Lisa R. Collier, CPA, CFE, CIDA
State Auditor

An Actuarial Analysis of

The Health and Human Services Commission's Fiscal Year 2024 Medicaid Managed Care Rates

September 1, 2023

Members of the Legislative Audit Committee:

The General Appropriations Act[1] directed the State Auditor's Office to conduct an actuarial analysis of the Health and Human Services Commission's (Commission) fiscal year 2024 Medicaid managed care rates and report on the actuarial soundness of the rates, as well as provide an analysis of key factors that affect the rates. This is the third report that the State Auditor's Office has released to address those requirements.

The State Auditor's Office contracted with the actuarial firm Milliman, Inc. (Milliman) to evaluate the actuarial soundness of the rates and analyze key factors that affect the rates, including rate structure, historical cost and enrollment data, data validation, adjustments, trend assumptions, program changes, non-benefit cost assumptions, and COVID-19 impacts. Milliman concluded that, overall, the Commission followed methods to produce actuarially sound fiscal year 2024 capitation rates. Additionally, Milliman did not identify a program-wide pattern of over- or under-funding or material issues that indicate the rates are not actuarially sound. However, Milliman made several recommendations to improve the actuarial process and mitigate the risk of future unsoundness. Those recommendations have some themes:

- In general, the risk groups the Commission developed have sufficient membership and/or claim volume to develop a credible underlying cost profile. However, Milliman recommended combining STAR Kids' risk groups to enhance credibility and reduce annual volatility.
- The Commission developed trend and programmatic adjustment factors and applied those to broad categories of service (which are medical, long-term supports and services, pharmacy, and non-emergency medical transportation). Milliman recommended that the Commission adopt the common practice of developing and applying trends and other adjustment factors to more granular categories of service, such as inpatient facility, outpatient facility, emergency room services, physician services, and other categories.
- The non-benefit expense (such as administrative costs and taxes) assumptions applied in the fiscal year 2024 rates appear reasonable compared to historical program experience; however, there have been changes in program requirements that may have impacted administrative requirements between prior years and fiscal year 2024. Milliman recommended that the Commission expand its rate report documentation so that oversight entities or another actuary could reasonably understand the development of those assumptions.

Actuarial Soundness

Actuarial soundness is a prospective, forward-looking determination. Actuarially sound capitation rates provide adequate, but not excessive, program-wide funding for what is reasonably expected to happen.

Actuaries rely on the Actuarial Standards of Practice (ASOP) and the Centers for Medicare and Medicaid Services' guidance to develop capitation rates. Based on their experience and professional judgement, different actuaries working from the same information may produce different rates that are actuarially sound.

[1] Rider 5, page X-7, the General Appropriations Act (87th Legislature); and Rider 5, page X-6, the General Appropriations Act (88th Legislature).

Milliman made a total of 16 recommendations—14 recommendations are retained from its analysis conducted in 2022 and 2 are new recommendations. That August 2022 report[2], which was a review of the fiscal year 2023 rates, contained 25 recommendations.

Milliman's report also includes observations, which either (1) indicate Milliman's agreement with key aspects of the rate development process or (2) identify less significant methodological or technical deviations from best practices. Milliman's actuarial report is presented in Attachment 1.

The Commission has reviewed Milliman's recommendations and observations and the Commission's response is presented in Attachment 2. In its response, the Commission emphasized that its rates are actuarially sound and provided comments to support its current methodology. It stated it would continue to monitor its rate-setting processes to determine if adjustments are appropriate.

Sincerely,

Lisa R. Collier, CPA, CFE, CIDA
State Auditor

Attachment 1 – Milliman's Actuarial Report
Attachment 2 – Commission Response to Actuarial Report

cc: The Honorable Greg Abbott, Governor
Members of the House Appropriations Committee
Members of the Senate Finance Committee
Ms. Cecile Erwin Young, Executive Commissioner, Health and Human Services Commission

[2] See *Actuarial Analysis of the Health and Human Services Commission's Fiscal Year 2023 Medicaid Managed Care Rates* (SAO Report #22-042, August 2022).

Milliman Report: Review of FY 2024 Texas Medicaid Managed Care Capitation Rate Development Process

MILLIMAN REPORT

Texas State Auditor's Office

Review of FY 2024 Texas Medicaid Managed Care Capitation Rate Development Process

September 1, 2023

Jill Bruckert, FSA, MAAA
Principal and Consulting Actuary

Nicholas Gersch, FSA, MAAA
Consulting Actuary

Greg Herrle, FSA, MAAA
Principal and Consulting Actuary

Alisa Gordon, FSA, MAAA
Consulting Actuary

17335 Golf Parkway
Suite 100
Brookfield, WI 53045
USA
Tel +1 262 784 2250

milliman.com

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Milliman

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APPENDICES

I. EXECUTIVE SUMMARY

The Texas State Auditor's Office ("the Office") contracted with Milliman to conduct an actuarial analysis and review of the Fiscal Year ("FY") 2024 Medicaid managed care capitation rates developed by the Health and Human Services Commission ("the Commission"), and the Commission's contracted actuaries (which will also be referred to as "the Commission"). The contract between Milliman and the Office, signed December 16, 2021 and effective January 3, 2022, applies to our analysis and this report.

For purposes of this report, Milliman performed a concurrent rate setting review of the FY 2024 capitation rates produced by the Commission. Through rigorous review, we familiarized ourselves with the rate setting approach for each of the six Medicaid programs in Texas. We reviewed the development of each interim rate component or key factor immediately after it was completed by the Commission. Our intent was to not interfere or slow down the normal rate development process and timeline adopted by the Commission, but rather conduct our review as expeditiously as possible given the legislative timeline.

In working with the Commission, we also interacted with their contracted actuary who certifies the Medicaid managed care capitation rates. As such, we use the phrase "the Commission" throughout this report to indicate decisions made, approaches taken, or information provided that is ultimately the responsibility of the Commission, regardless of whether the action was specifically performed by the Commission or their contracted actuary. The Office specifically reviewed the Commission's oversight of its rate development process and contracted actuary and issued a separate report (SAO report #23-005).

The authors of this report are employees of Milliman, a well-known thought leader in managed Medicaid programs, among other healthcare markets. The observations, conclusions and recommendations in this report are solely the opinions of the authors of this report and not those of Milliman, although "we" and "Milliman" may be used interchangeably on occasion throughout the report. We performed the requested actuarial services for the Office by applying the highest professional actuarial standards to evaluate the actuarial soundness of the FY 2024 managed care capitation rates.

For any questions related to this report, please contact Lisa Collier, State Auditor, or Lauren Godfrey, Assistant State Auditor at 512 936 9500.

STATE AUTHORITY FOR THE ACTUARIAL REVIEW

The 2022 to 2023 General Appropriations Act for the State of Texas was created by the 87th Legislature in the Regular Session of 2021.[1] Article X of the General Appropriations Act specifies the sums of money that are for the support, maintenance, or improvement of the designated legislative agencies.[2] The Office is one of the designated legislative agencies mentioned in Article X.[3]

Within the Office's section of the General Appropriations Act, the Office was instructed to conduct an Actuarial Analysis of the Commission's managed care rates for FY 2023 and FY 2024.[4] Within 45 days of the submission of the managed care rates by the Commission to the Legislative Budget Board, the Office shall provide and file a report on the actuarial soundness of the rates, as well as an analysis of the key factors that affect the rates with the Speaker of the House, Lieutenant Governor, House Appropriations Committee, and the Senate Finance Committee.[5]

This actuarial report written by Milliman is the third report released to address the requirements of the General Appropriations Act. In 2022 the Office provided Milliman's review of the FY 2023 capitation rates and the Office's audit report about the rate setting process used by the Commission.[6]

The 2024 to 2025 General Appropriations Act for the State of Texas provides continued funding and authorization for the actuarial analysis of Health and Human Services Managed Care Rates in Rider 5 of Article X.[7]

[1] General Appropriations Act for the 2022-23 Biennium, Eighty-seventh Texas Legislature, Regular Session, 2021, Text of Conference Committee Report on Senate Bill No.1, Retrieved from: General_Appropriations_Act_2022_2023.pdf (texas.gov).
[2] Ibid, The Legislature, X-1, pg. 979.
[3] Ibid, The Legislature, X-6, pg. 984.
[4] Ibid, The Legislature, X-7, pg. 985.
[5] Ibid.
[6] Ibid.
[7] General Appropriations Act, Eighty-Eighth Texas Legislature, House Bill No. 1, Retrieved from: https://capitol.texas.gov/tlodocs/88R/billtext/pdf/HB00001F.pdf

MILLIMAN BACKGROUND AND REVIEW PROCESS

Milliman is an industry leader in the Medicaid managed care space, with over 20 states currently relying on Milliman actuaries to certify their capitation rates, including other large states and states with similar program types as Texas. A complete understanding of the factors, risks, and processes underlying the determination of actuarial soundness of the managed care capitation rates is integral to the rate setting process. Milliman has been at the forefront of developing best practices for actuarial soundness and advancing the discussion since the beginning of managed care.

As the Centers for Medicare and Medicaid Services ("CMS"), the Actuarial Standards Board, and other entities release proposed standards and regulations, Milliman studies the regulations and provides timely and thorough analysis and discussion related to the implications of new or updated requirements For example, Milliman published several white papers related to the Medicaid managed care regulations released in 2016, along with the proposed updates released in November 2018. These papers represent professional opinions across Milliman's Medicaid experts and provide valuable guidance to the industry.

In addition to requirements related to actuarial soundness promulgated by CMS and the Actuarial Standards Board, we also considered requirements established by the State of Texas in our review of the FY 2024 rates. Each year, there may be legislative changes that require adjustments in rate development and requirements on how rates are set. We understand the importance of retaining flexibility and keeping an open mind when considering guidance and requirements that come from multiple sources and that may even appear inconsistent.

REPORT OVERVIEW

This report is structured in multiple sections to document our review of the FY 2024 capitation rates:

- The remainder of Section I provides the key findings from our review of the FY 2024 rates and rate setting process.
- Section II includes an overview of capitation rate setting and the regulations and authorities that must be adhered to during capitation rate development.
- Section III provides a summary of each of the six key Texas Medicaid programs to highlight each program's key characteristics, similarities, and differences.
- Section IV discusses our overall approach to identifying risk levels and the level of review of each capitation rate component.
- Section V provides an overview of each rate setting component: rate structure, base data, trend adjustments, program adjustments, non-benefit expenses, and CMS compliance.
- Section VI provides detailed descriptions of each of our recommendations and observations.

Appendices A through F include additional program details, including key data sources and a description of the Commission's rate development methodology.

- Appendix A – STAR
- Appendix B – STAR Health
- Appendix C – Dental
- Appendix D – STAR+PLUS
- Appendix E – STAR Kids
- Appendix F – Dual Demonstration

FY 2024 RATE REVIEW FINDINGS

Evaluation of Actuarial Soundness

A key component of our review was to assess the actuarial soundness of the FY 2024 capitation rates. Actuarial soundness is codified in the Code of Federal Regulations ("CFR") to specify that "actuarially sound capitation rates are projected to provide all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the managed care organization ("MCO") for the time period and the population covered under the terms of the contract" (the pertinent regulation is 42 CFR § 438.4[8]).

In addition to the CFR definition, ASOP No. 49 includes the following language related to actuarial soundness and actuarially sound rates:

> Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes.[9]

While the regulations include a definition of actuarial soundness, the evaluation of actuarial soundness is more nuanced. Actuarial soundness is not a black or white, yes or no evaluation, and cannot be audited the same way product inventory can be audited to determine whether the correct number of items in a warehouse were noted on financial statements. Instead, ***there is a range of reasonable results that produce actuarially sound rates***, stemming from the fact that rates are an ***estimate*** of future, unknown experience. If ten actuaries received identical information, they would likely produce ten distinct capitation rates within a reasonable range of actuarially sound results. In summary, actuarial soundness is ensuring the developed capitation rates provide adequate, but not excessive, program-wide funding for what is reasonably expected to happen, or what is reasonably achievable by participating MCOs.

The Commission provided all requested materials to conduct our review of the FY 2024 Texas Medicaid capitation rates. Our review did not uncover material issues that would lead us to believe the rates are not actuarially sound. We concluded that the Commission generally followed methods to produce actuarially sound capitation rates, but Milliman has several recommendations to improve the actuarial process and mitigate the risk of future unsoundness. Additionally, we did not identify a program-wide pattern of over- or under-funding present in the FY 2024 capitation rates.

It is important to understand that actuarial soundness is a prospective, forward-looking determination. By their very nature, capitation rates must be established prior to knowing the actual cost of the program for the upcoming rating period. Unanticipated market changes happen throughout the year that may cause MCO costs to be higher or lower than anticipated when the Commission sets the capitation rates. If MCOs incur an unexpected financial gain or loss, that does not mean the capitation rates were not actuarially sound when they were set.

