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January 15, 2024

Mr. Michael Joyner
Chief Actuary
Health and Human Services Commission
4601 West Guadalupe
Austin, Texas 78751

Re: STAR Health Rate Amendment HHS0010427 A-3

Dear Mr. Joyner:

This letter amends the report titled State of Texas Medicaid Managed Care STAR Health Program Rate Setting State Fiscal Year 2024 and dated July 7, 2023. The amended FY2024 capitation rates were developed using identical methods and assumptions as the rates described in the original report. The amended rates are assumed to be payable for the period February 1, 2024 through August 31, 2024.

A. Summary of the Revisions

The following sections detail all changes implemented since the original certification and indicates where further information regarding the changes can be found.

Latuda Preferred Drug List Change

Effective January 25, 2024, the brand drug Latuda will be changing from preferred to non-preferred status. Given that the preferred drug list (PDL) change will be effective in the middle of the month, the mid-year change will be effective on the first day of the following month, February 1, 2024. As a result of this change, utilization will shift from the higher gross cost brand name drug to the lower gross cost generic equivalent.

B. Report Amendments

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

Section I. Introduction

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

this mid-year adjustment.

Section II. Base Period Data

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

Section III. Overview of Rate Setting Methodology

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

The only difference between the rating methodology outlined in the original report and this amendment are:

- Inclusion of a Latuda Preferred Drug List change to reflect utilization shift from higher gross cost brand name drug to lower gross cost generic equivalent during the period February 1, 2024 through August 31, 2024.

Section IV. Adjustment Factors

The following language has been added to this section.

Latuda Preferred Drug List Adjustment

Effective January 25, 2024, the brand drug Latuda will be changing from preferred to non-preferred status. As a result of this change, utilization will shift from the higher gross cost brand name drug to the lower gross cost generic equivalent. Attachment 4 – Revised includes a summary of the derivation of this adjustment factor.

Section V. Administrative Fees, Taxes and Risk Margin

No changes applicable to this section.

Section VI. Summary

This section is replaced with the following mid-year rates effective February 1, 2024 through August 31, 2024.

The February 1, 2024 through August 31, 2024 total premium rate for the STAR Health program is $964.73 per member per month. The total premium rate is made up of the medical component of $886.59, the prescription drug component of $75.78 and the NEMT component of $2.36. Attachment 1 Exhibit B - Revised shows the derivation of the revised prescription drug premium rate for this period.

The premium rates for the period September 1, 2023 through January 31, 2024 are unchanged from the original report.

Section VII. Actuarial Certification of the Revised FY2024 STAR Health Plan Premium Rates

We, Evan L. Dial, Khiem D. Ngo, David G. Wilkes and Dustin J. Kim are with the firm Rudd and Wisdom, Inc., Consulting Actuaries. All are Fellows of the Society of Actuaries (FSAs). We are all 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 rates for the period February 1, 2024 through August 31, 2024 and to provide the actuarial certification required under Centers for Medicare and Medicaid Services (CMS) requirements 42 CFR 438.4.

We certify that the amended FY2024 premium rates developed by HHSC and Rudd and Wisdom satisfy the following:

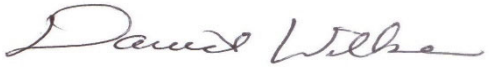
(a) The premium rates have been developed in accordance with generally accepted actuarial principles and practices;
(b) The premium rates are appropriate for the populations and services covered under the managed care contract; and
(c) The premiums are actuarially sound as defined in the regulations.

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.

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.



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Section VIII. Attachments

The following sections indicate any revisions applicable to each of the attachments in the original actuarial report dated July 7, 2023.

Attachment 1 - *Summary of FY2024 STAR Health Rating Analysis*

Exhibit B Revised. This exhibit presents summary information regarding the amended FY2024 STAR Health prescription drug rate development. Included on the exhibit are base period (FY2022) experience, projected February 2024 through August 2024 enrollment, trend and provider reimbursement adjustment factors and administrative costs. The only change to this exhibit from the original rate development is the addition of the Latuda Adjustment.

