STATE OF TEXAS
MEDICAID MANAGED CARE
STAR HEALTH PROGRAM RATE SETTING
STATE FISCAL YEAR 2024

Prepared for:
Texas Health and Human Services Commission
STAR Health HHS0010427 A-2

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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 2024 (FY2024, September 2023 through August 2024) premium rate for the STAR Health program. STAR Health is a managed health care program for Foster Care clients in Texas implemented on April 1, 2008. A single managed care organization, Superior Health Plan (Superior), covers this population in all 254 counties (statewide). This report presents the rating methodology and assumptions used in developing the FY2024 premium rate.

Rudd and Wisdom has provided actuarial services to the Texas Medicaid program for over 35 years. We have participated in the state's managed care rating process since its inception in 1993. We have worked closely with HHSC staff in developing the FY2024 STAR Health premium rate.

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

- Monthly STAR Health enrollment for the period September 2012 through March 2023 with a projection through August 2024. These enrollment figures were provided by HHS Forecasting staff.

- Detailed MCO encounter data for FY2022. The encounter data is a dataset that includes detail claim information for every claim incurred during FY2022 and paid through November 30, 2022. The dataset includes but is not limited to (1) individual member information – date of birth, risk group, MCO; (2) provider information – type of provider, NPI, bill type, taxonomy code; (3) procedure information – diagnosis, procedure code, claim modifier; and (4) payment information – paid amount, billed amount. This information is used to identify the providers and services which will receive or have received reimbursement changes in order to determine the cost impact of such changes.

- Claim lag reports provided by Superior for the period September 2019 through February 2023. These reports include monthly paid claim amounts by month of service. These reports summarize the detail encounter data.

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

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

- Financial Statistical Reports (FSR) from the MCO for FY2020, FY2021, FY2022 and the first six months of FY2023. The FSR contains detailed information regarding monthly enrollment, revenue, incurred claims and administrative expenses, as reported by the HMO. These reports are prepared by the MCO and are audited by an external audit organization. A MCO that participates in multiple programs and/or service areas submits a separate FSR for each individual area and program combination.

- Reports from the EQRO summarizing their analysis of the MCO's encounter claims data.

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

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

    - Subcapitated services make up approximately 4.3% of total plan cost and are primarily dental services. Information about these arrangements was provided by Superior and verified with the audited FSRs. These items were reviewed for reasonableness by comparing the reported expense amounts to those expenses in other programs along with the historical dental expenditures within the STAR Health program.

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

- Information from both HHSC and Superior regarding historical service coordination expenditures and enhanced requirements for FY2024.

    - Service Coordination expenses make up approximately 6.2% of total plan cost and are separate from the included administrative allowance. Information about service coordination expenses was provided by the MCO and verified with the FSRs. Effective September 1, 2023 the service coordination requirements in the STAR Health program will increase significantly. This increase has been reflected in the assumed service coordination expense of $60.00 per member per month included in the rate development.

- Information provided by HHSC regarding the expected impact of FY2022, FY2023 and FY2024 Medicaid provider reimbursement rate changes.

- Information provided by HHSC regarding FY2022 MCO claims cost by type of service for certain services. This information was obtained from the encounter database.

- Current (FY2023) STAR Health premium rate.

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

II. Base Period Data

The actuarial model used to derive the FY2024 STAR Health premium rate relies primarily on historical MCO experience. The historical claims experience for the program was analyzed and estimates for the base period were developed. The base period for the medical and prescription drug components was defined as FY2022 (September 1, 2021 through August 31, 2022) while the base period for the NEMT component was defined as July 1, 2022 through December 31, 2022. The reason for NEMT's differing base period is that the NEMT service was recently carved into managed care (effective June 1, 2021) and we utilized the most recent, credible information available. During the initial transition to managed care the NEMT experience was much lower than expected which is not indicative of future expenditure patterns. Estimates of the base period include an estimate of incurred but unpaid claims (IBNR). Given that there are six months of runout beyond the base period the IBNR estimates for medical and prescription drug are immaterial. The IBNR estimate is based on claims paid through February 2023 and represents the following percentage of claims by type of service:

- Medical - ~0.00%
- Prescription Drug – ~0.00%
- NEMT – 7.3%

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

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

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

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

the base period, the FFS reimbursement that will be in place during the rating period and the applicable percentage change determined.

HHSC employs the Institute for Child Health Policy (ICHP) as an External Quality Review Organization. ICHP reviews the detail encounter data and provides certification of the data quality. ICHP performs four types of analyses:

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

Below is an excerpt from their data certification report:

The EQRO considers the required data elements for all MCO-SA combinations in all programs to be accurate and complete, meeting the following components of Texas Government Code § 533.0131 for data certification purposes:

1. *The encounter data for the most recent measurement year are complete, accurate, and reliable.*
2. *No statistically significant variability in the encounter data is attributable to incompleteness, inaccuracy, or other deficiency as compared to equivalent data for similar populations and when evaluated against professionally accepted standards.*

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

After accumulating all of the information to be used in the rate setting process, a comparison of the various sources of claims data was performed to check for consistency. The comparison includes (i) the claim lag reports provided by the MCOs in the supplemental data request, (ii) the claim amounts reported in the FSRs and (iii) the claim amounts included in the encounter data files. The three data sources are compared to ensure consistent results such that the three are considered interchangeable in aggregate. The use of these multiple data sources allows for a dynamic, flexible rating model that is not constrained to the data limitation of a single source.

Based on the review of the data by the EQRO, HHSC and Rudd and Wisdom, we have concluded that all data sources are consistent, complete and accurate. It is our opinion that the data collected for the rate development is of high quality and we have no concerns over the availability or applicability to the FY2024 rate development. The accumulation of data sources noted above have been assigned full credibility. Given the history of managed care data available for the STAR Health program, the rate development is based exclusively on managed care data.

III. Overview of the Rate Setting Methodology

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

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

- Inpatient Hospital
- Outpatient Hospital
- Physician Services
- Other Professional Services
- Lab, X-ray and Radiology Services
- Medical Supplies
- Behavioral Health Services
- EPSDT Medical Services
- Family Planning and Genetics Services
- Comprehensive Care Program Services
- Vision Services
- Hearing Services
- Home Health Services
- Emergency Room Services
- Ambulance Services
- Dental and Orthodontia Services
- Prescription Drugs
- Non-Emergency Medical Transportation Services
- COVID-19 related expenses for testing, treatments and vaccines

Examples of services specifically excluded from the analysis include:

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

All expenses related to these, any other non-capitated services and any value-added services have been excluded from the FY2024 rating analysis.

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

We projected the FY2024 cost by estimating base period average claims cost and then applying trend and other adjustment factors including various programmatic, reimbursement, benefit and policy-related adjustment factors. These adjustment factors are described in Section IV of this report. We added capitation expenses for services capitated by Superior (such as radiology and dental services), a net cost of reinsurance, a reasonable provision for administrative expenses, service coordination expenses, taxes and risk margin in order to project the total FY2024 cost under the plan.

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

Attachment 1 to this report provides a description of the calculation of the FY2024 STAR Health premium rate. Attachment 2 contains a summary of recent program incurred claims experience. Attachment 3 summarizes the development of the trend assumptions. Attachment 4 details the calculation of the rate adjustment factors for provider rate changes. Attachment 5 details the calculation of the anticipated impact of the Public Health Emergency (PHE) unwinding on FY2024 program costs. Attachment 6 details the calculation of the Community First Choice (CFC) component of the premium which is eligible for an enhanced federal match rate. Attachment 7 provides information on in-lieu of services (ILOS). Attachment 8 provides the required index summarizing the applicable sections from the 2023-2024 Medicaid Managed Care Rate Development Guide.

IV. Adjustment Factors

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

Trend Factors - Medical

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

The trend assumption was calculated as the average trend during FY2017, FY2018, FY2019 and the first six months of FY2020 and equals 4.7%. STAR Health trends after February 2020 were evaluated but not considered due to the significant impact the COVID-19 pandemic had on average expenditures and enrollment. During the PHE, the STAR Health program experienced significant membership growth and abnormally low trends that are not indicative of future cost growth as the PHE unwinding process begins. It is expected that as the PHE ends and continuous eligibility unwinds that future STAR Health trends will return to the pre-PHE averages experienced within the program.

Trend Factors – Rx

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

The trend analysis included a review of STAR Health utilization and cost experience data paid through March 31, 2023. Incurred monthly utilization (days supply per member) and cost per service (plan payments per days supply) statistics were developed through February 2023. From this experience, the average annual utilization and cost per service were determined for each of the six 12-month periods ending February 2023.

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

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

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

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

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

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

Trend Factors – NEMT

The rating methodology uses assumed trend factors to adjust the base period claims cost to the rating period. Due to the impact on NEMT utilization and cost from the COVID-19 pandemic and the PHE, experience after February 2020 was deemed unusable for purposes of developing trend projections. The NEMT trend factors used in this analysis are a combination of utilization and inflation components. The NEMT trend factors were developed using a combination of i) actual statewide NEMT trend experience for all Medicaid managed care programs and ii) the industry

trend from the Consumer Price Index published by the Bureau of Labor Statistics for transportation services. The annual trend assumption of 3.30% was used in the rating analysis to project historical experience forward to the rating period. Attachment 3 – Exhibit C presents a summary of the NEMT trend analysis.

Provider Reimbursement Adjustments

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

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

Potentially Preventable Readmission Quality Improvement

Effective September 1, 2019, HHSC began utilizing an adjustment to the base period data that analyzes inefficiencies and potentially preventable expenses that unnecessarily increase managed care costs. This analysis was performed using the 3M™ PPR methodology which is a computerized algorithm to identify readmissions with a plausible clinical relationship to the care rendered during or immediately following a prior hospital admission. An expected reduction of PPR events of 10% has been applied for FY2024. Attachment 4 presents a summary of the derivation of the adjustment factor.

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

Removal of Invalid Clinician Administered Drugs (CADs)

By HHSC rule, all outpatient medical claims for clinician-administered drugs must contain a Healthcare Common Procedure Coding System (HCPCS) code, an NDC number, the NDC unit of measure, and the NDC quantity. The MCO must edit claims using the Texas HHSC NDC to HCPCS Crosswalk file. If such a claim is missing the NDC information, or the NDC is not valid for the corresponding HCPCS code, then the drug is not considered a covered Medicaid benefit and the MCO must deny or reject the entire claim or claim line item. As a result, the base period data was reviewed and clinician administered drugs which were submitted under an invalid NDC

were excluded from the rating analysis. Attachment 4 presents a summary of the derivation of this adjustment factor.