Our assessment of each program's actuarial soundness is based on our evaluation of the rate materials and supporting documentation, supplemental information provided by the Commission, our interpretation of CMS and actuarial guidance, and Milliman's collective experience certifying Medicaid capitation rates in over 20 states. While we recognize each Medicaid program is unique, all states are equally subject to the same CMS policy authority, regulatory authority, and the actuarial standards of practice.

Classification of Review Feedback

Throughout the report and its attachments, we categorize our review conclusions into *recommendations* and *observations*.

[8] 42 CFR § 438.4(a) - Actuarial soundness, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.4.

[9] ASOP No. 49, Medicaid Managed Care Capitation Rate Development and Certification, the Actuarial Standards Board, pg. 2, Retrieved from: https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwigrJeFudv4AhXeJzQIHYunCwQQFnoECAMQAQ&url=https%3A%2F%2Fflrules.org%2Fgateway%2FreadRefFile.asp%3FrefId%3D10582%26filename%3Dasop049_179%2520V2.pdf&usg=AOvVaw0eBNMlC2pWlKoB18UhMkq0.

Recommendations, which are more significant in nature, note where the capitation rate development process varies from commonly accepted rate setting practices, is not consistent with the regulatory guidance, or introduces an elevated risk of actuarial soundness.

Observations, which are less significant in nature, note specific methodological or technical deviations from Medicaid capitation rate setting best practices based on our interpretation of the regulatory guidance, actuarial standards of practice, and our observations in other state Medicaid programs. Throughout the report, we also include acknowledgement of adherence to best practices in the "observations" section to indicate our agreement with key aspects of the rate development.

The presence of recommendations and observations for a given program does not equate to the rates being actuarially unsound. We reviewed how the recommendations and observations affect the final rate (not each individual component) to review actuarial soundness, where the impact was quantifiable.

Summary of Recommendations and Observations

Exhibits 1 and 2 summarize the recommendations and observations from our review of the FY 2024 capitation rates produced by the Commission. We also note whether each recommendation or observation is new or if it is retained or modified from our review of the FY 2023 capitation rates. Several of the recommendations and observations are applicable across multiple Texas Medicaid managed care programs, as noted in the exhibits, due to consistent methodologies used by the Commission in the development of the capitation rates. Other recommendations and observations are only applicable to a single program, due to unique characteristics of the populations or services included in the program.

In Exhibit 1 we categorize each recommendation into one or more of the following subcategories.

- ***Introduces actuarial soundness risk:*** The current methodologies or assumptions introduce additional risk into the development of the capitation rates that the resulting rates may not be reasonable, appropriate, and attainable for MCOs. These recommendations do not mean the FY 2024 capitation rates are not actuarially sound, which is a concept applied to the total final rate. However, the current assumptions or methodologies may result in specific components of the capitation rates (e.g., medical trend assumptions) being over- or under-stated and may result in future capitation rates being unsound under certain circumstances.

- ***Does not follow common actuarial practices:*** While there is general regulatory and actuarial guidance on items that must be considered in the development of Medicaid managed care capitation rates, there are not prescriptive approaches that must be used, recognizing that each State's Medicaid program is unique. As such, each actuary has flexibility in developing the methodologies to calculate the capitation rates (e.g., developing a methodology to select trend assumptions). These recommendations reflect areas within the capitation rate development where the selected methodology either a) differs from the range of actuarial practices observed in states with similar programs or b) differs from general actuarial principles.

- ***Regulation compliance:*** The current methodologies or assumptions do not follow current CMS regulations and / or guidelines for developing FY 2024 capitation rates. In addition, this subcategory is used to flag recommendations where the level of documentation in the FY 2024 actuarial certification does not include the required information listed in the 2023-2024 CMS Medicaid Managed Care Rate Development Guide.

Lastly, for methodologies where we have recommended enhancements, we include an estimate of the directional impact of the current methodology on the funding of the capitation rates or a description why the directional impact is not estimated:

- The current methodology increases the risk of over-funding the capitation rates, shown as (+) in Exhibit 1.

- The current methodology increases the risk of under-funding the capitation rates, shown as (-) in Exhibit 1.

- The impact of the current methodology is not quantifiable using the information gathered in our review, but introduces risk that the capitation rates may be either over- or under-funded, shown as "Unknown" in Exhibit 1.

- The current methodology does not change program wide funding; however, it may shift funding between risk groups or SDAs within the program, shown as "Potential Risk Group or SDA Impact" in Exhibit 1.

- There are a few recommendations that are documentation related and do not have a financial impact, shown as "No Financial Impact" in Exhibit 1.

The recommendations have a few themes:

1. In general, based on our review, the risk groups developed by the Commission appear to have **sufficient data underlying the base data to develop capitation rates that are fully credible**. A fully credible risk group has sufficient membership and / or claim volume to smooth out normal variability in claim experience and form a stable source for base data to use as the underlying cost profile to which trend and programmatic adjustments are applied to estimate future costs for the given population. **We recommend the Commission carefully review historical experience by risk group in the STAR Kids program**, which may not be fully credible at the MCO and service delivery area ("SDA") level relied upon to develop the capitation rates.

2. **Trend and programmatic adjustment factors** are currently developed and applied to very broad categories of service (i.e., medical, long-term supports and services, pharmacy, and Non-Emergency Medical Transportation). **We recommend the Commission move away from this approach and adopt the common practice of developing and applying trends and other adjustment factors at more granular categories of service**, such as inpatient facility, outpatient facility, emergency room services, physician services, etc. This level of granularity helps increase the transparency in the rate setting process for all stakeholders. Additional granularity would allow the Commission to monitor actual costs at the service category level compared to the estimated costs in the capitation rates and make necessary adjustments in future capitation rate setting processes.

3. The **non-benefit expense assumptions** applied in the FY 2024 capitation rates are reasonable and documented alongside historical program experience; however, **we recommend the Commission expand the capitation rate report to include additional documentation** so that CMS, or another actuary, could reasonably understand the development of these assumptions and identify the final non-benefit expenses paid to MCOs after comparing the community rates to the individual MCO experience rates in the STAR and STAR Kids programs.

4. Other specific recommendations to enhance the methodologies used to develop the FY 2024 capitation rates.

Of the 25 recommendations in our FY 2023 rate review, 14 are retained in our FY 2024 review. Six of the FY 2023 recommendations were removed because the Commission addressed the concerns in the recommendation (including one that was partially addressed and merged with another recommendation), four of the recommendations are no longer applicable for FY 2024, and one recommendation was merged with another. There are also two recommendations new for FY 2024. The following recommendations were removed:

- **Review current structure of patient liability in the capitation rates** *(STAR+PLUS)*: The Commission partially addressed this recommendation by isolating patient liability in the base period and trending patient liability costs separately from gross costs. We merged this recommendation with Recommendation P in this report.

- **Consider the inclusion of patient liability in the base data development** *(STAR+PLUS)*: The Commission addressed the concerns expressed in this recommendation by isolating patient liability in the base period and trending patient liability costs separately from gross costs.

- **Include new DHMO in projected FY 2023 membership and expenditures** *(Dental)*: This recommendation is no longer applicable in FY 2024 because all three DHMOs have experience in the base period, so the Commission used a different methodology than in FY 2023.

- **Apply separate trends to patient liability and remaining net state costs** *(STAR+PLUS)*: The Commission addressed the concerns expressed in this recommendation by isolating patient liability in the base period and trending patient liability costs separately from gross costs.

- **Do not introduce changes in SDA distribution between Year 1 and Year 2 of the calculation when using statewide trend assumptions** *(STAR, STAR+PLUS, STAR Kids)*: The Commission addressed the concerns expressed in this recommendation by changing their trend calculation to aggregate statewide trends using the SDA distribution in Year 1.

- **Calculate the nursing facility COVID-19 add-on impact gross of patient liability** *(STAR+PLUS)*: This recommendation is no longer applicable due to the COVID-19 Public Health Emergency (PHE) ending on May 11, 2023.

- **Evaluate the impact of medical service utilization differences in the recently extended eligibility period for pregnant women** *(STAR)*: This recommendation is no longer applicable in FY 2024 because the eligibility period extension for pregnant women was not approved by CMS, so it is not reflected in the FY 2024 capitation rates.

- **Evaluate the impact of the recently extended eligibility period for pregnant women** *(STAR Health)*: This recommendation is no longer applicable in FY 2024 because the eligibility period extension for pregnant women was not approved by CMS, so it is not reflected in the FY 2024 capitation rates.

- **Include supporting documentation for the development of the administrative costs** *(all programs)*: This recommendation in the Non-Benefit Expense section was merged with a related recommendation in the CMS Compliance section.

- **Review administrative allocations across risk groups to remove incentives to enroll higher cost risk groups** *(STAR+PLUS)*: The Commission implemented variable trends that vary between the nursing facility and non-nursing facility risk groups. This update mitigates the risk of incentivizing the enrollment of members in higher cost risk groups.

- **Enhance supporting documentation to describe the methodology for estimating FY 2023 projected enrollment used in the rate development** *(Dental)*: This recommendation is no longer applicable in FY 2024 because all three DHMOs have experience in the base period, so the Commission used a different methodology than in FY 2023.

Exhibit 2 lists the observations from our review and notes to which program(s) they are applicable. As noted above, observations are less significant in nature than recommendations. While recommendations include deviations from common actuarial practices, observations note variation from best actuarial practices. There can be a range of common actuarial practices that produce reasonable capitation rates. However, best actuarial practices are those that produce reasonable capitation rates, provide adequate documentation for stakeholders to clearly understand the methodologies and assumptions used to develop capitation rates, and through historical monitoring of program experience relative to prior projections, and reduce uncertainty in estimating capitation rates.

Of the 23 observations in our FY 2023 rate review, 18 are retained in our FY 2024 review. Four of the FY 2023 observations were removed because the Commission addressed the concerns addressed in the observation, and one of the observations is no longer applicable for FY 2024. There are also two observations new for FY 2024. The following observations were removed:

- **There is not a clear process for the treatment of MCO self-reported third-party revenue (TPR) data** *(STAR, STAR Health, STAR+PLUS, STAR Kids)*: The Commission addressed the concerns expressed in this observation by modifying the MCO supplemental data request to include an MCO attestation regarding how TPR is reported in the submission.

- **Member selection adjustment does not capture current duration of members** *(Dual Demo)*: The Commission addressed the concerns expressed in this observation by weighting the adjustment based on dual demonstration members from each year who are still enrolled in FY 2022.

- **The PHE cost related adjustment uses the same formulaic approach across all Medicaid populations, which may not produce reasonable results for all risk groups**: The Commission addressed the concerns expressed in this observation by limiting the impact of the PHE to only apply to risk groups where enrollment increased materially during the PHE.

- **Supporting documentation indicates pharmacy trends are set by drug type, which is inconsistent with the actual methodology used**: The Commission addressed the concerns expressed in this observation by changing the documentation in the rate certification.

- **Supporting documentation should describe methodology for estimating FY 2023 projected enrollment used in the rate development** *(Dental)*: This observation is no longer applicable in FY 2024 because all three DHMOs have experience in the base period, so the Commission used a different methodology than in FY 2023.

CAVEATS AND LIMITATIONS

This report has been prepared for the Texas State Auditor's Office ("the Office") to communicate our review of FY 2024 Medicaid managed care capitation rates for the Texas Medicaid managed care programs. This report and its attachments are subject to the terms of Milliman's contract with the Office effective January 3, 2022. This information may not be appropriate for other purposes.

The contents of this document are not intended to represent a legal or professional opinion or interpretation on any matters. Milliman makes no representations or warranties regarding the contents of this report to third parties. Similarly, third parties are instructed that they are to place no reliance upon this information prepared for the Office by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

Milliman has developed certain approaches and models to produce the review results included in this document. The intent of the models was to review the Commission's FY 2024 capitation rates for technical accuracy, methodology soundness, and documentation completeness for the intended purposes based on generally accepted Medicaid managed care capitation rate setting practice, relevant actuarial standards of practice, and CMS Medicaid managed care capitation rate development guide.