Exhibit D Revised presents a comparison of the projected expenditures under the current (September 1, 2023 through January 31, 2024) premium rates and the proposed (February 1, 2024 through August 31, 2024 premium rates). The projection is split by medical, pharmacy and NEMT.

The reasons for the rate changes shown in Exhibit D Revised are due solely to the Latuda formulary change discussed above. There are no other changes applicable to the revised rate development.

Attachment 2 – *STAR Health Incurred Claims Experience*

No changes applicable to this section.

Attachment 3 – *STAR Health Trend Analysis*

There have been no changes to this section.

Attachment 4 - *Provider Reimbursement Adjustment*

The following language has been added to the *Pharmacy Adjustments* section.

Effective January 25, 2024 Latuda will be changing from preferred to non-preferred status.

Attachment 5 – *PHE Related Cost Adjustment*

There have been no changes to this section.

Attachment 6 – *Community First Choice (CFC)*

There have been no changes to this section.

Attachment 7 – *In Lieu of Services*

There have been no changes to this section.

Attachment 8 - *FY2024 STAR Health Rate Certification Index*

The index below includes the pages of the original report, dated July 7, 2023 and this amendment letter that correspond to the applicable sections of the 2023-2024 Medicaid Managed Care Rate Development Guide, dated May 2023.

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 period February 1, 2024 through August 31, 2024 and revise those currently in effect as of September 1, 2023.

iii. (a) The certification letter is on page 3 of the amendment letter.

(b) The final capitation rates are shown on page 2 of the amendment letter.

(c) (i) See pages 1 and 5 through 6 of the original report.

(ii) The rates included in this amendment are for the period February 1, 2024 through August 31, 2024.

(iii) See page 1 of the original 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 12 and 45 through 49 of the original report for discussion on how COVID-19 and the PHE unwind process have been accounted for in the FY2024 rate development.

xiii. Acknowledged.

B. Appropriate Documentation

i. The actuary is certifying capitation rates. See pages 2 and 3 of the amendment letter.

ii. Acknowledged.

iii. Acknowledged.

iv. Not applicable.

v. Acknowledged.

vi. Acknowledged. See page 3 of the amendment letter.

vii. See pages 50 through 51 of the original report.

viii. (a) See pages 18 through 22 of the original report and pages 13 and 14 of the amendment letter.

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

(c) FY2023 rates were not adjusted by a *de minimis* amount using the authority in 42 C.F.R 438.7(c)(3).

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

x. (a) Texas Medicaid Managed Care data has been studied for all programs, risk groups and service delivery areas through December 2022 to study the impact of COVID and the PHE. See pages 45 through 49 of the original report.

(b) See pages 11 through 12 and 45 through 49 of the original report.

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

(d) See pages 11 through 12 and 45 through 49 of the original report. Similar to the prior rating period we are making a prospective adjustment to the FY2024 capitation rates. In addition, the revised experience rebate provisions utilized during FY2022 and FY2023 have been returned to their pre-PHE provisions.

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 original report.

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

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

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

(d) Not applicable.

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

(b) See page 3 of the original report.

(c) No errors found in the data.

(d) See pages 41 through 44 of the original report and page 15 of the amendment letter.

(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 52 of the original 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 18 through 22 of the original report and page 15 of the amendment letter.

ii. (a) See pages 18 through 22 of the original report and page 15 of the amendment letter.

(b) There have been no significant changes in the development of the benefit cost since the last certification. The only change is due to the Latuda status change described on page 1 of the amendment letter which is effective February 1, 2024.

(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 33 through 40 of the original report.

(b) See pages 33 through 40 of the original report.

(c) See pages 33 through 40 of the original report.

(d) See pages 33 through 40 of the original report.

(e) Not applicable.

iv. Not applicable.

v. See page 52 of the original 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 FY2024 premium rate.