Federally Qualified Health Center (FQHC) Wrap Payment Removal

Effective September 1, 2017, MCOs were no longer required to reimburse FQHCs the full encounter rate. The MCOs are expected to reimburse FQHCs at a rate that is comparable to the reimbursement of all other non-FQHC providers providing similar services. Subsequently, the FQHC will be reimbursed by HHSC up to their full encounter rate outside of the capitation rate. The rating adjustment was calculated by collecting the FQHC wrap payments paid by the MCOs during the base period. Attachment 4 presents a summary of the derivation of this adjustment factor.

Insulin Price Adjustment

The three pharmaceutical manufacturers Eli Lilly, Novo Nordisk and Sanofi have publicly announced that the list price for certain insulins will be reduced by about 70% no later than January 1, 2024. Attachment 4 includes additional information regarding the application of the insulin price adjustment factors.

Makena Formulary Adjustment

Effective April 7, 2023, Makena and its generic equivalent hydroxyprogesterone were removed from the formulary. Attachment 4 includes additional information regarding the application of the Makena formulary adjustment factors.

NEMT Adjustment

Effective January 1, 2023, reimbursement for Individual Transportation Participant (ITP) service increased to $0.655 per mile. The base period claims cost for ITP service has been adjusted to reflect this change. Attachment 4 includes additional information regarding the application of the ITP adjustment factors.

Public Health Emergency (PHE) Related Cost Adjustment

Beginning in March 2020 and continuing into 2023, the PHE has had a significant impact on average STAR Health expenditures. Average enrollment during the FY2022 base period is over 40% larger than the enrollment prior to the PHE and average costs for all services has dropped significantly. The PHE officially ended May 11, 2023 and the PHE unwind process has begun with disenrollments beginning in June 2023. The unwinding process will take many months and the disenrollments are expected to be staggered throughout FY2024. Given the significant disenrollment in the STAR Health program, it is expected that the average cost during the FY2024 rating period will increase significantly towards the pre-PHE levels. A rate adjustment was calculated in order to estimate the impact of the PHE unwinding process and the associated disenrollment on average cost in FY2024. Attachment 5 presents a summary of the derivation of this adjustment factor.

Service Coordination

STAR Health members and their families receive help with coordinating care. The MCO provides service coordination which requires the MCO to work with the member, the member's family and the member's doctors and other providers to help the member get the medical care and long-term services and supports they need. The service coordinators partner with health care providers and the members' families to ensure care is holistically integrated and coordinated. They find ways to avoid preventable hospital admissions, readmissions, and emergency room visits, resulting in shared savings to benefit both the providers and MCOs, and most importantly the members themselves. Service coordination expenses were included in the rate development based on the amounts reported by the MCO in their audited FSRs along with information from HHSC and the MCO regarding increased requirements effective September 1, 2023. The enhanced service coordination requirements will be most comparable to the STAR Kids service coordination model which is expected to significantly increase the service coordination expense for the STAR Health program. The service coordination expense included in the FY2024 STAR Health rate development is $60.00 per member per month.

Community First Choice Initiative

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

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

The CFC services include:

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

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

COVID-19

COVID-19 and the associated Public Health Emergency (PHE) have had an unprecedented impact on the historical enrollment and claims data beginning March 2020 and continuing through the FY2022 base period. Significant enrollment growth has resulted in reductions in average cost which varies by program and risk group. During FY2020 through FY2023, HHSC addressed the additional risk associated with the PHE with multiple approaches including paying COVID-19 related expenditures on a non-risk basis, adjusting the base period used in rate development and

revising the experience rebate structure.

With the expiration of the PHE on May 11, 2023 and the commencement of the PHE unwinding process, the Medicaid programs are expected to eventually return to enrollment and average cost patterns that are in line with historical pre-PHE norms. In our opinion, the pre-PHE base period, March 2019 through February 2020, which was used for the FY2022 and FY2023 rate developments is outdated for use in developing FY2024 rates. As a result, the base period has been updated to FY2022 which aligns with managed care regulations. Given that this data was during the middle of the PHE, it must be adjusted to reflect the expected impact of the PHE unwinding process. The PHE Related Cost adjustments described above and included in Attachment 5 have been developed based on an extensive review of program-specific data and information about the PHE unwinding process including disenrollment by the various member cohorts and their timing. The PHE-related cost adjustment is intended to adjust the base period for expected changes to the enrollment, acuity and average cost for each program.

Effective September 1, 2023, all COVID-19 related expenses for testing, treatments and vaccines will be covered under the capitation rate with no further non-risk payments. Given the historical information available regarding COVID-19 and the stabilization of the monthly cost patterns, we believe the FY2022 base period data is a reasonable basis for projecting future expenses. The FY2022 base period includes claims experience for all COVID-19 related expenses and no further adjustment is needed to account for the carve-in of COVID-19 related expenses. While we cannot predict future COVID-19 outbreaks or variants just like we cannot predict higher or lower than average flu seasons, we believe the FY2022 data demonstrates sufficient consistency to be an appropriate basis for rate development.

Given the adjustments to the base period, utilizing FY2022 data, and transitioning COVID-19 services into the capitation rate, HHSC will revert the experience rebate structure to its original structure.

Pre-tax Income as a % of Revenues	MCO Share	HHSC Share
≤ 3%	100%	0%
> 3% and ≤ 5%	80%	20%
> 5% and ≤ 7%	60%	40%
> 7% and ≤ 9%	40%	60%
> 9% and ≤ 12%	20%	80%
> 12%	0%	100%

V. Administrative Fees, Taxes and Risk Margin

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

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

	Administrative Expense less Service Coordination		
	Actual	Average Annual ECI	Inflation Adjusted
FY2019	47.30	3.8%	56.88
FY2020	50.77	4.1%	59.62
FY2021	53.95	4.1%	60.86
FY2022	50.51	3.6%	54.16
FY2023	44.78	2.3%	45.81
Average			
FY19-FY23	49.46		55.47
FY19-FY22	50.63		57.88

The actual administrative expenses reported by year were adjusted for inflation by applying the annual growth in the Employee Cost Index (ECI) as reported by the US Bureau of Labor and Statistics. Based on this analysis the expected range of administrative costs for FY2024 was deemed to be $55-58.

Based on the administrative fee formula included in the rate development, the average administrative expense included in the capitation rate (medical, pharmacy and NEMT components combined) is $57.84 which is in line with the range of historical average cost excluding service coordination. The FY2023 average administrative cost appears to be an outlier and is attributable to the significant enrollment growth of the STAR Health program. As the PHE ends, and enrollment declines to pre-PHE levels, it is expected that per capita administrative cost will increase from the FY2023 amount.

The fixed and variable components of the administrative cost assumption are not intended to account for different administrative cost categories. The combined administrative assumption is intended to be a reasonable amount to cover all administrative costs. This formula is reviewed annually to ensure consistency with the reported administrative costs. For informational purposes the $9 fixed component of the medical administrative expense formula breaks down into two categories:

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

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

The premium rate also includes provisions for premium tax (1.75% of premium), maintenance tax ($0.0725 pmpm) and a risk margin (1.5% of premium). The premium tax and maintenance tax are based on Texas Department of Insurance requirements.

VI. Summary

The FY2024 total premium rate for the STAR Health program is $969.42 per member per month. The total premium rate is made up of the total medical component of $886.59, the prescription drug component of $80.47 and the NEMT component of $2.36. This rate will be effective for the period September 1, 2023 through August 31, 2024. Attachment 1 shows the derivation of the premium rate for each component.

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

As noted in Section IV, Texas is eligible for an enhanced match rate for CFC services. CFC services of $2.61 pmpm are a component of the total rate. Further information regarding the calculation of this amount can be found in Attachment 6.

VII. Actuarial Certification of FY2024 STAR Health Premium Rate

We, Evan L. Dial, Dustin J. Kim, Khiem D. Ngo and David G. Wilkes are with the firm Rudd and Wisdom, Inc., Consulting Actuaries. All are Fellows of the Society of Actuaries (FSAs), members of the American Academy of Actuaries and meet the Academy's qualification standards for rendering this opinion.

Rudd and Wisdom has been retained by the Texas Health and Human Services Commission (HHSC) to assist in the development of the STAR Health premium rate for the period September 1, 2023 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 STAR Health premium rate developed by HHSC and Rudd and Wisdom satisfies the following:

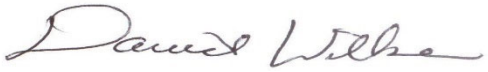
(a) The premium rate has been developed in accordance with generally accepted actuarial principles and practices;
(b) The premium rate is appropriate for the populations and services covered under the managed care contract; and
(c) The premium is actuarially sound as defined in the regulations.

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

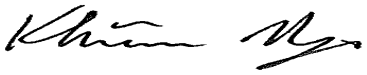
The assumptions, methodologies and factors used in developing the certified capitation rates are based on valid rate development standards and represent actual cost differences in providing covered services to the covered populations, and these differences do not vary with the rate of FFP associated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

Please note that actual health plan contractor experience will differ from these projections. Rudd and Wisdom has developed these rates on behalf of the State to demonstrate compliance with the CMS requirements under 42 CFR 438.3(c), 438.3(e), 438.4, 438.5, 438.6 and 438.7. Any health plan contracting with the State should analyze its own projected premium needs before deciding whether to contract with the State.

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



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



Khiem D. Ngo, F.S.A., M.A.A.A.

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

VIII. Attachments

Attachment 1

Summary of FY2024 STAR Health Rating Analysis

Exhibit A presents summary information regarding the FY2024 STAR Health medical rate development. Included on the exhibit are base period (FY2022) experience, projected FY2024 enrollment, trend and provider reimbursement adjustment factors, assumed capitation rates, reinsurance and administrative costs.