The information and conclusions in this report rely extensively on data and explanations provided by the Commission related to the development of FY 2024 Medicaid managed care capitation rates for the Texas Medicaid managed care programs. We used the same information the Commission used and did not independently verify it but reviewed the information for general completeness and reasonableness. Our results and conclusions may not be appropriate if this information is not accurate or not complete. The authors of this report are actuaries for Milliman, members of the American Academy of Actuaries and meet the Qualifications Standards of the Academy to render the actuarial opinion contained herein. To the best of their knowledge and belief, this information is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

II. OVERVIEW OF CAPITATION RATE SETTING

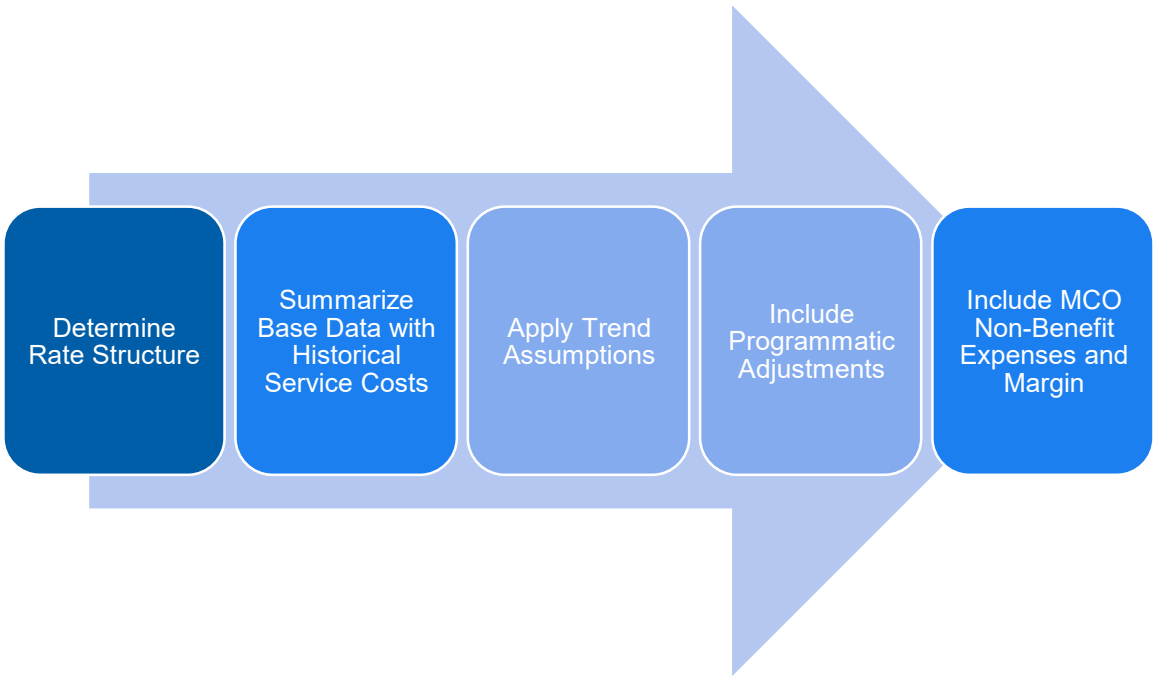
CAPITATION RATE SETTING PROCESS

States use Medicaid managed care capitation rates as the payment mechanism to reimburse MCOs for coordinating care for Medicaid beneficiaries. A capitation rate is a predetermined amount paid from the State to the MCO each month for each member enrolled in their plan. This payment is often referred to as a per-member-per-month ("PMPM") amount because it is paid monthly to the MCO on behalf of each enrolled member. The capitation rate can vary by member based on individual demographics (such as age and gender), service area, covered services, or other characteristics that may result in a different cost profile for the member. In exchange for the capitation rate, the MCO assumes financial liability through a risk-based contract with the State, which could lead to the actual costs for any given member to be more or less than the capitation rate. At an individual member level, the capitation rate may be too high or too low; however, the intent is that appropriately set capitation rates will be adequate to cover the program-wide costs under the managed care contract on average across all the members enrolled across all MCOs in the given program.

Capitation rates are generally structured into three components to provide reasonable and adequate program-wide funding to the MCOs to facilitate care for their members:

- **Service Costs**: The estimated costs that MCOs will need to reimburse hospitals, physicians, and other health care providers for services rendered to their members.
- **Non-Benefit Expenses**: The estimated administrative costs, taxes, fees, or other contractual requirements that the MCOs incur to facilitate care to their members. Examples of administrative requirements include claims processing, MCO employee costs, information technology, care management, and other operational costs.
- **Margin**: The margin assumption provides compensation for the financial and other risks assumed by the MCOs. These risks include mispricing, investment, inflation, and regulatory risks, as well as risks associated with social, economic, and legal environments.

The figure below provides an overview of the major steps used to develop capitation rates. Each step of the process is described at a high level below. Further discussion of the detailed steps for each Texas Managed Care program are included in the program specific Appendices to this report.



Determine Rate Structure

The rate structure of a program determines the groupings of members (which are referred to as risk groups by the Commission) for which a capitation rate will be developed. An MCO will receive the same capitation rate, or payment amount, for each member within a risk group. There are two main actuarial considerations in designing an effective rate structure:

- Defining risk groups to reflect material cost profile differences of members due to risk factors that are prospectively known. Examples of this include coverage differences, eligibility differences, health status differences, and regional cost differences. It is important these features are known prospectively so individuals can be assigned the appropriate risk group at the time of their enrollment.

- The level of credibility, or predictive nature, of future costs of any resulting risk group. A fully credible risk group creates a stable base of historical costs that can be used to develop capitation rates and perform analyses to understand historical trend or programmatic changes.

Summarize Base Data with Historical Service Costs

The base data represents the historical service costs and enrollment for the covered population used as the baseline to establish the historical cost profile of each selected risk group. Selecting and validating the base data is a crucial step in the capitation rate development to ensure that appropriate data forms the foundation of projecting costs for the rating period for which the capitation rates will be effective.

Apply Trend Assumptions

Trend is generally defined as the percentage change in costs for covered services from the base period to the rating period. Trend usually comprises two components: (1) the change in service utilization, also known as “utilization trend,” and (2) the change in service cost on a per unit basis, also known as “unit cost trend.” In capitation rate development, trend assumptions are typically selected to represent the estimated change in costs from one year to the next. These annual trend assumptions are then applied to the base period data in a compounding manner for the amount of time between the base data and the rating period to produce the projected costs.

Include Programmatic Adjustments

Programmatic adjustments are applied to the trended base experience to account for any other estimated changes between the base period and the rating period that are not included in the trend assumptions. Examples of programmatic adjustments include:

- New or changing benefits
- Changes to provider reimbursement
- New or changing populations
- New programs or initiatives that affect managed care
- Any other changes to the managed care program that have a material impact on the cost of the program

Include MCO Non-Benefit Expenses and Margin

The development of the non-benefit expense component of the rate includes the estimated administrative costs, taxes, fees, or other contractual requirements that the MCOs incur to facilitate care to their members. This also includes a provision for margin intended to account for financial risk, statutory capital requirements, and opportunity cost of capital.

ACTUARIAL STANDARDS OF PRACTICE AND REGULATIONS

The development of Medicaid capitation rates must adhere to published guidance from the American Academy of Actuaries (“AAA”), CMS, and federal regulations to ensure compliance with generally accepted actuarial practices and regulatory requirements. The Actuarial Standards Board sets the standards for appropriate actuarial practice in the United States through the development and promulgation of the ASOPs.[10] These ASOPs describe the procedures an actuary should follow when performing actuarial services and identify what the actuary should disclose when

[10] All Standards - About the Actuarial Standards Board, Actuarial Standards Board, Retrieved from: Standards of Practice- Actuarial Standards Board.

communicating the results of those services.[11] There are also other rate certification and submission requirements per the Final Rule,[12] subsequent amendments, and other guidance from federal authorities and federal legislation.

For a detailed list of the specific ASOPs and regulations, please see the "Actuarial Standards of Practice and Regulations" section in our Review of FY 2023 Texas Medicaid Managed Care Capitation Rate Development Process report. However, we also note the new inclusion of the federal Consolidated Appropriations Act of 2023[13] that must also be considered in the rate development process.

ADDITIONAL BACKGROUND ON ACTUARIAL SOUNDNESS

As outlined in the Executive Summary, a key component of our review was to assess the actuarial soundness of the FY 2024 capitation rates. Actuarial soundness is codified in the Code of Federal Regulations ("CFR") to specify that "actuarially sound capitation rates are projected to provide all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the managed care organization ("MCO") for the time period and the population covered under the terms of the contract" (the pertinent regulation is 42 CFR § 438.4[14]).

In addition to the CFR definition, ASOP No. 49 includes the following language related to actuarial soundness and actuarially sound rates:

> Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes.[15]

Furthermore, Medicaid managed care capitation rates for MCOs must be reviewed and approved by CMS as actuarially sound rates.[16] CMS determines whether Medicaid managed care capitation rates are actuarially sound through regulatory mandated provisions.[17] The capitation rates must have been developed in accordance with the rate development standards specified in 42 CFR § 438.5 and generally accepted actuarial principles and practices.[18] Any differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations must be based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations.[19]

To determine whether the Medicaid managed care capitation rates are actuarially sound, CMS will also look at whether the populations to be covered and the services to be furnished under the contract are appropriate.[20] The actuarial soundness requirement is specific to payments for each rate cell underneath the contract.[21] Payments from any rate cell must not cross-subsidize or be cross-subsidized by payments for any other rate cell.[22] The capitation rates must

[11] All Standards - About the Actuarial Standards Board, Actuarial Standards Board, Retrieved from: Standards of Practice- Actuarial Standards Board.

[12] 42 CFR § 438.4 - Actuarial soundness, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438?toc=1

[13] Consolidated Appropriations Act of 2023, Public Law 117-328, December 29, 2022, Retrieved from: BILLS-117hr2617enr.pdf (congress.gov).

[14] 42 CFR § 438.4(a) - Actuarial soundness, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.4.

[15] ASOP No. 49, Medicaid Managed Care Capitation Rate Development and Certification, the Actuarial Standards Board, pg. 2, Retrieved from: https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwigrJeFudv4AhXeJzQIHYunCwQQFnoECAMQAQ&url=https%3A%2F%2Fflrules.org%2Fgateway%2FreadRefFile.asp%3FrefId%3D10582%26filename%3Dasop049_179%2520V2.pdf&usg=AOvVaw0eBNMlC2pWlKoB18UhMkq0.

[16] 42 CFR § 438.4(b) - Actuarial soundness, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.4.

[17] Ibid.

[18] 42 CFR § 438.4(b)(1) - Actuarial soundness, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.4.

[19] Ibid.

[20] 42 CFR § 438.4(b)(2) - Actuarial soundness, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.4.

[21] 42 CFR § 438.4(b)(4) - Actuarial soundness, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.4.

[22] 42 CFR § 438.4(b)(5) - Actuarial soundness, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.4.

be certified by an actuary.[23] The actuarial soundness of the rates also requires that any applicable state special contract provisions are met.[24] During the submission of the rates, the rates need to be provided to CMS in a format and within a timeframe that meets the requirements of 42 CFR § 438.7.[25] The actuarially sound rates must also be developed in such a way that the MCO could reasonably achieve the MLR standard, as calculated in 42 CFR § 438.8, of at least 85 percent for the rate year.[26]

The managed care regulation requires that states develop valid managed care capitation rates in accordance with generally accepted actuarial principles and practices.[27] The 2023-2024 Medicaid Managed Care Rate Development Guide is for states to use when setting rates with respect to any managed care program subject to federal actuarial soundness requirements during rating periods starting between July 1, 2023 and June 30, 2024.[28] The guide provides detail around CMS' expectations of information to be included in actuarial rate certifications, and the guide will be used as a basis for CMS' review.[29]

CMS uses the term "rate certification" to mean both the letter (or attestation) from the actuary that specifically certifies that the rates are actuarially sound and meets the requirements of CMS regulations and any supporting documentation that relates to the letter or attestation, including the actuarial report, other reports, letters, memorandums, other communications, and other workbooks or data.[30] Within Medicaid managed care, the most important quality for an actuary to possess is a complete understanding of the factors, risks, and processes underlying the determination of actuarial soundness of capitation rates.

Given that Medicaid managed care capitation rate setting is a highly specialized practice, technically complex, and requires consideration of many factors throughout the rate development process, there are chances for rates to be overstated or understated in a systemic way due to miscalculation, lack of due diligence in validating data and information as provided by MCOs and related State entities, and inappropriate use of methodologies for establishing rate structure and developing actuarial assumptions.

[23] 42 CFR § 438.4(b)(6) - Actuarial soundness, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.4.

[24] 42 CFR § 438.4(b)(7) - Actuarial soundness, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.4. The special contract provisions mentioned are related to payment, which can be found in 42 CFR § 438.6. These special contract provisions related to payment include: the base amount, incentive arrangements, pass-through payments, risk corridor, state plan approved rates, supplemental payments, and a withhold arrangement, 42 CFR § 438.6, Special contract provisions related to payment, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.6.

[25] 42 CFR § 438.4(b)(8) - Actuarial soundness, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.4.

