286	18,388,746	1.0000	18,388,746	607.17	0.980
Jun-13	30,527	17,744,832	1.0000	17,744,832	581.28	0.979
Jul-13	30,606	18,239,471	1.0000	18,239,471	595.94	0.954
Aug-13	30,809	17,310,821	1.0000	17,310,821	561.88	0.893
Sep-13	30,699	17,974,450	1.0000	17,974,450	585.51	0.975
Oct-13	30,921	19,545,774	1.0000	19,545,774	632.12	0.994
Nov-13	30,871	17,358,888	0.9993	17,370,659	562.69	0.945
Dec-13	30,423	16,445,488	0.9993	16,456,847	540.93	0.991
Jan-14	30,109	20,211,000	0.9983	20,244,752	672.38	1.057
Feb-14	30,353	16,890,653	0.9984	16,918,303	557.38	0.965
Mar-14	30,457	19,874,040	0.9973	19,926,985	654.27	1.074
Apr-14	30,646	20,126,880	0.9977	20,173,658	658.28	1.043
May-14	30,857	18,808,363	0.9968	18,869,304	611.51	1.007
Jun-14	30,948	17,437,931	0.9964	17,501,332	565.51	0.973
Jul-14	31,157	18,838,496	0.9960	18,913,810	607.05	1.019
Aug-14	31,275	17,512,157	0.9931	17,634,166	563.84	1.003
Sep-14	31,285	17,748,364	0.9914	17,902,327	572.23	0.977
Oct-14	31,546	19,131,522	0.9846	19,430,757	615.96	0.974
Nov-14	31,361	17,215,832	0.9695	17,756,523	566.20	1.006
Dec-14	30,964	17,191,453	0.9322	18,441,404	595.58	1.101
FY2012	374,047			217,654,478	581.89	
FY2013	363,516			217,435,096	598.14	1.028
FY2014	368,716			221,530,039	600.81	1.004
9/13-12/13	122,914			71,347,729	580.47	
9/14-12/14	125,156			73,531,010	587.52	1.012

Attachment 3

Provider Reimbursement Adjustments

This attachment presents information regarding rating adjustments for the various provider reimbursement and benefit revisions that became effective (or will become effective) after the base period used in rate setting (FY2014) and before the end of FY2016.

The benefit and provider reimbursement changes recognized in the FY2016 rate setting are listed below. The rating adjustments for these provider reimbursement changes were calculated by applying actual health plan encounter data to the old and new reimbursement bases and the resulting impact determined. The attached exhibit presents a summary of the derivation of the adjustment factors.

- Effective May 1, 2013 HHSC implemented revisions to hospital reimbursement to account for Potentially Preventable Readmissions (PPR). The reimbursement reductions amount to 1-2% depending on a hospitals performance during the evaluation time period. Revised PPR reductions will become effective September 1, 2015. This adjustment includes the restoration of reductions in effect during FY2014 that will no longer be in place during FY2016.

- Effective March 1, 2014 HHSC implemented revisions to hospital reimbursement to account for Potentially Preventable Complications (PPC). The reimbursement reductions amount to 2-2.5% depending on a hospitals performance during the evaluation time period. Revised PPC reductions will become effective September 1, 2015. This adjustment includes the restoration of reductions in effect during FY2014 that will no longer be in place during FY2016.

- Effective September 1, 2014 and again on September 1, 2015 HHSC revised the standard dollar amounts applied to the inpatient reimbursement for certain Children's Hospitals, safety net and trauma hospitals.

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

- Prior to September 1, 2015 HHSC will require all managed care organizations to incorporate EVV into their management duties for Personal Assistance Services (PAS), Personal Care Services (PCS) and Private Duty Nursing (PDN). Based on an analysis of the impact of EVV on these services in the fee-for-service program the following savings assumptions have been developed:
    - PAS: 4.0%
    - PCS: 4.0%
    - PDN: 3.5%

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

- Effective September 1, 2015 HHSC will increase the reimbursement applicable to rural hospitals for outpatient services including imaging services.

- Effective September 1, 2015 HHSC will make revisions to the reimbursement for certain therapy services.

- Effective September 1, 2015 HHSC will increase the reimbursement for attendant care services including personal care services (PCS).

The attached exhibit presents a summary of the rating adjustment factors. All adjustment factors were calculated by repricing the FY2014 base period encounter data with both the old and new reimbursement terms and comparing the relative difference.

FY2016 STAR Health Rating Analysis
Provider Reimbursement Adjustments
Estimates Based on FY2014 STAR Health Encounter Data

Provider Reimbursement Adjustment Factor

EVV	-901,134
Targeted Case Management	156,517
Outpatient Rural Hospital Reimbursement Increase	131,607
Outpatient Rural Hospital Imaging Reimbursement Increase	9,443
Therapy Reimbursement Reduction	-3,118,958
PCS Reimbusrement Increase	33,018
Overall Provider Reimbursement Changes	-3,689,508
FY2014 Total Claims	221,530,039
Provider Reimbursement Adjustment	-1.67 %

Hospital Adjustment Factor

Standard Dollar Amount Increases	1,093,576
PPR Reduction/Restoration	12,464
PPC Reduction/Restoration	-99,131
FY2014 Total Claims	221,530,039
Hospital Reimbursement Adjustment	0.45 %

Attachment 4

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 has been divided into two components (1) increased cost associated with CFC implementation and (2) CFC eligible services previously included in the STAR Health premium rate.

1. Increased Cost Due to CFC Implementation

As previously discussed, there will be no increased cost associated with the implementation of CFC within the STAR Health program.

2. CFC Eligible Services Previously Included in 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 will now be 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 now eligible for the enhanced CFC match.

b. Determine the percentage of individuals receiving personal care services eligible for the enhanced CFC match. There is limited information regarding the number of STAR Health members that will be eligible for CFC services. This estimated percentage is based on information from the Department of Aging and Disability Services (DADS) and represents the percentage of recipients receiving personal care services through DADS who are eligible for CFC.

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

Based on this calculation the projected CFC portion of the total premium rate which is eligible for the enhanced federal match is $3.40.

FY2016 STAR Health Rating Analysis
CFC Enhanced Match Calulation

FY2014 Personal Care Services	3,301,797
FY2014 Total Claims	221,530,039
PCS % of Total	1.5%
% Eligible (1)	30.0%
CFC % of Total Premium (2)	0.45%
FY2016 Premium Rate	761.46
CFC Portion of Premium Rate	3.40

Footnotes:
(1) Projected percentage of total STAR Health population eligible for CFC.
(2) PCS % of Total Claims multipllied by % Eligible.