The actuarial model used to derive the FY2024 STAR Health premium rate relies primarily on historical MCO experience. The historical claims experience for the program was analyzed and estimates for the base period were developed. Claim payments associated with the American Rescue Plan Act (ARPA), which temporarily increased the reimbursement for certain services during the period March 2022 through August 2022, have been removed from the base period since the reimbursement increase did not continue beyond August 31, 2022. These estimates were then projected forward to FY2024 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 FY2024 cost under the plan.

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

Exhibit B presents summary information regarding the FY2024 STAR Health prescription drug rate development. Included on the exhibit are base period (FY2022) experience, projected FY2024 enrollment, trend and provider reimbursement adjustment factors and administrative costs.

Exhibit C presents summary information regarding the FY2024 STAR Health NEMT rate development. Included on the exhibit are base period (July 2022 through December 2022) experience, projected FY2024 enrollment, trend and provider reimbursement adjustment factors and administrative costs.

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

Exhibit D presents a comparison of the projected expenditures under the current (FY2023) premium rates and the FY2024 premium rates. The projection is split by medical, pharmacy and NEMT.

The primary cost drivers behind the rate reduction are (a) the updating of the base period to FY2022 and (b) the lingering impact of the PHE on enrollment and average cost as disenrollments are expected to be staggered throughout FY2024. The PHE has resulted in significant enrollment growth and large reductions in the average cost for all services which is expected to partially continue into FY2024 as the significant number of disenrollments will not be complete until the 3rd or 4th quarter of FY2024.

FY2024 STAR Health Rating Analysis
Rate Development for the STAR Health Program - Medical

	Rating Period FY2024 Total	PMPM
Base Period Used in Rating	FY2022	
Base Period Experience		
Member Months	543,219	
Estimated Incurred Claims	296,453,828	545.74
ARPA Claims	-612,736	-1.13
Estimated Incurred Claims - Net of ARPA	295,841,092	544.61
Projected FY2024 Rating Period Experience		
Member Months	473,300	
Assumed Annual Trend Rate		4.70 %
Provider Reimbursement Adjustment		0.38 %
Hospital Reimbursement Adjustment		-0.47 %
PHE Related Cost Adjustment		16.58 %
Projected Incurred Claims	329,108,244	695.35
Capitation Expenses		
Dental Services	19,741,357	41.71
Radiology	80,461	0.17
Settlements and Miscellaneous Expenses	2,333,371	4.93
Total	22,155,189	46.81
Service Coordination	28,398,020	60.00
Reinsurance Expenses		
Gross Premium	0	0.00
Projected Reinsurance Recoveries	0	0.00
Net Reinsurance Cost	0	0.00
Administrative Expenses		
Fixed Amount	4,259,703	9.00
Percentage of Premium	22,030,225	5.25 %
Total	26,289,929	55.55
Premium Tax	7,343,408	1.75 %
Maintenance Tax pmpm	34,314	0.07
Risk Margin	6,294,350	1.50 %
Projected Premium	419,623,343	$ 886.59

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	473,300	
Assumed Annual Trend Rate		1.60 %
PHE Adjustment		15.63 %
Insulin Price Adjustment		-0.74 %
Makena Adjustment		-0.03 %
Projected Incurred Claims	36,092,690	76.26
Administrative Expenses	757,281	1.60
Premium Tax	666,513	1.75 %
Risk Margin	571,297	1.50 %
Projected Premium	38,086,478	$ 80.47

FY2024 STAR Health Rating Analysis
Rate Development for the STAR Health Program - NEMT

	Rating Period FY2024 Total	PMPM
Base Period Used in Rating	7/2022-12/2022	
Base Period Experience		
Member Months	275,304	
Estimated Incurred Claims	408,505	1.48
Projected FY2024 Rating Period Experience		
Member Months	473,300	
Assumed Annual Trend Rate		3.30 %
Mileage Reimbursement Adjustment		2.11 %
Projected Incurred Claims	750,871	1.59
Administrative Expenses		
Fixed Amount	82,828	0.175
Percentage of Premium	245,738	22.00%
Total		
Premium Tax	19,547	1.75 %
Risk Margin	16,755	1.50 %
Projected Premium	1,116,989	$ 2.36

FY2024 STAR Health Rating Analysis

	Projected PMPM		Projected FY2024 Premium		
	Current Rates	FY2024 Rates	Current Rates	FY2024 Rates	% Rate Change
Medical	991.71	886.59	469,376,674	419,623,343	-10.6%
Pharmacy	99.63	80.47	47,154,912	38,086,478	-19.2%
NEMT	1.89	2.36	894,538	1,116,989	24.9%
Total	1,093.23	969.42	517,426,124	458,826,809	-11.3%

Attachment 2

STAR Health Incurred Claims Experience

The attached exhibit presents a summary of STAR Health incurred claims experience by type of service during the base period used in the rate setting analysis. For each month during the experience period the exhibits show enrollment, claims incurred during the month and paid through February 28, 2023 and estimated incurred claims.

FY2024 STAR Health Rating Analysis
Estimated STAR Health Incurred Claims

Month	Number of Members	Professional Claims Incurred and Paid	Completion Factor	Estimated Incurred Claims	Estimated Incurred pmpm	Trend Factor
Sep-19	32,685	7,712,706	1.0000	7,712,706	235.97	
Oct-19	32,771	8,643,480	1.0000	8,643,480	263.75	
Nov-19	32,439	7,619,461	1.0000	7,619,461	234.89	
Dec-19	31,825	7,350,910	1.0000	7,350,910	230.98	
Jan-20	31,584	8,168,332	1.0000	8,168,332	258.62	
Feb-20	31,558	7,717,924	1.0000	7,717,924	244.56	
Mar-20	31,872	7,246,919	1.0000	7,246,919	227.38	
Apr-20	32,916	6,717,492	1.0000	6,717,492	204.08	
May-20	33,617	7,226,627	1.0000	7,226,627	214.97	
Jun-20	34,349	7,848,040	1.0000	7,848,040	228.48	
Jul-20	35,185	7,940,011	1.0000	7,940,011	225.66	
Aug-20	36,297	7,865,301	1.0000	7,865,301	216.69	
Sep-20	37,527	8,211,483	1.0000	8,211,483	218.82	0.927
Oct-20	38,684	8,338,339	1.0000	8,338,339	215.55	0.817
Nov-20	39,718	7,635,791	1.0000	7,635,791	192.25	0.818
Dec-20	40,633	7,948,730	1.0000	7,948,730	195.62	0.847
Jan-21	41,538	7,984,464	1.0000	7,984,464	192.22	0.743
Feb-21	42,375	6,977,846	1.0000	6,977,846	164.67	0.673
Mar-21	43,222	9,040,125	1.0000	9,040,125	209.16	0.920
Apr-21	43,343	8,726,438	1.0000	8,726,438	201.33	0.987
May-21	43,881	8,272,788	1.0000	8,272,788	188.53	0.877
Jun-21	44,478	8,557,782	1.0000	8,557,782	192.40	0.842
Jul-21	44,902	8,400,250	1.0000	8,400,250	187.08	0.829
Aug-21	45,414	8,482,926	1.0000	8,482,926	186.79	0.862
Sep-21	45,610	8,429,880	1.0000	8,429,880	184.83	0.845
Oct-21	45,531	8,293,656	1.0000	8,293,656	182.15	0.845
Nov-21	44,932	7,718,607	1.0000	7,718,607	171.78	0.894
Dec-21	44,852	7,434,673	1.0000	7,434,673	165.76	0.847
Jan-22	44,830	7,509,823	1.0000	7,509,823	167.52	0.871
Feb-22	44,873	7,191,195	1.0000	7,191,195	160.26	0.973
Mar-22	44,977	8,417,055	1.0000	8,417,055	187.14	0.895
Apr-22	45,235	7,914,363	1.0000	7,914,363	174.96	0.869
May-22	45,468	7,850,777	1.0000	7,850,777	172.67	0.916
Jun-22	45,627	7,803,172	1.0000	7,803,172	171.02	0.889
Jul-22	45,729	7,143,369	1.0000	7,143,369	156.21	0.835
Aug-22	45,555	8,166,018	1.0000	8,166,018	179.26	0.960
Sep-22	45,728	7,827,418	0.9980	7,843,104	171.52	0.928
Oct-22	45,951	7,767,376	0.9920	7,830,016	170.40	0.935
Nov-22	46,106	7,303,063	0.9800	7,452,105	161.63	0.941
Dec-22	46,235	6,722,742	0.9380	7,167,102	155.02	0.935
FY2020	397,098			92,057,203	231.82	
FY2021	505,715			98,576,961	194.93	0.841
FY2022	543,219			93,872,588	172.81	0.887

FY2024 STAR Health Rating Analysis
Estimated STAR Health Incurred Claims

		Emergency Room				
Month	Number of Members	Claims Incurred and Paid	Completion Factor	Estimated Incurred Claims	Estimated Incurred pmpm	Trend Factor
Sep-19	32,685	645,803	1.0000	645,803	19.76	
Oct-19	32,771	684,525	1.0000	684,525	20.89	
Nov-19	32,439	724,288	1.0000	724,288	22.33	
Dec-19	31,825	684,325	1.0000	684,325	21.50	
Jan-20	31,584	643,998	1.0000	643,998	20.39	
Feb-20	31,558	646,177	1.0000	646,177	20.48	
Mar-20	31,872	570,597	1.0000	570,597	17.90	
Apr-20	32,916	341,186	1.0000	341,186	10.37	
May-20	33,617	466,172	1.0000	466,172	13.87	
Jun-20	34,349	474,280	1.0000	474,280	13.81	
Jul-20	35,185	534,589	1.0000	534,589	15.19	
Aug-20	36,297	517,160	1.0000	517,160	14.25	
Sep-20	37,527	553,582	1.0000	553,582	14.75	0.747
Oct-20	38,684	634,421	1.0000	634,421	16.40	0.785
Nov-20	39,718	617,806	1.0000	617,806	15.55	0.697
Dec-20	40,633	594,156	1.0000	594,156	14.62	0.680
Jan-21	41,538	613,730	1.0000	613,730	14.78	0.725
Feb-21	42,375	520,690	1.0000	520,690	12.29	0.600
Mar-21	43,222	700,293	1.0000	700,293	16.20	0.905
Apr-21	43,343	811,451	1.0000	811,451	18.72	1.806
May-21	43,881	866,565	1.0000	866,565	19.75	1.424
Jun-21	44,478	799,286	1.0000	799,286	17.97	1.301
Jul-21	44,902	835,745	1.0000	835,745	18.61	1.225
Aug-21	45,414	804,187	1.0000	804,187	17.71	1.243
Sep-21	45,610	880,757	1.0000	880,757	19.31	1.309
Oct-21	45,531	872,137	1.0000	872,137	19.15	1.168
Nov-21	44,932	895,539	1.0000	895,539	19.93	1.281
Dec-21	44,852	832,454	1.0000	832,454	18.56	1.269
Jan-22	44,830	784,131	1.0000	784,131	17.49	1.184
Feb-22	44,873	701,625	1.0000	701,625	15.64	1.272
Mar-22	44,977	831,659	1.0000	831,659	18.49	1.141
Apr-22	45,235	826,018	1.0000	826,018	18.26	0.975
May-22	45,468	884,567	1.0000	884,567	19.45	0.985
Jun-22	45,627	744,498	1.0000	744,498	16.32	0.908
Jul-22	45,729	833,747	1.0000	833,747	18.23	0.980
Aug-22	45,555	924,135	1.0000	924,135	20.29	1.146
Sep-22	45,728	1,057,338	0.9980	1,059,457	23.17	1.200
Oct-22	45,951	1,101,290	0.9920	1,110,171	24.16	1.261
Nov-22	46,106	1,089,683	0.9800	1,111,921	24.12	1.210
Dec-22	46,235	944,008	0.9380	1,006,405	21.77	1.173
FY2020	397,098			6,933,100	17.46	
FY2021	505,715			8,351,912	16.52	0.946
FY2022	543,219			10,011,267	18.43	1.116