[26] 42 CFR § 438.4(b)(9) - Actuarial soundness, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.4.

[27] Rate Review and Rate Guides, 2023-2024 Medicaid Managed Care Rate Development Guide, Medicaid.gov, Retrieved from: Rate Review and Rate Guides | Medicaid.

[28] Ibid.

[29] Ibid.

[30] 2022-2023 Medicaid Managed Care Rate Development Guide, Centers for Medicare & Medicaid Services, April 2022, pg. 3, Retrieved from: 2022-2023 Medicaid Managed Care Rate Development Guide.

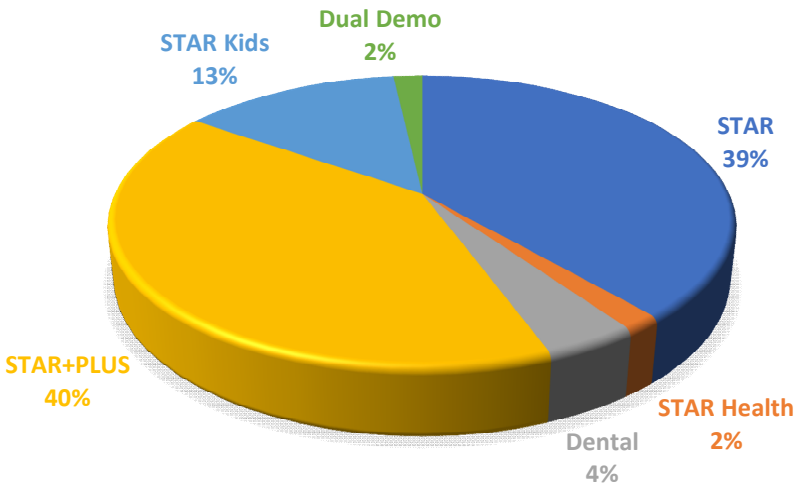
III. PROGRAM SUMMARY OVERVIEW

Managed Care refers to a health system in which managed care organizations (MCOs) agree to coordinate and provide comprehensive healthcare to a population in exchange for a fixed payment per-person per-month, otherwise known as a capitation rate.[31] The Commission develops capitation rates on a state fiscal year basis, effective from September to August of each year.[32] The Texas Medicaid program has six certified managed care programs, which are the focus of this concurrent Medicaid capitation rate review report.[33] These managed care programs include the following:

- STAR Managed Care[34]
- STAR Health Managed Care[35]
- Medicaid Dental[36]
- STAR+PLUS Managed Care[37]
- STAR Kids[38]
- Dual-Eligibles Integrated Care Demonstration Project ("Dual Demonstration")[39]

In total, these six programs will cover approximately 4.3 million Medicaid beneficiaries at a total cost of approximately $28.0 billion (excluding directed payments) in FY 2024. Figure 1 shows the distribution of projected FY 2024 expenditures by program.

FIGURE 1: DISTRIBUTION OF FY 2024 EXPENDITURES



[31] Managed Care Services, Overview, Texas Health and Human Services, Retrieved from: Managed Care Services | Provider Finance Department (texas.gov).

[32] Ibid.

[33] Managed Care Services, Overview, Texas Health and Human Services, Retrieved from: Managed Care Services | Provider Finance Department (texas.gov).

[34] STAR Managed Care, Rate Setting Actuarial Analysis, Texas Health and Human Services, Retrieved from: STAR Managed Care | Provider Finance Department (texas.gov).

[35] STAR Health Managed Care, Rate Setting Actuarial Analysis, Texas Health and Human Services, Retrieved from: STAR Health Managed Care | Provider Finance Department (texas.gov)

[36] Medicaid Dental, Rate Setting Actuarial Analysis, Texas Health and Human Services, Retrieved from: Medicaid Dental | Provider Finance Department (texas.gov).

[37] STAR+PLUS Managed Care, Rate Setting Actuarial Analysis, Texas Health and Human Services, Retrieved from: STAR+PLUS Managed Care | Provider Finance Department (texas.gov).

[38] STAR Kids, Rate Setting Actuarial Analysis, Texas Health and Human Services, Retrieved from: https://pfd.hhs.texas.gov/managed-care-services/star-kids.

[39] Dual-eligible Integrated Care Demonstration Project, Rate Setting Actuarial Analysis, Texas Health and Human Services, Retrieved from: Dual-eligible Integrated Care Demonstration Project (Dual Demo) | Provider Finance Department (texas.gov).

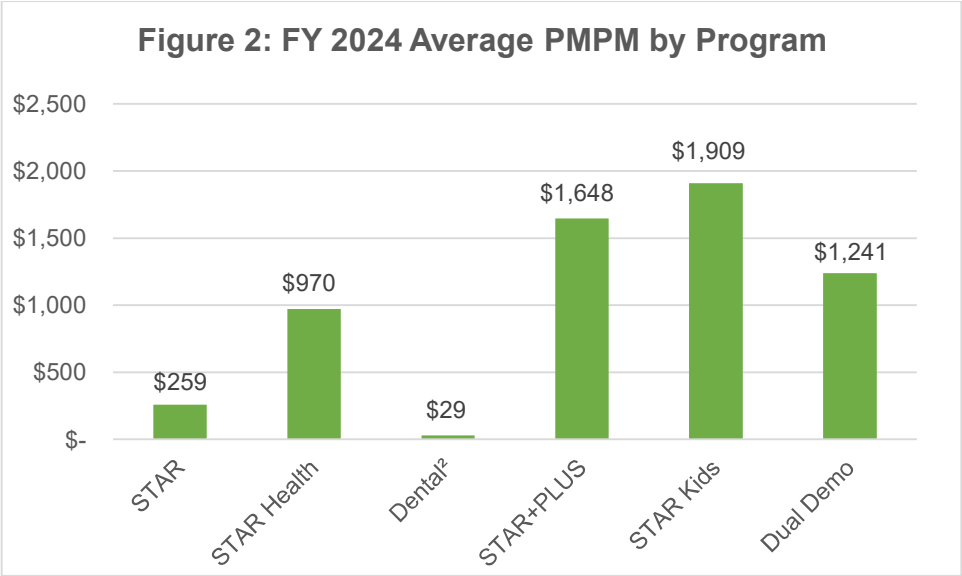
Table 1 below summarizes the FY 2024 estimated enrollment and costs by program, as well as a brief description of the covered population and services. The 4.3 million beneficiaries noted above exclude those enrolled in the Dental program to avoid double counting such individuals as they are also receiving other services and enrolled in one of the five other managed care programs.

Table 1
Texas Medicaid Managed Care Rate Review
Program Summaries
Program Summary Overview

Program	Average Estimated FY 2024 Beneficiaries	Projected FY 2024 Program Costs[A]	Summary of Covered Population	Summary of Covered Services
STAR	3,479,439	$10,809,000,000	Low-income families, children, pregnant women, and some former foster care youth	Primary care, acute care, pharmacy, and non-emergency medical transportation (NEMT) services
STAR Health	39,442	$459,000,000	Children in foster care	Primary care, acute care, dental, pharmacy, and NEMT services
Dental	3,296,966	$1,149,000,000	Medicaid children through age 20; excludes Medicaid members over age 20, STAR Health members (dental coverage provided through STAR Health), and Medicaid members in some Medicaid paid facilities	Diagnostic, preventive, restorative, orthodontic, and other dental services
STAR+PLUS	570,057	$11,275,000,000	Adults 21 or older with disabilities or dual eligible who necessitate long-term services and supports (LTSS)	Long term care, acute care, pharmacy, and NEMT services
STAR Kids	165,137	$3,782,000,000	Children younger than 21 with disabilities or dual eligible who necessitate LTSS	Long term care, acute care, pharmacy, and NEMT services
Dual Demo	33,701	$502,000,000	Adults 21 or older who are full benefit dual-eligible with a Type Program Code of 3 (MAO, RSDI Increase), 13 (SSI, Recipient), 14 (MAO, SSI Related) or 18 (MAO, Disabled Adult Children)[B]	Long term care, acute care, pharmacy, and NEMT services

[A] *Excludes directed payments.*
[B] *MAO = Medicare Advantage Organization; RSDI = Retirement, Survivors and Disability Insurance; SSI = Social Security Income.*

There is a significant cost difference on a PMPM basis for the covered populations and covered services within each program, as shown in Figure 2. For example, health care costs for individuals enrolled in the STAR+PLUS program are estimated on average to cost over six times the cost of an individual enrolled in the STAR program.



The remainder of this section provides a broad description of each of the six programs included in our review.

STAR Managed Care

The STAR managed care program, which consists of 16 MCOs across 13 SDAs, covers the greatest number of Texans with Medicaid.[40] The STAR population includes low-income children, pregnant women, and families.[41] Members in the STAR program, who select their health plan from one of the approved MCOs,[42] have access to acute care Medicaid benefits, such as:

- Regular checkups with the doctor
- Prescription drugs and vaccines
- Hospital care and services
- X-rays and lab tests
- Vision and hearing care
- Access to medical specialists and mental health care
- Treatment of special health needs and pre-existing conditions[43]

Some STAR members with special health care needs may receive additional service management to assist with the coordination of Medicaid and non-Medicaid benefits.[44]

STAR Health Managed Care

The STAR Health program, which consists of one MCO contracted on a statewide basis, is managed in partnership with Texas Department of Family and Protective Services ("DFPS") to cover individuals with varying levels of DFPS involvement. Specifically, STAR Health covers following groups of individuals:

- Children in DFPS conservatorship who are under 18 years old
- Children in the Adoption Assistance or Permanency Care Assistance program who are transitioning from STAR Health to STAR or STAR Kids

[40] STAR Medicaid Managed Care Program, Texas Health and Human Services, Retrieved from: STAR Medicaid Managed Care Program | Texas Health and Human Services.

[41] Ibid.

[42] Ibid.

[43] Ibid.

[44] Ibid.

- Youth aged 21 years and younger with voluntary extended foster care placement agreements ("Extended Foster Care")

- Youth aged 20 and younger who are Former Foster Care Children ("FFCC")[45]

Members in the STAR Health program have access to acute care benefits, such as:

- Regular checkups at the doctor and dentist
- Prescription drugs and vaccines
- Hospital care and services
- X-rays and lab tests
- Vision and hearing care
- Access to medical specialists and mental health care
- Treatment of special health needs and pre-existing conditions
- A 24/7 nurse hotline for caregivers and caseworkers
- Access to the Health Passport, a patient-centered and internet based electronic health record[46]

Medicaid Dental

Children and young adults have access to dental health services through the Medicaid Dental program. The Commission contracts with three Dental Health Maintenance Organizations (DHMOs), which operate similarly to the MCOs in other programs, on a statewide basis for these services. The dental policies outline the types of procedures and treatments for which the Commission will pay for specific conditions.[47] Below are several types of dental health services offered for children and young adults in Medicaid.[48]

Preventive Services include:

- Dental examinations, which include initial or periodic
- Cleaning, specifically prophylaxis
- Oral health education
- Application of topical fluoride
- Application of sealants to certain teeth
- Maintenance of space[49]

Treatment Services include:

- Restorations, especially fillings and crowns
- Endodontic treatment, especially pulp therapy and root canals
- Periodontic treatment, especially gum disease
- Prosthodontics, especially full or partial dentures
- Oral surgery, especially extractions
- Maxillofacial prosthetics[50]

Emergency Dental Services include:

- Procedures necessary to control bleeding, relieve pain, and eliminate acute infection
- Procedures that are required to prevent imminent loss of teeth
- Treatment of injuries to the teeth or supporting structures[51]

Orthodontic Services include (a prior authorization is needed before receiving the services):

- Correction of cleft palate
- Crossbite therapy

[45] STAR Health, Texas Health and Human Services, Retrieved from: STAR Health | Texas Health and Human Services.

[46] Ibid.

[47] Medicaid Medical & Dental Policies, Texas Health and Human Services, Retrieved from: Medicaid Medical & Dental Policies | Texas Health and Human Services.

[48] Dental Providers, Texas Health and Human Services, Retrieved from: Dental Providers | Texas Health and Human Services.

[49] Ibid.

[50] Ibid.

[51] Ibid.