(c) All enrollment data during retroactive enrollment periods are included in the base period data used to develop the FY2024 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 has been included in the base period data, the trend calculations and all other adjustment factors.

vii. See pages 41 through 44 of the original report and page 15 of the amendment letter.

viii. See pages 41 through 44 of the original report and page 15 of the amendment letter.

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 13 through 14 of the original report.

ii. See pages 13 through 14 of the original report.

iii. See pages 13 through 14 of the original 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 10 and 45 through 49 of the original report.

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

(c) See pages 45 through 49 of the original report.

(d) See pages 45 through 49 of the original report.

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

(f) See pages 45 through 49 of the original report.

(g) As detailed in pages 45 through 49 of the original 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

FY2024 STAR Health Rating Analysis
Rate Development for the STAR Health Program - Prescription Drug

	Rating Period FY2024	
	Total	PMPM
Base Period Used in Rating	FY2022	
Base Period Experience		
Member Months	543,219	
Estimated Incurred Claims	35,023,726	64.47
Other Costs/Refunds	-48,890	-0.09
Total Cost	34,974,837	64.38
Projected FY2024 Rating Period Experience		
Member Months	244,157	
Assumed Annual Trend Rate		1.60 %
PHE Adjustment		15.63 %
Insulin Price Adjustment		-0.74 %
Makena Adjustment		-0.03 %
Latuda Adjustment		-5.95 %
Projected Incurred Claims	17,510,960	71.72
Administrative Expenses	390,651	1.60
Premium Tax	323,788	1.75 %
Risk Margin	277,533	1.50 %
Projected Premium	18,502,198	$ 75.78

FY2024 STAR Health Rating Analysis

	Projected PMPM		Projected FY2024 Premium		
	Current	Revised	Current	Revised	% Rate Change
Medical	886.59	886.59	216,466,927	216,466,927	0.0%
Pharmacy	80.47	75.78	19,647,293	18,502,198	-5.8%
NEMT	2.36	2.36	576,210	576,210	0.0%
Total	969.42	964.73	236,690,431	235,545,335	-0.5%

FY2024 STAR Health Rating Analysis
Provider Reimbursement Adjustments
Estimates Based on FY2022 STAR Health Encounter Data

Medical - Provider Reimbursement Adjustment Factor

Remove FQHC Wrap Payment	-4,846,278
Removal of Invalid CAD	-3,506
Outpatient Behavioral Health Reimbursement Changes	1,881,033
Vaccine Administration Reimbursement Changes	256,166
Non-Invasive Perinatal Screening	8,793
Prescribed Pediatric Extended Care Centers	50,002
Private Duty Nursing	1,246,626
Ground Ambulance	128,805
Attendant Care	740,586
Rural Hospital Outpatient	341,853
Birth and Women's Health Related Surgeries	12,040
Evaluation and Management Services	1,302,965
Total Provider Reimbursement Changes	1,119,085
FY2022 Total Claims	296,453,828
Provider Reimbursement Adjustment	0.38 %

Medical - Hospital Reimbursement Adjustment Factor

Standard Dollar Amount Changes	-436,691
PPR Reduction/Restoration	54,654
PPC Reduction/Restoration	-110,220
PPR Efficiency Improvements	-911,293
Total Hospital Reimbursement Changes	-1,403,550
FY2022 Total Claims	296,453,828
Hospital Reimbursement Adjustment	-0.47 %

Pharmacy Adjustment Factors

FY2022 Total Claims	35,023,726
Insulin Reimbursement Change	-259,289
Adjustment	-0.74 %
Makena Formulary Change	-10,962
Adjustment	-0.03 %
Latuda Formulary Change	-2,083,657
Adjustment	-5.95 %

NEMT Carve-in Adjustment Factors

7/2022-12/2022 Total Claims	408,505
Impact of Mileage Reimbursement Change	8,619
Adjustment	2.11 %