FY2024 STAR Health Rating Analysis
Estimated STAR Health Incurred Claims

Month	Number of Members	Outpatient Claims Incurred and Paid	Completion Factor	Estimated Incurred Claims	Estimated Incurred pmpm	Trend Factor
Sep-19	32,685	1,003,375	1.0000	1,003,375	30.70	
Oct-19	32,771	1,218,721	1.0000	1,218,721	37.19	
Nov-19	32,439	1,086,654	1.0000	1,086,654	33.50	
Dec-19	31,825	1,014,334	1.0000	1,014,334	31.87	
Jan-20	31,584	1,112,411	1.0000	1,112,411	35.22	
Feb-20	31,558	1,009,555	1.0000	1,009,555	31.99	
Mar-20	31,872	860,276	1.0000	860,276	26.99	
Apr-20	32,916	781,160	1.0000	781,160	23.73	
May-20	33,617	1,221,752	1.0000	1,221,752	36.34	
Jun-20	34,349	1,306,716	1.0000	1,306,716	38.04	
Jul-20	35,185	1,285,786	1.0000	1,285,786	36.54	
Aug-20	36,297	1,225,978	1.0000	1,225,978	33.78	
Sep-20	37,527	1,423,763	1.0000	1,423,763	37.94	1.236
Oct-20	38,684	1,457,680	1.0000	1,457,680	37.68	1.013
Nov-20	39,718	1,245,088	1.0000	1,245,088	31.35	0.936
Dec-20	40,633	1,286,527	1.0000	1,286,527	31.66	0.993
Jan-21	41,538	1,425,534	1.0000	1,425,534	34.32	0.974
Feb-21	42,375	1,193,973	1.0000	1,193,973	28.18	0.881
Mar-21	43,222	1,749,438	1.0000	1,749,438	40.48	1.500
Apr-21	43,343	1,655,767	1.0000	1,655,767	38.20	1.610
May-21	43,881	1,502,841	1.0000	1,502,841	34.25	0.942
Jun-21	44,478	1,630,976	1.0000	1,630,976	36.67	0.964
Jul-21	44,902	1,589,651	1.0000	1,589,651	35.40	0.969
Aug-21	45,414	1,529,430	1.0000	1,529,430	33.68	0.997
Sep-21	45,610	1,553,117	1.0000	1,553,117	34.05	0.898
Oct-21	45,531	1,618,417	1.0000	1,618,417	35.55	0.943
Nov-21	44,932	1,442,282	1.0000	1,442,282	32.10	1.024
Dec-21	44,852	1,558,447	1.0000	1,558,447	34.75	1.097
Jan-22	44,830	1,467,939	1.0000	1,467,939	32.74	0.954
Feb-22	44,873	1,344,832	1.0000	1,344,832	29.97	1.064
Mar-22	44,977	1,648,313	1.0000	1,648,313	36.65	0.905
Apr-22	45,235	1,442,968	1.0000	1,442,968	31.90	0.835
May-22	45,468	1,432,110	1.0000	1,432,110	31.50	0.920
Jun-22	45,627	1,555,565	1.0000	1,555,565	34.09	0.930
Jul-22	45,729	1,561,366	1.0000	1,561,366	34.14	0.964
Aug-22	45,555	1,731,215	1.0000	1,731,215	38.00	1.128
Sep-22	45,728	1,634,485	0.9980	1,637,761	35.82	1.052
Oct-22	45,951	1,492,320	0.9920	1,504,355	32.74	0.921
Nov-22	46,106	1,477,806	0.9800	1,507,965	32.71	1.019
Dec-22	46,235	1,373,850	0.9380	1,464,659	31.68	0.912
FY2020	397,098			13,126,719	33.06	
FY2021	505,715			17,690,668	34.98	1.058
FY2022	543,219			18,356,571	33.79	0.966

FY2024 STAR Health Rating Analysis
Estimated STAR Health Incurred Claims

Month	Number of Members	Inpatient Claims Incurred and Paid	Completion Factor	Estimated Incurred Claims	Estimated Incurred pmpm	Trend Factor
Sep-19	32,685	7,054,096	1.0000	7,054,096	215.82	
Oct-19	32,771	8,568,122	1.0000	8,568,122	261.45	
Nov-19	32,439	6,162,988	1.0000	6,162,988	189.99	
Dec-19	31,825	6,465,650	1.0000	6,465,650	203.16	
Jan-20	31,584	6,476,672	1.0000	6,476,672	205.06	
Feb-20	31,558	5,993,452	1.0000	5,993,452	189.92	
Mar-20	31,872	5,607,642	1.0000	5,607,642	175.94	
Apr-20	32,916	4,708,095	1.0000	4,708,095	143.03	
May-20	33,617	5,730,517	1.0000	5,730,517	170.46	
Jun-20	34,349	4,882,526	1.0000	4,882,526	142.14	
Jul-20	35,185	6,732,615	1.0000	6,732,615	191.35	
Aug-20	36,297	6,650,048	1.0000	6,650,048	183.21	
Sep-20	37,527	5,051,915	1.0000	5,051,915	134.62	0.624
Oct-20	38,684	5,719,705	1.0000	5,719,705	147.86	0.566
Nov-20	39,718	6,243,066	1.0000	6,243,066	157.18	0.827
Dec-20	40,633	7,980,963	1.0000	7,980,963	196.42	0.967
Jan-21	41,538	5,147,805	1.0000	5,147,805	123.93	0.604
Feb-21	42,375	5,531,765	1.0000	5,531,765	130.54	0.687
Mar-21	43,222	6,809,924	1.0000	6,809,924	157.56	0.896
Apr-21	43,343	5,123,819	1.0000	5,123,819	118.22	0.826
May-21	43,881	6,161,094	1.0000	6,161,094	140.40	0.824
Jun-21	44,478	6,698,952	1.0000	6,698,952	150.61	1.060
Jul-21	44,902	7,128,921	1.0000	7,128,921	158.77	0.830
Aug-21	45,414	5,942,630	1.0000	5,942,630	130.85	0.714
Sep-21	45,610	5,779,614	1.0000	5,779,614	126.72	0.941
Oct-21	45,531	6,375,235	1.0000	6,375,235	140.02	0.947
Nov-21	44,932	5,607,063	1.0000	5,607,063	124.79	0.794
Dec-21	44,852	5,407,358	1.0000	5,407,358	120.56	0.614
Jan-22	44,830	5,713,699	1.0000	5,713,699	127.45	1.028
Feb-22	44,873	4,894,657	1.0000	4,894,657	109.08	0.836
Mar-22	44,977	5,554,703	1.0000	5,554,703	123.50	0.784
Apr-22	45,235	5,821,998	1.0000	5,821,998	128.71	1.089
May-22	45,468	5,755,661	1.0000	5,755,661	126.59	0.902
Jun-22	45,627	5,362,127	1.0000	5,362,127	117.52	0.780
Jul-22	45,729	4,363,476	1.0000	4,363,476	95.42	0.601
Aug-22	45,555	4,956,121	1.0000	4,956,121	108.79	0.831
Sep-22	45,728	5,997,787	0.9980	6,009,807	131.42	1.037
Oct-22	45,951	5,697,950	0.9920	5,743,901	125.00	0.893
Nov-22	46,106	5,521,479	0.9800	5,634,162	122.20	0.979
Dec-22	46,235	3,845,470	0.9380	4,099,648	88.67	0.735
FY2020	397,098			75,032,423	188.95	
FY2021	505,715			73,540,559	145.42	0.770
FY2022	543,219			65,591,710	120.75	0.830