- Treatment for severe, handicapping malocclusion
- Treatment for facial accidents involving severe traumatic deviation[52]

STAR+PLUS Managed Care

STAR+PLUS, which consists of four MCOs across 13 SDAs, is a Texas Medicaid managed care program for adults with disabilities or age 65 or older.[53] Adults in STAR+PLUS select their health plan from the MCOs approved to provide Medicaid healthcare and long-term services and supports.[54] Adults with complex medical needs can choose to live and receive care in a home setting instead of a nursing facility.[55]

Within STAR+PLUS, MCOs must have a service coordinator visit with the member within 30 days of enrolling in the program[56] to gain an understanding of the member's needs and develop a plan of care. In addition to acute care services (i.e., those covered by STAR) and nursing facility services, covered individuals in STAR+PLUS have access to long-term services and supports that can include:

- Day Activity and Health Services ("DAHS")
- Primary Home Care ("PHC")[57]

Other services under the STAR+PLUS Home and Community-Based Services ("HCBS") Waiver include:

- Personal assistance services
- Adaptive aids
- Adult foster care home services
- Assisted living
- Emergency response services
- Home delivered meals
- Medical supplies
- Minor home modifications – for instance, making changes to your home so you can safely move around
- Nursing services
- Respite care, more specifically short-term care to provide a break for caregivers
- Therapies, which include occupational, physical, and speech-language therapy
- Transitional assistance services[58]

STAR Kids

Effective November 1, 2016, the Commission implemented a new managed care program for disabled children named STAR Kids.[59] The STAR Kids program, which consists of nine MCOs across 13 SDAs, is available statewide and is mandatory for those Medicaid clients under age 21 who meet at least one of the following:

- Receive Social Security Income ("SSI") and SSI-related Medicaid
- Receive SSI and Medicare
- Receive Medically Dependent Children Program ("MDCP") waiver services
- Receive Youth Empowerment Services ("YES") waiver services

[52] Dental Providers, Texas Health and Human Services, Retrieved from: Dental Providers | Texas Health and Human Services.

[53] STAR+PLUS, Texas Health and Human Services, Retrieved from: STAR+PLUS | Texas Health and Human Services.

[54] Ibid.

[55] Ibid.

[56] Ibid.

[57] Ibid.

[58] Ibid.

[59] STAR Kids, Rate Setting Actuarial Analysis, Texas Health and Human Services, Retrieved from: https://pfd.hhs.texas.gov/managed-care-services/star-kids.

- Receive Intellectual and Developmental Disabilities ("IDD") waiver services (e.g., Community Living Assistance and Support Services ("CLASS"), Deaf Blind with Multiple Disabilities ("DBMD"), Home and Community-based Services ("HCS"), and Texas Home Living ("TXHmL")

- Reside in a community-based intermediate care facility for individuals with intellectual disabilities ("ICF-IID")[60]

Members in the STAR Kids program, who select their health plan from one of the approved MCOs have access to acute care Medicaid benefits, such as:

- Regular checkups with the doctor and dentist
- Prescription drugs and vaccines
- Hospital care and services
- X-rays and lab tests
- Vision and hearing care
- Access to medical specialists and mental health care
- Treatment of special health needs and pre-existing conditions

These individuals also have access to a number of additional specialized services, including:

- Personal care services
- Private duty nursing services
- Day Activity and Health Services ("DAHS")
- MDCP waiver services

Dual Demonstration

Effective March 1, 2015, the Commission implemented a new managed care program for certain clients dually enrolled in Medicare and Medicaid (also known as dual-eligible) – the Texas Dual Eligible Integrated Care Demonstration Project (Dual Demonstration).[61] The program is a joint venture between the federal authority CMS and the Commission as part of the Financial Alignment Demonstration capitated model established by the Medicare-Medicaid Coordination Office and is designed to better align the financial incentives of Medicare and Medicaid and to improve coordination of care for dual-eligibles.[62] The Dual Demonstration program is an innovative payment and service delivery model to improve coordination of services for dual-eligible members, enhance quality of care, and reduce costs for both the state and the federal government.[63] Through an individual being enrolled in a single Medicare-Medicaid health plan, Medicare and Medicaid benefits work together to better meet the member's health-care needs.[64] The program is voluntary and open to eligible beneficiaries in the following counties: Bexar, Dallas, El Paso, Harris, Hidalgo and Tarrant.[65] The Dual Demonstration program is currently offered through the same four MCOs that participate in the STAR+PLUS program.

The objectives of the Dual Demonstration program include:

- Making it easier for clients to get care
- Promoting independence in the community
- Eliminating cost shifting between Medicare and Medicaid
- Achieving cost savings for the state and federal government through improvements in care and coordination[66]

A person must meet the following eligibility criteria to enroll in the Dual Demonstration program:

- Be 21 or older
- Have Medicare Part A, B and D, and be receiving full Medicaid benefits
- Be enrolled in the Medicaid STAR+PLUS program for at least 30 days[67]

[60] STAR Kids, Rate Setting Actuarial Analysis, Texas Health and Human Services, Retrieved from: https://pfd.hhs.texas.gov/managed-care-services/star-kids.

[61] Dual-eligible Integrated Care Demonstration Project, Rate Setting Actuarial Analysis, Texas Health and Human Services, Retrieved from: Dual-eligible Integrated Care Demonstration Project (Dual Demo) | Provider Finance Department (texas.gov).

[62] Ibid.

[63] Dual Eligible Project (MMP), Texas Health and Human Services, Retrieved from: Dual Eligible Project (MMP) | Texas Health and Human Services.

[64] Ibid.

[65] Dual-eligible Integrated Care Demonstration Project, Rate Setting Actuarial Analysis, Texas Health and Human Services, Retrieved from: Dual-eligible Integrated Care Demonstration Project (Dual Demo) | Provider Finance Department (texas.gov).

[66] Dual Eligible Project (MMP), Texas Health and Human Services, Retrieved from: Dual Eligible Project (MMP) | Texas Health and Human Services.

[67] Ibid.

The program does not include clients who reside in intermediate care facilities for individuals with intellectual disabilities and related conditions, or individuals with developmental disabilities who get services through one of the following waivers:

- Community Living Assistance and Support Services
- Deaf Blind with Multiple Disabilities Program
- Home and Community-Based Services
- Texas Home Living[68]

Other dual-eligible members may opt to enroll in the program including:

- Individuals in a Medicare Advantage plan not operated by the same parent organization that operates a STAR+PLUS dual eligible project ("MMP") and who meet the eligibility criteria for the demonstration, may enroll if they disenroll from their Medicare Advantage plan

- Individuals in the Program of All-Inclusive Care for the Elderly ("PACE") who meet the eligibility criteria may enroll if they disenroll from PACE and enroll in the Medicaid STAR+PLUS program for at least 30 days

- Eligible individuals participating in the CMS Independence at Home demonstration may switch to this demonstration project[69]

Individuals in the Dual Demonstration program receive access to their full STAR+PLUS benefits, as well as Medicare benefits. Under this demonstration, Medicare and Medicaid each contribute to the total capitation payment to the participating MCOs. CMS develops the portion of the capitation payment for Medicare covered services, while the Commission develops the portion of the capitation rate for Medicaid services. Our review focuses only on the Medicaid portion of the total capitation payment.

[68] Dual Eligible Project (MMP), Texas Health and Human Services, Retrieved from: Dual Eligible Project (MMP) | Texas Health and Human Services.

[69] Ibid.

IV. RISK LEVEL CLASSIFICATION

RISK LEVEL CLASSIFICATION OVERVIEW

The review of each program included thousands of data points and assumptions related to rate structure, base data, data source validation, base data adjustments, trend assumptions, program changes, non-benefit load assumptions, COVID-19 impacts, and other special contract arrangements. We used a risk assessment process that directed our review toward high-value and high-risk components and fewer resources to low-value and low-risk components.

As we catalogued the various rate components of each program, we performed an initial risk assessment and high-level review of all rate components to place them into the matrix shown below. In collaboration with the Office, we determined the error risk and financial value parameters, as defined below:

- **Error Risk**: The risk that an error can occur in the development of a given component of the development of the capitation rates. For example, a complex calculation or calculation that includes multiple steps would have a higher risk of error.
- **Financial Risk**: The risk that an error or methodology choice in the development of a given component of the development of the capitation rates can result in over-or-under funding of the program. For example, an application and development of a 5% adjustment has a higher financial risk than a 0.5% adjustment.

The combination of the error risk and financial risk classified each rate component into a color; red, yellow, or green. The depth of our review corresponds to the colors in the matrix; with the highest level of review on the red classification, as defined below.

Figure 3: Rate Component Prioritization Matrix

		Financial Value		
		Low	Medium	High
Risk of Error	Low	Low	Low	Medium
	Medium	Low	Medium	High
	High	Medium	High	High

- We spent the most time and effort on the red areas because they have the highest risk of impacting the actuarial soundness of the capitation rates. Examples that fall into the red categories include data validation procedures, trend assumptions, and significant program changes.
- The yellow areas were subject to a significant review, but at a lower intensity than the red areas. Examples that fall into the yellow categories include less significant program changes, modest fee schedule changes, non-benefit expenses, and CMS compliance.
- We reviewed the green areas for reasonableness, but did not devote the significant time and effort needed for a detailed review, as they do not materially impact actuarial soundness based on our initial risk review. Examples that fall into the green categories include modest data adjustments (e.g., incurred but not reported claim estimates, third party liability recovery adjustments) and rate structure. We still recommend process improvements for the green areas of risk, and we have documented them in our report.
- All calculations in the rate model were thoroughly checked for mechanical errors (i.e., mathematical errors).

RATE DEVELOPMENT COMPONENTS

We structured our review of the FY 2024 rate development process into six key components that consider the rate development overview and risk level classification, noted above. We offer a brief description of these six components below. Each component's *general* prioritization classification is noted in parenthesis and the color of the box; some components have multiple prioritization levels because there are various underlying components that required review.

Rate Structure (low)

- The rate structure component encompasses the development of separate rating groups based on similar cost profiles with consideration for population credibility

Base Data (high)

- The base data development encompasses the selected data sources and time periods, validation of selected data, and any adjustments to the collected data

Trend Adjustments (high)

- The trend adjustment component encompasses the utilization and unit cost factors applied to the base period data to estimate expenditures during the FY 2024 rating period

Program Adjustments (high / med / low)

- The program adjustment component includes additional adjustments to account for changes between the base period and FY 2024, such as provider contracting, changes in covered benefits, policy updates, and the impact of the public health emergency. The level of review varies by program adjustment based upon the assessed risk introduced by the given assumption.

Non-Benefit Expenses (medium)

- The non-benefit expense development relates to the inclusion of administrative costs and risk margin that are required to be part of Medicaid capitation rates

CMS Compliance (medium)

- The CMS compliance component evaluates the compliance with CMS regulations and guidance, as well as other guidance issued by the Actuarial Standards Board

V. REVIEW PROCESS

We detail our review methodology below for each of the six rate development components noted in Section II. Overview of Capitation Rate Setting.

Additionally, we refer the reader to our Review of FY 2023 Texas Medicaid Managed Care Capitation Rate Development Process report for additional background related to the policy authority that guides the review of each of these components.

RATE STRUCTURE

We reviewed the rate structure of each program in the context of data credibility and program goals. Specifically, we sought to address the following questions related to the rate cell structure:

1. Based upon general actuarial practices for Medicaid managed care capitation rate setting and experience in states with similar programs, is the rate structure of each program designed to reflect material cost profile differences of members?

2. Do the resulting risk groups in this rate structure design have appropriate credibility for projecting total cost, as well as informing more assumptions at a more detailed level (e.g., trends, program changes, service category detail)?

3. Are there any unique characteristics of the program that are commonly addressed through the rate structure, such as incentivizing MCOs to align with program goals?

Unlike the base data development review, there is not an explicit technical analysis associated with our review of the rate structure, partly due to the nature of this component and partly due to its risk classification as "low risk." Instead, we took a qualitative look at the rate structure used to calculate base data, develop assumptions, and set final capitation rates. Please see the risk matrix in the risk level classification section in this main report.

There are a few aspects of the rate structure of each program that are outside of the scope of our review:

1. Risk Adjustment: Risk adjustment is commonly applied to capitation rates to reflect that the capitation rates are developed for each risk group in total across the program, but there is expected variation in the costs for each Managed Care Organization due to differences in the health status of the population enrolled in their plan (i.e., one plan may have a higher percentage of individuals with an expensive chronic condition). A review of the risk adjustment methodologies is not included in the scope of our review of the FY 2024 Texas Medicaid managed care capitation rates since risk adjustment is applied on a budget neutral basis, meaning it does not increase or decrease the total program funding, just the allocation of payments across MCOs within a risk group.

2. Directed Payments: States commonly use directed payment programs to stipulate or increase funding to a certain type of provider type outside of the normal reimbursement methodology for these providers. A review of the directed payment development is not included in the scope of our review of the FY 2024 Texas Medicaid managed care capitation rates since directed payment programs are separately developed, reviewed, and funded outside the standard capitation rate development process.

BASE DATA DEVELOPMENT

The approach used to perform the base data development review was a combination of comprehensive in-depth review of base data development for a sample Service Delivery Area ("SDA") and a targeted methodology review of base data development for all SDAs. The counties included in each SDA are defined by the Commission and consider historical definitions and other considerations, such as provider locations and procurement goals. The comprehensive in-depth review for the sample SDA is intended to gain a detailed understanding of the Commission's base data development approach and leverage such understandings to identify potential risks and gaps in the existing process as compared to the best practices we would expect for a similar program. We selected a sample SDA that had at least three managed care organizations ("MCOs") for each program, and we selected a different SDA for each program. For programs where rates are developed on a statewide basis (i.e., no distinct rates by SDA), we reviewed the base data for the whole program.

The following describes the specific tasks we performed for the two levels of review for the base date development for medical (both acute care services and long-term care services) and pharmacy data.

Review tasks performed for the sample SDA:

- Full replication of base data development at the risk group and the major base data component level for each participating managed care organization ("MCO") within the sample SDA.
- Detailed review of each base data adjustment as applied by the Commission for the sample SDA to assess its technical accuracy and methodology soundness.
- Independent reconciliation of expenditures between the Financial Statistical Reports ("FSRs") and the MCO supplemental data for the base period.
- Summary of the replication and reconciliation results in exhibit format for the selected sample SDA.

Review tasks performed for all SDAs:

- Technical accuracy of calculating final base per-member-per-month for all SDAs for both plan experience rates and community rates.
- Evaluation of methodology soundness associated with the current base data development approach.

TREND

We conducted a comprehensive in-depth review of the trend assumptions given their importance in the rate development process. This allowed us to gain a thorough understanding of the Commission's FY 2024 trend development methodology, for which we relied on supporting information provided by the Commission. We used this information to identify high-risk steps or assumptions within the trend development process for further review, such as the normalization and aggregation processes.

In addition to the in-depth methodological review, we also analyzed the overall selected medical, pharmacy, and NEMT trends for appropriateness.

PROGRAMMATIC ADJUSTMENTS

We used a combination of in-depth methodology review (inclusive of technical verification of calculations where necessary) and high-level reasonability review to account for the wide range of risk classification within the program changes. We first separated the program changes into two buckets based on the magnitude of the numerical impact of each program change on the rates. Within the bucket of smaller magnitude changes, we identified any program changes that could have additional calculation or methodology risk associated with them to decide whether they should receive a more detailed review alongside program changes with larger magnitudes.

We conducted an in-depth methodology review of the program changes in the first bucket (i.e., those with the largest impact or misestimation risk). We reviewed the key data files provided by the Commission along with the rate certification documents that describe the program changes and calculation methodology in detail. In addition to reviewing the methodology, we examined how the changes apply to specific populations and SDAs, if applicable, within the rate development process.

For the program changes with smaller financial impact, we reviewed the resulting factors by risk group and SDA, if applicable, for overall reasonableness. We did not conduct a thorough technical or methodology review since these adjustments do not carry significant risk of miscalculation and do not have a material impact on the actuarial soundness of the rates.

NON-BENEFIT EXPENSES

We reviewed the non-benefit expense development from the three following perspectives:

- The methodology and narrative disclosed by the Commission in the rate certification

- Relative to historical non-benefit expenses reported by the MCOs
- Relative to non-benefit expenses nationally, both actual levels experienced and amounts other states use in developing capitation rates

As a medium risk item, we did not conduct a thorough technical review due to the limited calculation risk. However, we recognize the resulting assumptions are an important part of the final rate development and we reviewed the included non-benefit expenses for appropriateness.

CMS COMPLIANCE AND DOCUMENTATION

We reviewed the Commission's FY 2024 rate certifications for compliance with the CMS 2023-2024 Medicaid managed care rate setting guidance.[70] While we are not conducting a compliance review on CMS' behalf, we reviewed the rate certification to ensure that the Commission provided information for all portions of the CMS 2023-2024 Medicaid managed care rate setting guidance and provided sufficient documentation to comply with actuarial standards of practice.

We also compared the Commission's final reports to the technical items we reviewed in other areas of our report to ensure the documentation accurately described the underlying rate methodology.

[70] 2023-2024 Medicaid Managed Care Rate Development Guide, Centers for Medicare & Medicaid Services, May 2023, Retrieved from: 2023-2024 Medicaid Managed Care Rate Development Guide.

VI. REVIEW CONCLUSIONS

Our review conclusions include commentary related to the reasonableness and / or technical accuracy of each rate development component. We further categorize our review conclusions into recommendations and observations.

Recommendations, which are more significant in nature, note where the capitation rate development process varies from commonly accepted rate setting practices, is not consistent with regulatory guidance, or introduces actuarial soundness risk.

Observations, which are less significant in nature, note specific methodological or technical deviations from Medicaid capitation rate setting best practices based on our interpretation of regulatory guidance, actuarial standards of practice, and our observations in other state Medicaid programs. Throughout the report, we also include acknowledgement of adherence to best practices in the "observations" section to indicate our agreement with key aspects of the rate development.

For each recommendation and observation below, we note the specific Texas Medicaid managed care program(s) to which the recommendation or observation applies and if the recommendation or observation was also applicable in our FY 2023 review. Given the reliance of the Dual Demonstration program upon the STAR+PLUS rates for many components, many of the recommendations included for the STAR+PLUS program are also applicable to the Dual Demonstration program.

RATE STRUCTURE

We evaluated the Commission's rate structure for the FY 2024 capitation rates by reviewing the actuarial report and rate development model created by the Commission.

Reasonableness of Resulting Rate Structure

The Commission's risk group definitions are generally consistent with commonly observed practices for similar programs in other states. The primary characteristics used to define risk groups for each program are summarized in Table 2.

Table 2
Texas Medicaid Managed Care Rate Review
Review Conclusions
Rate Structure Overview

Program	Risk Groups	Service Delivery Areas (SDAs)
STAR	Eligibility group and age	13 county and regional-based SDAs
STAR Health	N/A – single statewide rate	N/A – single statewide rate
Dental	Eligibility group and age	N/A – statewide rates by risk group
STAR+PLUS	Eligibility group, setting of care, and Medicare status	13 county and regional-based SDAs
STAR Kids	Eligibility group and age	13 county and regional-based SDAs
Dual Demo	Setting of care	6 county-based SDAs

With the exception of the STAR Kids program as noted below, we do not have significant concerns about the assumed credibility levels due to sufficient historical average enrollment in each risk group and SDA grouping. In some instances, we have recommendations or observations regarding the Commission's rate structure even though we may not necessarily have overall concerns with the final FY 2024 rate structure. These recommendations and observations are driven by potential issues that could arise due to the Commission's rate structure, but they may not necessarily produce unreasonable results in the FY 2024 rates.

Program-specific concerns and unique considerations are described below.

STAR

As observed by the Commission, there is significant NEMT claim variability at an SDA level for the AAPCA risk group. Using the statewide NEMT community rate for this risk group is a reasonable approach to address this volatility.

STAR Health

For a program like STAR Health that has a relatively small and narrowly defined eligibility group, it is reasonable that the Commission administers the program with a single risk group definition and through a single MCO. By using a single MCO, the STAR Health program avoids risks associated with member selection and acuity differences among MCOs. Similarly, the statewide rate mitigates credibility concerns that may arise at the SDA level for a smaller program, such as STAR Health. The STAR Health program had roughly 45,000 members (543,219 member months) in the base period (September 2021 through August 2022).

Dental

The use of statewide rates for the Dental program is consistent with standalone dental programs in other states.

STAR+PLUS

We do not have significant concerns about the assumed credibility levels due to sufficient historical average enrollment in each risk group and SDA grouping. In addition, it is generally expected that a lower number of member months is needed for full credibility for programs that include LTC costs compared to acute care programs due to less cost variability among members.

As observed by the Commission, there is significant NEMT claim variability at an SDA level for the three risk groups with the lowest membership levels (Medicaid Only – NF, IDD, and MBCCP) due to a combination of lower membership and a service that has lower utilization than other services included in the capitation rates. Using the statewide NEMT community rate for these risk groups is a reasonable approach to address this volatility.

STAR Kids

The Commission's current rate structure results in a high number of unique SDA and risk groupings for a relatively small program with a total enrollment of around 2.0 million member months (i.e., equivalent to a monthly average of approximately 169,000 members). While there is not a defined credibility threshold for this population, there are multiple SDA and risk groupings that may not be fully credible due to the lower number of enrolled members. These concerns are addressed in more detail in Recommendation B below.

Dual Demonstration

The Dual Demonstration risk group definitions are consistent with the STAR+PLUS risk group definitions for dual eligible members. This is important as the underlying base data used to develop the Dual Demonstration capitation rates is from the STAR+PLUS program. In our review of the STAR+PLUS program, we do not have concerns with the rate structure or credibility of the risk groups. Therefore, we also do not have any concerns with rate structure for the Dual Demonstration program.

We summarize the average enrollment associated with each risk group and SDA combination by program in Exhibits 3 through 7.

Rate Structure Recommendations

We note the following recommendations related to rate structure:

Recommendation A: Consider consolidating SDAs for the purpose of rate development
Applicable program(s): STAR, STAR+PLUS, STAR Kids
This recommendation is unchanged from the FY 2023 review.

As mentioned above, we do not have significant concerns about the assumed credibility levels of most of the Commissions risk group and SDA groupings, but the Commission may be able to improve the credibility or reduce the volatility of some risk group and SDA groupings by combining them. The Commission indicated SDAs used for rate development have changed some in prior years; however, the SDA definitions are largely driven by the procurement process and objectives. The Commission may consider whether additional efficiencies or credibility improvements may be achieved by combining some SDAs for the purpose of the community rate development. If the underlying cost drivers (e.g., risk profile, utilization patterns, and cost structures) are similar between SDAs, the Commission may be able to aggregate some SDAs during the rate development process. The Commission would still be able to define the SDAs separately from an operational perspective, but the same community rates could apply to multiple SDAs.

To the extent the adjustments and projection factors would be equivalent, combining SDAs would be budget neutral to the State. However, aggregating some SDAs with lower credibility could result in less volatility in the projection factors, especially in instances where the Commission relies solely on historical experience to calculate the projection factors.

We retained this recommendation from the FY 2023 review because it is a best practice to regularly revisit whether additional efficiencies or credibility improvements may be achieved by consolidating SDAs, although it may not be necessary to perform this review every year. The Commission indicated they did not consider consolidating SDAs for the purpose of rate development for FY 2024 for various reasons, including concerns about how to address different MCOs operating in different SDAs, provider contracting issues, and upcoming procurements.

Recommendation B: Consider combining risk groups to enhance credibility and reduce annual volatility
Applicable program(s): STAR Kids
This recommendation is unchanged from the FY 2023 review.

In general, the current design of the rate structure is a continuation of the traditional rate structure that relies primarily on detailed age grouping and location grouping. The STAR Kids risk groups also rely on waiver status-related eligibility differences to account for material risk and cost differences for covered members within this program. While some states have evolved toward the use of more consolidated age and regional groupings in their rate structure by leveraging risk adjusted capitation payment techniques for these populations, the current structure used by the Commission for this program is still commonly seen in other State Medicaid managed care programs.

However, the Commission's current rate structure does result in a high number of unique SDA and risk groupings for a relatively small STAR Kids program with a total enrollment of around 2.0 million member months (i.e., equivalent to a monthly average of approximately 169,000 members). While there is not a defined credibility threshold for this population, we note 21 community rates at risk group and SDA combination level that rely on the experience of less than 6,000 member months which are likely not fully credible on their own (i.e., equivalent to a monthly average of 500 members). When a high percentage of community rates are developed using experience that may not be fully credible, the overall funding risks at the program level increases to both the State and the MCOs, as community rates developed using less credible experience are generally subject to higher pricing risks. In addition, each community rate for this program is first developed at a more granular level (as described in Step One under Rate Development Process in Appendix E) using MCO level experience which has even lower credibility. As a result, additional pricing and funding risks are introduced to both the State and the MCOs for this program.

We recommend the Commission consider a feasibility study to modify the current rate structure for STAR Kids to consolidate the existing risk groups and / or SDA groupings for the purpose of achieving higher credibility and stability within the program.

In addition, we recommend the elimination of MCO experience rating as an interim step (Step One under Rate Development Process in Appendix E) for the community rate development due to the lower number of members in the STAR Kids program. Instead of using individual MCO base experience as the base data for MCO level rate development by SDA and risk group and then aggregating them together using projected enrollment mix across MCOs to create community rate by SDA and risk group (Step Two under Rate Development Process in Appendix E), we recommend the use of combined MCO base experience as the base data for community rate development.

We retained this recommendation because, although the Commission indicated that a statewide rating would improve credibility, they also indicated that there are no additional means to improve the credibility of the available data. The Commission said it will examine using multiple years of data in future rate setting cycles to improve the credibility of these populations in the STAR Kids program.