FY2024 STAR Health Rating Analysis
Estimated STAR Health Incurred Claims

		Vision				
Month	Number of Members	Claims Incurred and Paid	Completion Factor	Estimated Incurred Claims	Estimated Incurred pmpm	Trend Factor
Sep-19	32,685	134,595	1.0000	134,595	4.12	
Oct-19	32,771	132,192	1.0000	132,192	4.03	
Nov-19	32,439	112,776	1.0000	112,776	3.48	
Dec-19	31,825	103,208	1.0000	103,208	3.24	
Jan-20	31,584	92,667	1.0000	92,667	2.93	
Feb-20	31,558	83,482	1.0000	83,482	2.65	
Mar-20	31,872	66,328	1.0000	66,328	2.08	
Apr-20	32,916	20,679	1.0000	20,679	0.63	
May-20	33,617	57,385	1.0000	57,385	1.71	
Jun-20	34,349	86,391	1.0000	86,391	2.52	
Jul-20	35,185	86,371	1.0000	86,371	2.45	
Aug-20	36,297	85,202	1.0000	85,202	2.35	
Sep-20	37,527	102,858	1.0000	102,858	2.74	0.666
Oct-20	38,684	90,604	1.0000	90,604	2.34	0.581
Nov-20	39,718	90,304	1.0000	90,304	2.27	0.654
Dec-20	40,633	76,536	1.0000	76,536	1.88	0.581
Jan-21	41,538	86,465	1.0000	86,465	2.08	0.709
Feb-21	42,375	70,018	1.0000	70,018	1.65	0.625
Mar-21	43,222	106,387	1.0000	106,387	2.46	1.183
Apr-21	43,343	80,792	1.0000	80,792	1.86	2.967
May-21	43,881	76,393	1.0000	76,393	1.74	1.020
Jun-21	44,478	80,908	1.0000	80,908	1.82	0.723
Jul-21	44,902	86,766	1.0000	86,766	1.93	0.787
Aug-21	45,414	95,385	1.0000	95,385	2.10	0.895
Sep-21	45,610	83,592	1.0000	83,592	1.83	0.669
Oct-21	45,531	89,402	1.0000	89,402	1.96	0.838
Nov-21	44,932	81,363	1.0000	81,363	1.81	0.796
Dec-21	44,852	70,279	1.0000	70,279	1.57	0.832
Jan-22	44,830	70,156	1.0000	70,156	1.56	0.752
Feb-22	44,873	70,509	1.0000	70,509	1.57	0.951
Mar-22	44,977	93,364	1.0000	93,364	2.08	0.843
Apr-22	45,235	75,190	1.0000	75,190	1.66	0.892
May-22	45,468	66,448	1.0000	66,448	1.46	0.839
Jun-22	45,627	72,121	1.0000	72,121	1.58	0.869
Jul-22	45,729	72,540	1.0000	72,540	1.59	0.821
Aug-22	45,555	89,948	1.0000	89,948	1.97	0.940
Sep-22	45,728	90,913	0.9980	91,095	1.99	1.087
Oct-22	45,951	91,614	0.9920	92,353	2.01	1.024
Nov-22	46,106	87,064	0.9800	88,841	1.93	1.064
Dec-22	46,235	74,853	0.9380	79,801	1.73	1.102
FY2020	397,098			1,061,276	2.67	
FY2021	505,715			1,043,417	2.06	0.772
FY2022	543,219			934,912	1.72	0.834

FY2024 STAR Health Rating Analysis
Estimated STAR Health Incurred Claims

		Other - PDN, DME, Therapy				
Month	Number of Members	Claims Incurred and Paid	Completion Factor	Estimated Incurred Claims	Estimated Incurred pmpm	Trend Factor
Sep-19	32,685	8,447,566	1.0000	8,447,566	258.45	
Oct-19	32,771	8,921,493	1.0000	8,921,493	272.24	
Nov-19	32,439	8,151,095	1.0000	8,151,095	251.27	
Dec-19	31,825	8,071,619	1.0000	8,071,619	253.63	
Jan-20	31,584	8,535,919	1.0000	8,535,919	270.26	
Feb-20	31,558	8,130,523	1.0000	8,130,523	257.64	
Mar-20	31,872	8,458,523	1.0000	8,458,523	265.39	
Apr-20	32,916	8,021,317	1.0000	8,021,317	243.69	
May-20	33,617	8,226,757	1.0000	8,226,757	244.72	
Jun-20	34,349	8,467,313	1.0000	8,467,313	246.51	
Jul-20	35,185	8,725,313	1.0000	8,725,313	247.98	
Aug-20	36,297	8,801,441	1.0000	8,801,441	242.48	
Sep-20	37,527	8,851,273	1.0000	8,851,273	235.86	0.913
Oct-20	38,684	9,341,017	1.0000	9,341,017	241.47	0.887
Nov-20	39,718	8,715,080	1.0000	8,715,080	219.42	0.873
Dec-20	40,633	9,160,749	1.0000	9,160,749	225.45	0.889
Jan-21	41,538	8,916,954	1.0000	8,916,954	214.67	0.794
Feb-21	42,375	7,797,442	1.0000	7,797,442	184.01	0.714
Mar-21	43,222	9,389,107	1.0000	9,389,107	217.23	0.819
Apr-21	43,343	8,998,268	1.0000	8,998,268	207.61	0.852
May-21	43,881	8,986,824	1.0000	8,986,824	204.80	0.837
Jun-21	44,478	9,158,275	1.0000	9,158,275	205.91	0.835
Jul-21	44,902	9,389,091	1.0000	9,389,091	209.10	0.843
Aug-21	45,414	9,058,904	1.0000	9,058,904	199.47	0.823
Sep-21	45,610	8,911,607	1.0000	8,911,607	195.39	0.828
Oct-21	45,531	9,116,238	1.0000	9,116,238	200.22	0.829
Nov-21	44,932	8,892,207	1.0000	8,892,207	197.90	0.902
Dec-21	44,852	8,814,652	1.0000	8,814,652	196.53	0.872
Jan-22	44,830	8,311,975	1.0000	8,311,975	185.41	0.864
Feb-22	44,873	7,942,300	1.0000	7,942,300	177.00	0.962
Mar-22	44,977	9,186,557	1.0000	9,186,557	204.25	0.940
Apr-22	45,235	8,784,714	1.0000	8,784,714	194.20	0.935
May-22	45,468	9,267,507	1.0000	9,267,507	203.82	0.995
Jun-22	45,627	9,308,124	1.0000	9,308,124	204.00	0.991
Jul-22	45,729	9,512,622	1.0000	9,512,622	208.02	0.995
Aug-22	45,555	9,638,277	1.0000	9,638,277	211.57	1.061
Sep-22	45,728	9,115,102	0.9980	9,133,369	199.73	1.022
Oct-22	45,951	9,596,064	0.9920	9,673,452	210.52	1.051
Nov-22	46,106	9,377,528	0.9800	9,568,906	207.54	1.049
Dec-22	46,235	9,202,030	0.9380	9,810,266	212.18	1.080
FY2020	397,098			100,958,879	254.24	
FY2021	505,715			107,762,984	213.09	0.838
FY2022	543,219			107,686,780	198.24	0.930

FY2024 STAR Health Rating Analysis
Estimated STAR Health Incurred Claims

		Total - Medical				
Month	Number of Members	Claims Incurred and Paid	Completion Factor	Estimated Incurred Claims	Estimated Incurred pmpm	Trend Factor
Sep-19	32,685	24,998,140	1.0000	24,998,140	764.82	
Oct-19	32,771	28,168,533	1.0000	28,168,533	859.56	
Nov-19	32,439	23,857,263	1.0000	23,857,263	735.45	
Dec-19	31,825	23,690,046	1.0000	23,690,046	744.38	
Jan-20	31,584	25,029,999	1.0000	25,029,999	792.49	
Feb-20	31,558	23,581,114	1.0000	23,581,114	747.23	
Mar-20	31,872	22,810,285	1.0000	22,810,285	715.68	
Apr-20	32,916	20,589,928	1.0000	20,589,928	625.53	
May-20	33,617	22,929,211	1.0000	22,929,211	682.07	
Jun-20	34,349	23,065,266	1.0000	23,065,266	671.50	
Jul-20	35,185	25,304,685	1.0000	25,304,685	719.19	
Aug-20	36,297	25,145,129	1.0000	25,145,129	692.76	
Sep-20	37,527	24,194,873	1.0000	24,194,873	644.73	0.843
Oct-20	38,684	25,581,766	1.0000	25,581,766	661.30	0.769
Nov-20	39,718	24,547,136	1.0000	24,547,136	618.04	0.840
Dec-20	40,633	27,047,660	1.0000	27,047,660	665.66	0.894
Jan-21	41,538	24,174,953	1.0000	24,174,953	582.00	0.734
Feb-21	42,375	22,091,734	1.0000	22,091,734	521.34	0.698
Mar-21	43,222	27,795,273	1.0000	27,795,273	643.08	0.899
Apr-21	43,343	25,396,536	1.0000	25,396,536	585.94	0.937
May-21	43,881	25,866,505	1.0000	25,866,505	589.47	0.864
Jun-21	44,478	26,926,179	1.0000	26,926,179	605.38	0.902
Jul-21	44,902	27,430,424	1.0000	27,430,424	610.90	0.849
Aug-21	45,414	25,913,462	1.0000	25,913,462	570.61	0.824
Sep-21	45,610	25,638,566	1.0000	25,638,566	562.13	0.872
Oct-21	45,531	26,365,085	1.0000	26,365,085	579.06	0.876
Nov-21	44,932	24,637,062	1.0000	24,637,062	548.32	0.887
Dec-21	44,852	24,117,864	1.0000	24,117,864	537.72	0.808
Jan-22	44,830	23,857,723	1.0000	23,857,723	532.18	0.914
Feb-22	44,873	22,145,117	1.0000	22,145,117	493.51	0.947
Mar-22	44,977	25,731,650	1.0000	25,731,650	572.11	0.890
Apr-22	45,235	24,865,250	1.0000	24,865,250	549.69	0.938
May-22	45,468	25,257,069	1.0000	25,257,069	555.49	0.942
Jun-22	45,627	24,845,607	1.0000	24,845,607	544.54	0.899
Jul-22	45,729	23,487,120	1.0000	23,487,120	513.62	0.841
Aug-22	45,555	25,505,714	1.0000	25,505,714	559.89	0.981
Sep-22	45,728	25,723,043	0.9980	25,774,593	563.65	1.003
Oct-22	45,951	25,746,613	0.9920	25,954,247	564.83	0.975
Nov-22	46,106	24,856,623	0.9800	25,363,901	550.12	1.003
Dec-22	46,235	22,162,952	0.9380	23,627,881	511.04	0.950
FY2020	397,098			289,169,600	728.21	
FY2021	505,715			306,966,501	607.00	0.834
FY2022	543,219			296,453,828	545.74	0.899