Rate Structure Observations

We note the following observations related to rate structure:

Observation A: Rates are developed individually by MCO rather than across all MCOs
Applicable program(s): STAR, STAR Kids
This observation is unchanged from the FY 2023 review.

The risk adjusted community rates developed by the Commission for the STAR and STAR Kids programs are developed to be budget-neutral at the program level, in aggregate. By limiting the final MCO risk adjusted rates to be no greater than 108% of the individual MCO experience rate, the Commission essentially reduced the total program costs. While this process may generate savings to the State, the entire program may be at risk for underfunding due to

this mechanism. The risk of underfunding is not likely to be significant since this adjustment will primarily target outliers, but the final rates paid to MCOs are not budget neutral as a result of this mechanism.

The Commission notes this 108% cap is intended to incentivize efficient performance, since the lower-cost MCOs will ultimately receive rates that are approximately eight percent higher than their projected costs; however, the Commission did not document why they specifically chose eight percent.

We retained this observation from the FY 2023 review because the Commission's approach to developing the MCO-specific rates impacts the budget neutrality of the program, and the Commission did not provide support for the 108% cap.

Observation B: Allocation of benefit and non-benefit expenses in final rates to MCOs are not clearly identified

Applicable program(s): STAR, STAR Kids
*This observation is **modified** from the FY 2023 review.*

The Commission's final capitation rates paid to MCOs for the medical and pharmacy service groupings in the STAR and STAR Kids programs are based on the lesser of 108% of the individual MCO experience rate or the risk-adjusted community rate. In their response to this observation in FY 2023, the Commission stated that the administrative expense assumptions are provided in Section IV of the report, which corresponds to Section V in the FY 2024 rate certification. The rate certification does not clearly identify which MCOs have final rates based on the individual MCO experience rate or the community rate. This information is necessary to identify the final non-benefit expense included in the capitation rates since the final administrative expense PMPM paid to MCOs, specifically the fixed PMPM component, is impacted by either the risk adjustment factor or the 108% factor.

In addition, although the rate certification includes sufficient detail for another actuary to calculate the minimum loss ratios (MLR)[71] for community-based rates, the rate certification does not include sufficient detail for another actuary to calculate the MLR for the individual MCO experience-based rates because the Commission does not identify how the additional 8% is allocated between benefit and non-benefit expenses. If a portion of the 8% is allocated to benefit costs but the actual MCO experience is more aligned with base period experience benefit costs, then the actual MLR is likely to be less than the MLR priced into the capitation rate. In cases where the priced MLR is close to 85.0%, this creates the risk that the MCO final capitation rates is priced at an MLR less than 85.0%.

Table 3 shows how this issue may impact MLRs. In this illustrative example, the projected MLR based on MCO experience, without the 8% increase, is 85.4%. The 8% could be allocated in various ways, as shown in Table 3. These different allocation methods can result in materially different projected MLRs. However, actual MCO experience during the rate year will not necessarily align with the allocation assumed by the Commission in the rates. Absent MCO-specific considerations not reflected in the rate development, we would assume actual MCO benefit costs would be similar to the MCO's projected experience, as shown in the last column of Table 3. Therefore, the actual MLR could be significantly lower than the MLR priced into the capitation rates by the Commission if the 8% is allocated based on a different methodology.

Table 3
Texas Medicaid Managed Care Rate Review
Non-Benefit Expense Development
Illustrative Example of Benefit and Non-Benefit Allocations in Final Rates to MCOs

			108% of MCO Experience		
		MCO Experience	Evenly Allocated	Allocated to Benefit Costs	Allocated to Non-Benefit Costs
a	Projected benefit costs PMPM	$100.00	$108.00	$109.54	$100.00
b	Projected non-benefit expense PMPM net of taxes	$17.05	$18.41	$17.05	$26.58
c	Projected taxes PMPM	$2.16	$2.33	$2.16	$2.16
d = a + b + c	Projected total PMPM	$119.20	$128.74	$128.74	$128.74
e = a / (d - c)	Projected MLR	85.4%	85.4%	86.5%	79.0%

[71] From Medicaid.gov: https://www.medicaid.gov/medicaid/managed-care/guidance/medical-loss-ratio/index.html

We modified this observation from the FY 2023 rate review, including changing the observation from a non-benefit expense observation to a rate structure observation, to provide more detail about how the information in the rate certification is insufficient to determine the final allocation between benefit and non-benefit expenses paid to MCOs and to illustrate the potential implications for projected and actual minimum loss ratios.

We note, the Commission includes an experience rebate that helps mitigate the risk of program overfunding (i.e., low MLRs) by requiring the MCOs pay rebates to the Commission when profits reach certain levels. The specific experience rebate parameters for each program are included in the respective appendices.

Observation C: LTC rates developed separately for nursing facility and community residents

Applicable program(s): STAR+PLUS
This observation is unchanged from the FY 2023 review.

The Commission's current rate structure is a typical unblended rate structure for a managed long-term care (LTC) program. It follows generally accepted actuarial practices and aligns with actuarial soundness principles.

However, a unique aspect of the rate structure design for a managed LTC program is the potential to use the rate structure to promote the typical LTC program goal of serving members in the more cost effective care setting (i.e., home and community setting such as members' own homes, assisted living facilities, and adult day care centers) as appropriate for their functional acuity, to the extent possible. Many states with similar LTC programs achieve this goal by paying the MCOs a blended capitation rate across the different care settings (e.g., nursing facility, community setting).

Under a blended rate structure, the MCOs are paid one overall PMPM capitation rate for members within an eligibility category regardless of whether they receive care in a community setting or nursing facility. In general, the cost of providing care to an individual in a nursing facility is significantly more than providing the necessary care in community settings. When paid with blended rates, MCOs will be accountable for achieving a targeted membership mix between community settings and institutional settings, resulting in strong financial incentives to serve members in the community. For example, using the STAR+PLUS risk groups, under a blended rate structure approach the MCOs would be paid a blend of the Medicaid Only – NF and Medicaid Only – HCBS risk groups based upon a targeted membership mix. The targeted membership mix often includes a slight increase to the percentage of members in the HCBS risk group to further incentivize MCOs to transition members to community settings.

Because one of the goals for the STAR+PLUS program is to promote maintaining members in the community settings, the Commission could consider redesigning the rate structure to better align the MCOs' financial interest and this program goal by exploring the use of the blended rate structure mentioned above or other innovative payment and rating arrangements that are successful and currently used by other states.

We retained this observation from the FY 2023 review because the Commission did not indicate that any changes have been made to the development of LTC rates for nursing facility and community residents. The Commission has, however, published a paper[72] examining the benefits of blending LTC care where it was indicated that the Commission is unable to determine if a blended rate strategy would affect member choice of setting. The Commission concluded that feedback from stakeholders would be needed to assist with its potential implementation in the future. Although the blended rate among LTC members is not currently built into the rates, the Commission is actively considering the possibility of implementing this pricing method.

BASE DATA DEVELOPMENT

We gained an in-depth understanding of the Commission's FY 2024 base data development approach through a detailed review and replication of the base data, in conjunction with the Commission's responses to our review questions. We performed the detailed review and replication of base data development on sample SDAs for some programs and in entirety for other programs, as described in the Review Process section and outlined in Table 4.

[72] Capitation Rate Setting Strategy Used to Cover Long-Term Services and Supports Provided to Recipients Under the STAR+PLUS Medicaid Managed Care Program Report (texas.gov)

Table 4 Texas Medicaid Managed Care Rate Review Review Conclusions SDAs Included in Scope of Base Data Review	
Program	**Detailed Base Data Review Scope**
STAR	Travis SDA
STAR Health	Entire program
Dental	Entire program
STAR+PLUS	Bexar SDA
STAR Kids	Harris SDA
Dual Demonstration	Not applicable

Within the scope of our review, we reviewed the data and processes used by the Commission to develop base data. It is outside the scope of our review to independently develop capitation rates. Therefore, ***we did not produce our own estimates of base data***. We present our conclusions based on our review of the Commission's data and methods.

Base Data Technical Accuracy

We reviewed the technical accuracy of the base data calculations to ensure there were no technical errors in the Commission's base data calculations based on the Commission's base data methodology.

The development of the final medical, pharmacy, and NEMT base period data is accurate from a technical perspective for each risk group and each MCO / DHMO included in our comprehensive in-depth base data review. Using the raw enrollment data reported by the Commission and the expenditure data reported by the MCOs / DHMOs, we were able to replicate the calculation of the final medical, pharmacy, and NEMT base data using the Commission's approach, within a margin of rounding difference, at the risk group level for the sample SDA or entire program, as applicable. Please refer to the base data reconciliations in Exhibits 8 through 12 for details.

In some instances, we have recommendations or observations regarding the Commission's methodology or other factors even though we may not have concerns with the technical accuracy of the Commission's FY 2024 base data calculations. These recommendations and observations are driven by potential issues that could arise due to the Commission's methodology or other factors, but they may not necessarily produce unreasonable results in the base data for the FY 2024 rates.

Base Data Recommendations

We note the following recommendations related to base data development:

Recommendation C: Use state encounter data as the primary base data source for expenditure data
Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids
This recommendation is unchanged from the FY 2023 review.

In general, encounter data is the preferred data source for base expenditure data development, to the extent complete and accurate encounter data is available, because encounter data is comprehensive, auditable, and detailed. We recommend the use of encounter data as the primary base data source, since complete and accurate encounter data is available in Texas from the State's EQRO, who examines and certifies encounter data quality every year. Using encounter data will allow member and claim level validation to have the highest level of data integrity, including consistent grouping of expenditures at the detailed service category level across all MCOs / DHMOs for more sophisticated actuarial cost modeling. Using encounter data also enables member level matching of risk group assignment between enrollment and claims data. This is particularly important for STAR+PLUS for the purpose of ensuring risk group assignment consistency between enrollment and claims data as populations covered by this program are more prone to retroactive eligibility category ("dual" versus "non-dual") and risk group assignment changes [other community care ("OCC") versus home and community-based services ("HCBS") versus nursing facilities ("NF")]. While encounter data can play a primary role in the base data development, the MCO / DHMO FSRs and the MCO / DHMO supplemental data should continue to be collected and used as supplemental data sources for expenditures not paid through encounters, such as non-lag expenditures and administrative expenditures.

Although not explicitly required, CMS encourages states to use encounter data in the rate development. When encounter data is not the primary data source in the rate development, the CMS 2023-2024 Medicaid Managed Care Rate Development Guide[73] requires the actuary to provide an explanation. While the rate certification does not explicitly address why the encounter data is not used to develop the base data, our understanding is that encounter data for the most recent state fiscal year is typically not provided by the EQRO until the following March, which is typically too late to be used by the Commission as the foundation for the base data. We recognize this timing presents a hurdle that would need to be addressed for the Commission to be able to use the encounter data as the main data source for the base data development. For example, the Commission could explore ways to use preliminary encounter data to develop draft base data prior to the EQRO's final release, and the Commission could update rates with the validated data following its final approval by the EQRO in March.

In their response to this recommendation in the FY 2023 rate review, the Commission explained that they validate the MCO supplemental data, which is the Commission's primary base data source as reflected in the base period estimated incurred claims, against the encounter data. The Commission also explained that they consider their three data sources (i.e., FSRs, MCO supplemental data, and encounter data) to be interchangeable in aggregate. The Commission's response also noted that the encounter data submitted to ICHP by the MCOs does not include risk group. However, based on our experience with other states, we would expect the encounter data to include sufficient member-level detail (e.g., a member ID) such that the Commission could map the risk group onto the encounter data from the eligibility data. If it does not, we suggest the MCO submissions to ICHP be modified to include this information.

We retained this recommendation from the FY 2023 review because the recommendation is consistent with the approach preferred by CMS, and we believe the encounter data would allow the Commission to evaluate claim experience and develop capitation rate projection adjustments at a more granular level. The Commission indicated that there are issues with the encounter data for some MCOs, but they continue to explore the use of encounter data and the primary base data source.

Recommendation D: Use the state capitation payment file as the primary base data source for enrollment data

Applicable program(s): STAR, Dental, STAR+PLUS, STAR Kids
This recommendation is unchanged from the FY 2023 review.

For established managed care programs like those subject to this review, the state capitation payment file serves as the practical source of truth in terms of member level risk group assignment. This file includes the most current risk group assignment at the member and month level. Use of this file to assign members to risk groups in both the detailed enrollment data and the expenditure data for base period PMPM calculations will not only ensure risk group assignment consistency between enrollment and claims data, but this will also ensure that the capitation rates will be developed in a manner consistent with how they will be ultimately used for MCO / DHMO capitation payments at the risk group level.