FY2024 STAR Health Rating Analysis
Estimated STAR Health Incurred Claims

		Prescription Drug				
Month	Number of Members	Claims Incurred and Paid	Completion Factor	Estimated Incurred Claims	Estimated Incurred pmpm	Trend Factor
Sep-19	32,685	3,021,230	1.0000	3,021,230	92.43	
Oct-19	32,771	3,303,462	1.0000	3,303,462	100.80	
Nov-19	32,439	3,153,573	1.0000	3,153,573	97.22	
Dec-19	31,825	3,539,241	1.0000	3,539,241	111.21	
Jan-20	31,584	3,193,486	1.0000	3,193,486	101.11	
Feb-20	31,558	2,973,564	1.0000	2,973,564	94.23	
Mar-20	31,872	3,088,397	1.0000	3,088,397	96.90	
Apr-20	32,916	2,592,416	1.0000	2,592,416	78.76	
May-20	33,617	2,595,927	1.0000	2,595,927	77.22	
Jun-20	34,349	2,800,447	1.0000	2,800,447	81.53	
Jul-20	35,185	2,944,931	1.0000	2,944,931	83.70	
Aug-20	36,297	2,757,653	1.0000	2,757,653	75.97	
Sep-20	37,527	2,662,333	1.0000	2,662,333	70.94	0.768
Oct-20	38,684	2,705,869	1.0000	2,705,869	69.95	0.694
Nov-20	39,718	2,672,237	1.0000	2,672,237	67.28	0.692
Dec-20	40,633	2,926,640	1.0000	2,926,640	72.03	0.648
Jan-21	41,538	2,886,967	1.0000	2,886,967	69.50	0.687
Feb-21	42,375	2,618,020	1.0000	2,618,020	61.78	0.656
Mar-21	43,222	3,003,108	1.0000	3,003,108	69.48	0.717
Apr-21	43,343	2,793,598	1.0000	2,793,598	64.45	0.818
May-21	43,881	2,584,044	1.0000	2,584,044	58.89	0.763
Jun-21	44,478	2,969,656	1.0000	2,969,656	66.77	0.819
Jul-21	44,902	2,681,704	1.0000	2,681,704	59.72	0.714
Aug-21	45,414	2,924,913	1.0000	2,924,913	64.41	0.848
Sep-21	45,610	3,010,080	1.0000	3,010,080	66.00	0.930
Oct-21	45,531	2,909,874	1.0000	2,909,874	63.91	0.914
Nov-21	44,932	3,059,244	1.0000	3,059,249	68.09	1.012
Dec-21	44,852	3,010,986	1.0000	3,010,990	67.13	0.932
Jan-22	44,830	3,119,372	1.0000	3,119,372	69.58	1.001
Feb-22	44,873	2,636,712	1.0000	2,636,712	58.76	0.951
Mar-22	44,977	2,903,456	1.0000	2,903,456	64.55	0.929
Apr-22	45,235	2,837,621	1.0000	2,837,621	62.73	0.973
May-22	45,468	2,740,364	1.0000	2,740,364	60.27	1.023
Jun-22	45,627	2,865,160	1.0000	2,865,160	62.80	0.941
Jul-22	45,729	2,710,111	1.0000	2,710,111	59.26	0.992
Aug-22	45,555	3,220,737	1.0000	3,220,737	70.70	1.098
Sep-22	45,728	3,166,722	1.0000	3,166,722	69.25	1.049
Oct-22	45,951	3,094,676	1.0000	3,094,676	67.35	1.054
Nov-22	46,106	2,784,105	1.0000	2,784,105	60.38	0.887
Dec-22	46,235	2,744,534	1.0000	2,744,534	59.36	0.884
FY2020	397,098			35,964,327	90.57	
FY2021	505,715			33,429,088	66.10	0.730
FY2022	543,219			35,023,726	64.47	0.975

FY2024 STAR Health Rating Analysis
Estimated STAR Health Incurred Claims

		NEMT				
Month	Number of Members	Claims Incurred and Paid	Completion Factor	Estimated Incurred Claims	Estimated Incurred pmpm	Trend Factor
Sep-19	32,685	0	1.0000	0	-	
Oct-19	32,771	0	1.0000	0	-	
Nov-19	32,439	0	1.0000	0	-	
Dec-19	31,825	0	1.0000	0	-	
Jan-20	31,584	0	1.0000	0	-	
Feb-20	31,558	0	1.0000	0	-	
Mar-20	31,872	0	1.0000	0	-	
Apr-20	32,916	0	1.0000	0	-	
May-20	33,617	0	1.0000	0	-	
Jun-20	34,349	0	1.0000	0	-	
Jul-20	35,185	0	1.0000	0	-	
Aug-20	36,297	0	1.0000	0	-	
Sep-20	37,527	0	1.0000	0	-	
Oct-20	38,684	0	1.0000	0	-	
Nov-20	39,718	0	1.0000	0	-	
Dec-20	40,633	0	1.0000	0	-	
Jan-21	41,538	0	1.0000	0	-	
Feb-21	42,375	0	1.0000	0	-	
Mar-21	43,222	0	1.0000	0	-	
Apr-21	43,343	0	1.0000	0	-	
May-21	43,881	0	1.0000	0	-	
Jun-21	44,478	24,663	1.0000	24,663	0.55	
Jul-21	44,902	28,575	1.0000	28,575	0.64	
Aug-21	45,414	28,878	1.0000	28,878	0.64	
Sep-21	45,610	35,736	1.0000	35,736	0.78	
Oct-21	45,531	35,805	1.0000	35,805	0.79	
Nov-21	44,932	34,685	1.0000	34,685	0.77	
Dec-21	44,852	41,555	1.0000	41,555	0.93	
Jan-22	44,830	32,978	1.0000	32,978	0.74	
Feb-22	44,873	38,605	1.0000	38,605	0.86	
Mar-22	44,977	46,749	1.0000	46,749	1.04	
Apr-22	45,235	40,424	1.0000	40,424	0.89	
May-22	45,468	50,744	1.0000	50,744	1.12	
Jun-22	45,627	65,314	1.0000	65,314	1.43	2.582
Jul-22	45,729	64,714	1.0000	64,714	1.42	2.224
Aug-22	45,555	68,196	1.0000	68,196	1.50	2.354
Sep-22	45,728	75,196	1.0000	75,196	1.64	2.099
Oct-22	45,951	65,081	1.0000	65,081	1.42	1.801
Nov-22	46,106	56,823	1.0000	56,823	1.23	1.597
Dec-22	46,235	50,638	0.6451	78,494	1.70	1.832
CY2020	423,940			0	-	
CY2021	530,078			229,898	0.43	
7/2022-12/2022	275,304			408,505	1.48	3.421

Attachment 3

STAR Health Trend Analysis

Medical

The FY2024 rating methodology uses assumed medical trend factors to adjust the base period claims cost to the rating period (FY2024). The cost trend factors used in this analysis are a combination of utilization and inflation components. The projected trend rate assumptions were developed by the actuary based on an analysis of recent experience under the plan. The trend assumption is established on a statewide basis.

The trend analysis included a review of MCO claims experience data through February 28, 2023. Based on this information, estimates of monthly incurred claims were made through December 31, 2022. The claims cost and trend experience was reviewed separately by type of service.

Exhibit A provides a summary of the FY2017, FY2018, FY2019 and FY2020 trends by category of service. The FY2020 trend represents the trend during the period September 2019 through February 2020. All trends have been calculated as the average cost per member per month during the specified time period compared to the same time period during the prior fiscal year. For example, the FY2019 trend is calculated as the average cost per member per month during FY2019 divided by the average cost per member per month during FY2018.

All trends have been adjusted to remove the impact of the various provider reimbursement changes that have impacted the cost of the program. These adjustments are made for all items that have materially impacted historical costs and have distorted the trend from one time period to the next. For example, in September 1, 2019 the standard dollar amounts on which children's and rural hospital reimbursement is determined were revised resulting in a significant reimbursement increase for these facilities. As a result, the FY2020 observed trends are adjusted to remove the impact of the increased cost associated with these services to ensure the average cost during FY2019 and FY2020 are based on comparable services and reimbursement levels and the underlying trend is calculated.

Trends beyond February 2020 have been analyzed but excluded from the trend analysis due to the significant distortion caused by the COVID-19 pandemic and the corresponding PHE declaration. From March 2020 to December 2022, enrollment increased by over 40% while the average cost dropped by over 30%. These patterns are not expected to continue into FY2024 and therefore the trends for this time period have not been assigned any credibility.

The trend assumptions were then developed from an average of the FY2017, FY2018, FY2019 and September 2019 through February 2020 STAR Health trends. The weighting of each time period was based on the number of months within each time period.

Although the medical trends were reviewed by component – professional, outpatient, inpatient, etc., a single trend assumption was selected and applied in aggregate. The MCO is paid a single

capitation rate that does not vary by medical component. Splitting the analysis into separate components (inpatient, physician, etc…) does not add any additional accuracy to the analysis but could increase the probability of distortions in the projection due to reporting differences among fiscal years, small sample sizes in a given category of service, or variations in the trend projections that could emerge for a category. There is significant interaction amongst all categories of service as MCOs may shift cost away from inpatient toward outpatient and looking at an individual category in isolation could lead to overgeneralizations. The aggregate analysis performed takes into consideration all service categories and their interactions with one another without sacrificing accuracy.

Use of the aggregate trend captures all interactions between categories of service, including the ongoing shifts that occur, and is reflective of the expected level of cost trend in future periods.

Prescription Drug

The rating methodology uses assumed pharmacy trend factors to adjust the base period (FY2022) claims cost to the rating period (FY2024). The trend rate assumptions were developed by the actuary based on an analysis of recent pharmacy claims experience for STAR Health clients. The trend rate assumption is the same for all clients and all service areas.

The trend analysis included a review of STAR Health utilization and cost experience data paid through March 31, 2023. Incurred monthly utilization (days supply per member) and cost per service (plan payments per days supply) statistics were developed through February 2023. From this experience, the average annual utilization and cost per service were determined for each of the six 12-month periods ending February 2023.

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

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

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

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

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

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

NEMT

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

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

Statewide NEMT trend experience for all Medicaid managed care programs was used due to small sample size. The NEMT trend analysis only includes demand response service. Mileage reimbursement service was excluded since reimbursement is equal to the state's mileage reimbursement rate. All other NEMT services such as airfare, meals and lodging are excluded from the trend analysis due to low volume and variation from year to year. In addition, experience for MTO Region 1 and MTO Region 10 changed MTO provider effective September 1, 2017 and

experience for these regions was excluded from the trend analysis. The statewide NEMT trend assumptions were developed using an average of the three most recent 12-month period trends ending February 2020.

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

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

FY2024 STAR Health Rating Analysis
Trend Development - Medical

Historical Average Trend (1)	Professional	Outpatient - ER	Outpatient - Non ER	Inpatient	Vision	Other	Total
FY2017	-0.6%	1.9%	-4.0%	-2.1%	-4.1%	-3.6%	-2.8%
FY2018	4.4%	7.6%	10.0%	8.2%	5.8%	3.5%	5.2%
FY2019	6.0%	2.0%	4.5%	10.0%	0.0%	15.6%	9.3%
9/2019-2/2020	7.6%	7.9%	9.2%	13.6%	-8.2%	13.3%	9.7%

Trend Assumption (2) 4.7%

Footnotes:
(1) Trends have been adjusted to remove the impact of policy and reimbursement changes.
(2) Average trend during FY2017, FY2018, FY2019 and first six months of FY2020.

FY2024 Prescription Drug Rating Analysis
STAR Health Pharmacy Trends

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

FY2024 Prescription Drug Rating Analysis
STAR Health Pharmacy Trends

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

FY2024 STAR Health Rating Analysis
Trend Development - NEMT

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

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

Attachment 4

Provider Reimbursement Adjustments

This attachment presents information regarding rating adjustments for the various provider reimbursement and benefit revisions that became effective (or will become effective) after the beginning of the base period used in rate setting and before the end of FY2024.

The benefit and provider reimbursement changes recognized in the FY2024 rate setting are listed below. The rating adjustments for these provider reimbursement changes were calculated by applying actual MCO encounter data to the old and new reimbursement bases and the resulting impact determined. The attached exhibit presents a summary of the derivation of the adjustment factors.

<u>Provider Reimbursement Adjustments</u>

- Effective September 1, 2017, FQHC wrap payments were carved out of managed care. HHSC has developed policy language to ensure that FQHCs are reimbursed their full encounter rate; however, the MCO will only be responsible for reimbursing the FQHC an amount no less than the rate paid to non-FQHC providers providing similar services.

- Invalid clinician administered drugs have been removed from the base period. HHSC has provided guidance to the MCOs which specifies the reporting requirements for a CAD to be considered a valid claim.

- Effective March 1, 2022, HHSC made revisions to the reimbursement for outpatient behavioral health services.

- Effective September 1, 2022, HHSC made revisions to the reimbursement for vaccine administration services.

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

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

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

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

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

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

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

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

Hospital Reimbursement Adjustments

- As a result of annual evaluations, several hospitals have had their Standard Dollar Amount (SDA) revised between the base period and FY2024. In addition, increases will be applied to the SDA applicable to rural hospital deliveries effective September 1, 2023.

- Beginning May 1, 2013, HHSC implemented revisions to hospital reimbursement to account for Potentially Preventable Readmissions (PPR). The reimbursement reductions amount to 1-2% depending on a hospital's performance during the evaluation period and can change from one fiscal year to the next. A new PPR reduction list will become effective September 1, 2023. As a result, the adjustment factors represent the restoration of those reductions that were in place during the base period net of those reductions that will be in place during FY2024.

- Beginning March 1, 2014, HHSC implemented revisions to hospital reimbursement to account for Potentially Preventable Complications (PPC). The reimbursement reductions amount to 2-2.5% depending on a hospital's performance during the evaluation period and can change from one fiscal year to the next. A new PPC reduction list will become effective September 1, 2023. As a result, the adjustment factors represent the restoration of those reductions that were in place during the base period net of those reductions that will be in place during FY2024.

- Effective September 1, 2019, HHSC began utilizing an adjustment to the base period data that analyzes inefficiencies and potentially preventable expenses that unnecessarily increase managed care costs. This analysis was performed using the 3M™ PPR methodology which is a computerized algorithm to identify readmissions with a plausible clinical relationship to the care rendered during or immediately following a prior hospital admission. An expected reduction of PPR events of 10% has been applied for FY2024. The 10% PPR adjustment is intended to be an incremental step in improving the quality and efficiency of the managed care programs. This assumption will be monitored as actual experience develops and reassessed in future rating periods.

Pharmacy Adjustments

- The three pharmaceutical manufacturers Eli Lilly, Novo Nordisk and Sanofi have publicly announced that the list price for certain insulins will be reduced by approximately 70% no later than January 1, 2024.

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

NEMT Adjustments

- Effective January 1, 2023, reimbursement for Individual Transportation Participant (ITP) service increased to $0.655 per mile. The base period claims cost for ITP service has been adjusted to reflect this change.

The attached exhibit presents a summary of the rating adjustment factors. With the exception of the FQHC adjustment factor, all adjustment factors were calculated by repricing the FY2022 base period encounter data with both the old and new reimbursement terms and comparing the relative difference. Although the MCOs are not required to change their reimbursement levels based on changes implemented by HHSC, the Medicaid fee schedule serves as a primary negotiating tool for both MCOs and providers in Texas. Many MCO/provider reimbursement contracts are directly tied to the Medicaid FFS fee schedule through established percentages (e.g. 100%, 102%, 95% etc.). As a result, MCO reimbursement has historically changed in conjunction with Medicaid FFS fee schedule changes, both increases and decreases. Furthermore, it is common for provider reimbursement contracts that are directly tied to the Medicaid fee schedule (i.e. set at a % of Medicaid) to automatically adjust when the Medicaid fee schedule changes with no further need for recontracting. The correlation between managed care reimbursement and FFS fee schedules has been consistently observed throughout the history of the Texas managed care programs and is reiterated through discussions with the MCOs.

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

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

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 %

NEMT Carve-in Adjustment Factors

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

Attachment 5

PHE Related Cost Adjustment

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

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

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

Current Medicaid members are spread throughout these cohorts based on known eligibility information and type program/type of assistance but are not specific to Medicaid program. Each cohort contains members from any Medicaid program and the disenrollments and renewals are staggered throughout the twelve-month period with the majority occurring in the first six months. Based on the planned PHE unwinding process and detailed information regarding the specific Medicaid members within each cohort and their expected redetermination dates, HHS Forecasting has developed projected caseload forecasts for each Medicaid program by month, service delivery area, MCO and risk group through the end of FY2024.

Given that the FY2022 base period was heavily impacted by the PHE and the expected disenrollments that will occur during FY2024, it is necessary to calculate an adjustment factor to properly estimate the impact of the PHE unwind process. The PHE impact was not uniform across all Medicaid programs and the adjustment factors calculated are specific to the populations being rated based on historical program-specific experience.

<u>Medical and Pharmacy Adjustment</u>

In order to estimate the impact of the PHE unwind on the FY2024 medical and prescription drug average costs, we have analyzed the base period claims using two methods: (1) Cohort Methodology and (2) Non-Utilizer Distribution Methodology. Each method is a reasonable approach to measuring the PHE impact, which is inherently complicated since the task is to compare a period of known overstated enrollment and understated average cost with a rating period in which a theoretical disenrollment process will occur. Given the unknown factors associated with the PHE unwind process, we have averaged the results of the two reasonable methodologies, each assigned equal weighting, in order to minimize the reliance on a single data point in analyzing the

expected PHE-related cost impact. Items A and B below further describe the details of the two methodologies.

A. Cohort Methodology

HHSC provided a list of Medicaid IDs for members in Cohorts 1, 2 and 3. The cohorts are grouped based on various circumstances including how likely they are to be ineligible for coverage. Cohort 1 includes individuals most likely to be ineligible for coverage such as members who age out of the program. Cohort 2 includes individuals likely to transfer to another HHSC program such as pregnant women transitioning to the Healthy Texas Women Program. Cohort 3 includes the remaining population that could potentially be ineligible for coverage, but also includes individuals who could potentially remain eligible based on redetermination. Everyone who is not included in Cohorts 1, 2 and 3 is assumed to remain eligible under the program.

The base period average cost per member per month was determined for members within each cohort. The PHE adjustment was determined by comparing (1) the projected FY2022 average cost excluding members who are continuously enrolled due to the PHE to (2) the actual FY2022 average cost. Members who are expected to be ineligible (i.e., continuously enrolled due to PHE) and disenrolled from the program were identified starting with Cohort 1, then Cohort 2, etc. such that the number of members expected to remain in the program by risk group is less than or equal to the number of members enrolled prior to the PHE for the period March 2019 through February 2020. The adjustment factor was defined as the adjusted FY2022 average cost excluding members expected to be disenrolled divided by the actual FY2022 average cost including all members.

The derivation of the Cohort Method adjustment factors is included in Exhibit A.

B. Non-Utilizer Distribution Methodology

An analysis of the distribution of average monthly claims cost by member and by size during the PHE demonstrates material changes since being relatively stable prior to the PHE. Most notably, the percentage of members with $0 claims during a given month has increased significantly. In our opinion; this change is most closely tied to the large enrollment growth associated with the continuous eligibility requirements. We have further observed that the distribution of claimants utilizing services, i.e., claimants with greater than $0 in a given month, has not changed significantly during the PHE. Based on this analysis, we conclude that the distribution of non-utilizers is one of the primary causes of average cost differences during the PHE and the FY2022 base period.

The increase in the percentage of non-utilizers is largest in those programs and risk groups with the most enrollment growth. Consequently, those programs and risk groups are likely to be those most heavily impacted by the PHE unwind process.

The base period average cost was adjusted by applying the distribution of non-utilizers during the twelve-month period immediately preceding the PHE to the average cost per utilizer observed during the FY2022 base period. For example,

- FY2022 actual average cost = $100
- FY2022 percentage of non-utilizers – 55%
- FY2022 average cost per utilizer – $100 divided by (1-.55) = $222.22
- 3/2019-2/2020 percentage of non-utilizers – 30%
- FY2022 adjusted average cost - $222.22 multiplied by (1-.30) = $155.56
- PHE adjustment factor = $155.56 divided by $100 = 1.5556

The derivation of the Non-Utilizer Distribution Method adjustment factors is included in Exhibit A.

The two methodologies are then weighted 50/50 in order to estimate the full impact of the PHE-related cost impact on the FY2022 base period. The PHE adjustment factors calculated for each methodology is limited to no less than 1.0 since it is not expected that the PHE unwind would have a negative impact on average cost.

The methodologies described above assume that all impacted members will unwind and be disenrolled prior to the rating period. In other words, the calculated adjustment factors represent the full impact of the PHE. Given that the PHE unwind process will occur throughout FY2024, a weighting factor must be applied to the calculated adjustment in order to properly account for the partial impact expected during FY2024. The weighting factor has been calculated by analyzing the percentage of cumulative disenrollments expected each month during the rating period and developing a weighted average based on monthly enrollment. Risk groups that are not expected to have a reduction in enrollment are assigned a weight of 0% since the PHE unwind is not expected to impact these groups. Exhibit B provides the derivation of the weighting factor and the application to the full adjustment factor calculated in Exhibit A.

NEMT Adjustment

The impact of the PHE unwind process on NEMT was considered; however, an adjustment has not been applied due to the following reasons.

- Some of the MCOs capitate NEMT services and the subcapitated rate will not change after the end of the PHE.
- The basis for PHE adjustment is that the base period cost is understated compared to pre-PHE periods. That is not the case for NEMT services due to the NEMT carve-in to the MCOs effective June 1, 2021. Prior to this, NEMT services were provided by the Medical Transportation Organizations (MTOs). The average cost for NEMT services during the base period is higher than it was for the period March 2019 through February 2020.
- The PHE adjustment is developed by comparing non-utilizers between the base period and the pre-PHE period March 2019 through February 2020. Due to the NEMT carve-in effective June 1, 2021, utilization patterns have changed significantly. It would be inappropriate to assume non-utilizers will be similar to pre-PHE periods when NEMT services were provided by the MTOs.

In order to capture more recent NEMT experience and the changing utilization patterns, the base period for NEMT service has been defined as July 1, 2022 through December 31, 2022.

FY2024 STAR Health Rating Analysis
PHE Related Cost Adjustment

	Cohort Methodology		
	FY2022 PMPM		Adjustment
	Actual (1)	Adjusted (2)	Factor (3)
Medical	530.10	640.70	1.2086
Pharmacy	63.29	74.95	1.1843

	Non-Utilizer Distribution Methodology				
	% of Member with $0 (4)		FY2022	FY2022	Adjustment
	3/2019-2/2020	FY2022	Avg Cost/Utilizer (5)	Adjusted (6)	Factor (3)
Medical	30.8%	49.3%	1,046.17	723.63	1.3651
Pharmacy	59.1%	69.9%	210.03	85.86	1.3566

	Medical	Pharmacy
Cohort Method	1.2086	1.1843
Non-Utilizer Distribution Method	1.3651	1.3566
Weighed Average (7)	1.2869	1.2705

(1) Average cost pmpm from encounter database, does not include IBNR or subcapitated expenses paid to related party.
(2) Average cost excluding members in disenrollment cohorts 1, 2 and 3 that will lose continuous eligibility during PHE unwind.
(3) Adjusted divided by actual.
(4) Percentage of total population with $0 utilization during the measurement period.
(5) Average cost of members with claims greater than $0.
(6) Average Cost/Utilizer multiplied by (1-% of Member with $0 during 3/2019-2/2020).
(7) Average of the two methods.

FY2024 STAR Health Rating Analysis
PHE Related Cost Adjustment

	% of Total Disenrollment (1)
Sep-23	0%
Oct-23	0%
Nov-23	55%
Dec-23	56%
Jan-24	56%
Feb-24	56%
Mar-24	56%
Apr-24	71%
May-24	86%
Jun-24	100%
Jul-24	100%
Aug-24	100%
Weighted Impact (2)	57.8%

PHE Adjustment Factor (3)	
Medical	0.2869
Pharmacy	0.2705

PHE Adjustment Factor -Weighted (4)	
Medical	16.58%
Pharmacy	15.63%

(1) Cumulative percentage of disenrollments occurring by month.
(2) Annual weighted impact based on enrollment by month.
(3) From Exhibit A. Represents total impact upon completion of the PHE unwind.
(4) PHE Adjustment Factor multiplied by Weighted Impact.

Attachment 6

Community First Choice (CFC)

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

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

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

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

Based on this calculation, the projected CFC portion of the total premium rate which is eligible for the enhanced federal match is $2.61 per member per month.

FY2024 STAR Health Rating Analysis
CFC Enhanced Match Calculation

FY2022 Personal Care Services (1)	873,200
FY2022 Total Claims	296,453,828
PCS % of Total	0.3%
FY2024 Premium Rate	886.59
CFC Portion of Premium Rate (2)	2.61

Footnotes:
(1) Total PCS provided to CFC eligible members.
(2) PCS % of Total Claims multiplied by FY2024 Premium Rate.

Attachment 7

In Lieu of Services

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

a) For individuals between the ages of 21 and 64, services are provided in IMDs only in lieu of an acute care hospital setting. IMD services for individuals under age 21 and age 65 and over are covered pursuant to the Texas state plan.

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

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

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

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

The ILOS Cost Percentage has been estimated as follows:

1. Collect information on ILOS paid claims for items (b)-(e) above during the FY2022 base period. ILOS claims = $602,822
2. Divide #1 by total medical claims during the FY2022 base period. ILOS % of medical claims equals 0.2%.
3. Divide FY2024 projected medical claims by FY2024 total projected capitation equals 71.7%.
4. Multiply #3 by #2 = .717 * .002 = 0.1%

Based on this analysis the ILOS cost percentage is 0.1% which is immaterial. The ILOSs were considered in the rate development in the same manner as all other services. No special consideration or different approaches were applied to the ILOSs in comparison to any other category of service.

Attachment 8

FY2024 STAR Health Rate Certification Index

The index below includes the pages of this report 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 12-month period September 1, 2023 through August 31, 2024 (FY2024).

iii. (a) The certification letter is on page 16 of the report.

(b) The final capitation rates are shown on page 15 of the report.

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

(ii) See page 1 of the report.

(iii) See page 1 of the report.

(iv) Not applicable. There have been no changes since the prior certification.

(v) Not applicable. There are no special contract provisions related to payment within the STAR Health program.

(vi) Not applicable.

iv. Acknowledged.

v. Acknowledged.

vi. Acknowledged.

vii. Acknowledged.

viii. Not applicable.

ix. Not applicable.

x. Acknowledged.

xi. Acknowledged.

xii. See pages 5, 7, 11 through 12 and 45 through 49 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 15 and 16 of the report.

ii. Acknowledged.

iii. Acknowledged.

iv. Not applicable.

v. Acknowledged.

vi. Acknowledged. See page 16 of the report.

vii. See pages 50 through 51 of the report.

viii. (a) See pages 18 through 22 of the report.

(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 report.

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

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

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

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

(d) Not applicable.

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

(b) See page 3 of the report.

(c) No errors found in the data.

(d) See pages 41 through 44 of the report.

(e) Value added services and non-capitated services have been excluded from the analysis.

3. Projected Benefit Costs and Trends

A. Rate Development Standards

i. Acknowledged.

ii. Acknowledged.

iii. Acknowledged.

iv. Acknowledged. See page 52 of the report.

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

B. Appropriate Documentation

i. See pages 18 through 22 of the report.

ii. (a) See pages 18 through 22 of the report.

(b) There have been no significant changes in the development of the benefit cost since the last certification.

(c) All recoupments and recoveries resulting from overpayments to providers have been netted out of the claim payments used in the rate development. MCOs are required to adjust encounter data to remove all overpayments and correct the submitted information. Any provider recoveries not adjusted for in the submitted encounter data are excluded from the base period as a negative add-on payment.

iii. (a) See pages 33 through 40 of the report.

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

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

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

(e) Not applicable.

iv. Not applicable.

v. See page 52 of the report.

vi. (a) Restorative enrollment can occur when an individual is deemed to have been Medicaid eligible during a prior period. If the individual was eligible for and enrolled in Medicaid managed care during the prior six months, then the individual is retrospectively enrolled in the same managed care plan as their prior enrollment segment. The managed care plan is then retrospectively responsible for all Medicaid expenses incurred during this retrospective period and is also paid a retrospective premium for this time period.

(b) All claims paid during retroactive enrollment periods are included in the base period data used to develop the 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 report.

viii. See pages 41 through 44 of the report.

4. Special Contract Provisions Related to Payment

A. Incentive Arrangements

i. Rate Development Standards

Not applicable.

ii. Appropriate Documentation

Not applicable.

B. Withhold Arrangements

i. Rate Development Standards

Not applicable.

ii. Appropriate Documentation

Not applicable.

C. Risk-Sharing Arrangements

i. Rate Development Standards

Acknowledged.

ii. Appropriate Documentation

HHSC includes an experience rebate provision in its uniform managed care contracts which requires the MCOs to return a portion of net income before taxes if greater than the specified percentages. The net income is measured by the financial statistical reports (FSRs) submitted by the MCOs and audited by an external auditor. Net income is aggregated across all programs and service delivery areas. The aggregated net income is shared as follows:

Pre-tax Income as a % of Revenues	MCO Share	HHSC Share
≤ 3%	100%	0%
> 3% and ≤ 5%	80%	20%
> 5% and ≤ 7%	60%	40%
> 7% and ≤ 9%	40%	60%
> 9% and ≤ 12%	20%	80%
> 12%	0%	100%

D. State Directed Payments

i. Rate Development Standards

Not applicable.

ii. Appropriate Documentation

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

(b) Confirmed.

(c) Confirmed.

E. Pass-Through Payments

i. Rate Development Standards

Not applicable.

ii. Appropriate Documentation

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

5. Projected Non-Benefit Costs

A. Rate Development Standards

i. Acknowledged.

ii. Acknowledged.

B. Appropriate Documentation

i. See pages 13 through 14 of the report.

ii. See pages 13 through 14 of the report.

iii. See pages 13 through 14 of the report.

6. Risk Adjustment

A. Rate Development Standards

i. Acknowledged.

ii. Acknowledged.

B. Appropriate Documentation

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

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

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

7. Acuity Adjustments

A. Rate Development Standards

i. Acknowledged.

B. Appropriate Documentation

i. (a) See pages 10 and 45 through 49 of the report.

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

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

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

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

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

(g) As detailed in pages 45 through 49 of the report the adjustment has been calculated in accordance with generally accepted actuarial principles and practices.

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

Not applicable

Section III. New Adult Group Capitation Rates

Not applicable