The Commission's primary enrollment data source is the Commission's monthly enrollment file, which does not include member level details. The Commission's approach increases the risk of inconsistency between the enrollment and claims data because the Commission cannot validate that the same members are represented in both sources. In their response to this recommendation in the FY 2023 rate review, the Commission noted that the difference between their three enrollment data sources for the base period was less than 0.003% in aggregate across all Medicaid programs, but their response did not address potential variances at the program or risk group level. Additionally, the risk of inconsistency was lower in FY 2023 than in most years because the gap between the base period and the rate year was larger than the gap in most years due to the PHE (three-and-a-half years versus two years for FY 2024), allowing more time for operational or eligibility-related inconsistencies to be resolved.

[73] "2023-2024 Medicaid Managed Care Rate Development Guide," Centers for Medicare & Medicaid Services, May 2023, Retrieved from: 2023-2024 Medicaid Managed Care Rate Development Guide.

This recommendation does not apply to STAR Health because the program has a single risk group, so the potential impact on member level risk group assignment is not relevant.

We retained this recommendation from the FY 2023 review because the Commission's reliance on its monthly enrollment file as the primary source for base period enrollment introduces the risk of misalignment between base period enrollment data and base period expenditure data.

Recommendation E: Develop base period for each SDA by weighting each MCO's experience with actual enrollment instead of projected enrollment

Applicable program(s): STAR, STAR+PLUS, STAR Kids
This recommendation is unchanged from the FY 2023 review.

Medicaid managed care capitation rates are generally developed at the community level or program level by risk group to be consistent with the generally accepted rate setting principle[74] that capitation rates are developed to be actuarially sound for the program rather than for an individual MCO. Typically, the base period PMPM used for community rate development for any risk group in any region is calculated by dividing the total base period expenditures across all participating MCOs by the total base period enrollment across the same MCOs. Community base period PMPMs calculated using this approach represent the actual experience at the program level for a specific risk group in a specific region and serve as the baseline for cost projections at the regional level. If the actuary anticipates a material impact on regional costs due to changes in acuity or contracting based upon the difference in the mix of MCOs between the base period and the rating period, this impact is typically addressed through programmatic adjustment factors.

The Commission calculated the base period costs per member per month at the MCO level for each risk group and each SDA and then aggregated the costs per member per month weighted by each MCO's projected FY 2024 enrollment. Based on our understanding from conversations with the Commission, this approach is used to reflect that each MCO has a different contracted network of providers that leads to differences in costs for an individual if they are enrolled in one MCO versus another, rather than a difference in costs due to changes in acuity of the member if they move between MCOs. Therefore, the Commission's final base period claims represent the average provider contracting levels expected during FY 2024 rather than the actual average provider contracting levels during the base period. In addition, the Commission explained that the intent of using projected enrollment for base data aggregation is to ensure budget neutrality between community rates and MCO experience rates.

While the financial impact of this weighting methodology in the development of the community rate can go both ways, as shown in Table 5 for the STAR program, this approach introduces a projection assumption into the development of the base data and the resulting base data does not reflect the actual costs incurred by the MCOs during the base period.

Table 5
Texas Medicaid Managed Care Rate Review
STAR Program – Base Data
Difference in SDA-level PMPMs using Base Period Membership versus Projected Membership Weighting

	Medical + Pharmacy Percentage Difference							
SDA	Under Age 1	Age 1 to 5	Age 6 to 14	Age 15 to 20	TANF-Adults	Pregnant Women	AAPCA	Total
Bexar	0.00%	0.02%	0.13%	0.15%	-0.05%	0.27%	-0.15%	**0.10%**
Dallas	0.11%	0.11%	0.00%	0.06%	0.00%	0.08%	-0.38%	**0.06%**
El Paso	0.07%	0.01%	-0.01%	0.02%	-0.02%	0.19%	0.15%	**0.05%**
Harris	-0.10%	-0.13%	-0.26%	-0.75%	0.55%	0.00%	-1.44%	**-0.16%**
Hidalgo	0.05%	0.25%	0.16%	-0.01%	0.40%	-0.15%	1.44%	**0.11%**
Jefferson	-0.94%	-0.23%	-0.06%	0.04%	0.22%	0.06%	0.28%	**-0.15%**
Lubbock	0.11%	0.04%	0.05%	0.21%	0.22%	-0.09%	-0.45%	**0.05%**
MRSA Central	0.03%	0.00%	-0.04%	-0.03%	0.01%	-0.18%	-0.55%	**-0.07%**
MRSA Northeast	0.02%	-0.70%	-0.47%	-0.56%	-0.21%	0.01%	-1.25%	**-0.30%**
MRSA West	-0.09%	-0.18%	0.05%	0.20%	0.04%	-0.21%	-0.18%	**-0.07%**
Nueces	-0.05%	0.04%	-0.11%	-0.03%	0.02%	-0.88%	0.05%	**-0.23%**
Tarrant	-0.01%	0.02%	0.15%	0.26%	-0.10%	0.01%	0.29%	**0.06%**
Travis	0.21%	0.03%	-0.01%	0.22%	0.31%	0.89%	-0.20%	**0.29%**
Total	**-0.03%**	**-0.03%**	**-0.05%**	**-0.17%**	**0.19%**	**0.02%**	**-0.50%**	**-0.03%**

[74] ASOP No. 49, Section 3.1, pg. 3 to 4, Medicaid Managed Care Capitation Rate Development and Certification, March 2015, Retrieved from: https://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049_179.pdf.

If the Commission determines it is appropriate to apply an adjustment to reflect changes in average provider contracting levels driven by projected shifts in enrollment mix among MCOs between the base period and rating period, the Commission may consider applying this adjustment as a programmatic adjustment so it is transparent that actuarial judgement has been used to estimate a change in costs between the actual base period data and the rating period. In addition, careful consideration needs to be taken to ensure that any changes in costs over time due to MCO enrollment changes are normalized out of the trend calculations so that the impact is not double counted in the final capitation rates. This risk of double counting is primarily driven by the Commission's reliance on historical trends to develop projected trends since the historical trends may inherently reflect changes in average provider contracting levels due to enrollment shifts that may not persist. The current approach also introduces the risk of removing cost differences beyond provider reimbursement levels (e.g., underlying differences in member demographics or required levels of care).

We retained this recommendation from the FY 2023 review because the Commission weighted each MCO's experience with projected enrollment when developing the base data for each SDA in the FY 2024 rate development. In the Commission's response to this recommendation in our FY 2023 review, the Commission disagreed with this recommendation and indicated that a change to the weighting would violate the budget neutral nature of the rate development. However, we are not aware of any other state that reflects projected enrollment changes in the base data. The Commission stated that this calculation is intended to reflect "the impact that the varying average costs of each MCO have on the overall SDA average cost." The Commission's calculation implies that the average cost of each member is driven more by the MCO in which the member is enrolled rather than the member's acuity and utilization. Standard actuarial practice is to assume member acuity and utilization is the primary driver of cost. When capitation rates are developed based on program-wide average costs across MCOs, the MCOs with more efficient contracts benefit financially while the MCOs with less efficient contracts are incentivized to reduce costs. As such, we retained our recommendation to aggregate base data using historical enrollment and capture any expected utilization or cost changes through the trend and programmatic adjustments.

Recommendation F: Include supporting documentation for the development of the base period data

Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids
This recommendation is ***modified*** *from the FY 2023 review.*

The rate certification includes the following information to support the development of the base period data used for the FY 2024 capitation rates:

- Data sources, including the specific use of each of the three data sources in the base data development
- High level information about each of the main three data sources: MCO / DHMO supplemental data, FSRs, and encounter data
- Statement that the three main data sources were reviewed for reasonability and not audited
- Reliance on EQRO for encounter data validation
- Statement that based on the review by EQRO and the Commission the three data sources are consistent, complete, and accurate

The rate certification does not include documentation on how the data sources are validated, aggregated, and adjusted. We recommend the Commission expand the rate certification to include additional documentation so that CMS or another actuary could reasonably understand the development of the base data, including but not limited to:

- An overview of the Commission's reconciliation processes between the MCO / DHMO supplemental data and FSRs and whether a different approach is used for lag versus non-lag data
- The types of adjustments made to the raw data as of a result of the reconciliation process
- The aggregation process used to combine individual MCO / DHMO experience into overall program experience (not applicable to STAR Health)

We retained this recommendation with modifications from the FY 2023 review because the Commission added a Base Period Data section to each of the draft rate certification reports that explains how each of the data sources is used in the base data development. However, the FY 2024 rate certifications do not address all aspects of the recommendation included in the FY 2023 review.

Base Data Observations

The following approaches used by the Commission for base data development are reasonable and acceptable. These approaches are consistent with general rate setting practices in other states, and these approaches comply with Medicaid managed care rate setting guidance.

- Selection of SFY 2022 (September 2021 through August 2022) as the base period, and selection of an alternate base period of July 2022 through December 2022 for NEMT due to the recent transition of these services to managed care
- Use of validated MCO / DHMO self-reported expenditure data as the primary base expenditure data
- Use of the MCO / DHMO financial data (i.e., FSR) and the encounter data for expenditure data validation
- Applying an adjustment to base period lag expenditures to account for estimated IBNR
- Accounting for any known or anticipated changes of eligibility and / or covered services between the base period and the rating period through programmatic adjustments
- Use of a case-by-case approach to adjust MCO / DHMO lag expenditure and non-lag expenditure data, to the extent applicable

We note the following observations related to base data development:

Observation D: Summary-level enrollment data and expenditure data are gathered from separate sources
Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids
This observation is unchanged from the FY 2023 review.

The Commission collected summarized base period enrollment data and expenditure data separately from different entities (e.g., the Commission and the MCOs / DHMOs). To the extent that the data systems operated by the different entities are not always synchronized on a real-time basis, there can be a mismatch between the enrollment data and expenditure data. Even if the data is summarized across the same group of covered members in aggregate across all risk groups, mismatch risks can still occur at the risk group level due to the occurrence of retroactive eligibility and risk group changes at the member level.

The likelihood of retroactive eligibility changes and subsequent risk group assignment changes for members enrolled in the STAR+PLUS program is greater than in other programs; however, such potential inconsistencies can introduce risks on a PMPM basis in all programs. For example, when individuals are identified as dually eligible for both Medicaid and Medicare, it is common for their dual-eligible status to apply retroactively to prior months of enrollment. States typically reprocess the capitation payments paid to the applicable MCO to pay the capitation rate the member would have received for those prior months as if the dual-eligibility status was present at the time of payment. If this retroactive risk group change is included in the enrollment data set summarized by the Commission, but not in the internal enrollment data set the MCO used to assign risk group in the expenditure data, the expenditure data for the individual would not be assigned in the correct risk group. Such mismatch risks between enrollment and expenditure can have a material impact on the resulting base PMPM for the affected risk groups and the detailed member level data sources should be reconciled to understand if there is a material risk presented with this approach.

In their response to this observation in the FY 2023 rate review, the Commission noted that the difference between their three enrollment data sources for the base period was less than 0.003% in aggregate across all Medicaid programs, but their response did not address potential variances at the program or risk group level. Additionally, the risk of inconsistency was lower in FY 2023 than in most years because the gap between the base period and the rate year was larger than the gap in most years due to the PHE (three-and-a-half years versus two years for FY 2024), allowing more time for operational or eligibility-related inconsistencies to be resolved.

We retained this observation from the FY 2023 review because the Commission's use of separate sources for summary-level enrollment data and expenditure data introduces a risk that the enrollment data and expenditure data used in the base data development are misaligned, which could result in base period PMPMs that are not representative of program experience.

Observation E: Net reinsurance costs should not be included in the base data

Applicable program(s): STAR, STAR+PLUS, STAR Kids
This observation is unchanged from the FY 2023 review.

The MCO managed care contracts in the Texas Medicaid managed care market do not require MCOs to purchase reinsurance. It is an elective business decision for MCOs, especially small and local MCOs, to purchase reinsurance to the extent they want to mitigate the catastrophic component of the underwriting risks in operating their Medicaid managed care business. However, the Commission should not separately fund the cost of reinsurance through capitation rates outside risk margin, which as an explicit Medicaid capitation rate component, is intended to compensate for the full underwriting risks. While the Commission capped the amount of net reinsurance cost allowable in the base data at $0.50 PMPM for STAR and STAR+PLUS and $2.00 PMPM for STAR Kids, and it may not be material for the overall soundness of capitation rates, the Commission is potentially double counting the cost of this program to the State by adding net reinsurance costs on top of risk margin.

We retained this observation from the FY 2023 review because the Commission's treatment of net reinsurance costs in the base data may be double counting costs.

Observation F: Certain non-lag expenditures are allocated to risk groups on a PMPM basis instead of reflecting inherent utilization and cost differences

Applicable program(s): STAR, STAR+PLUS, STAR Kids
This observation is unchanged from the FY 2023 review.

Non-lag expenditures are payments made or recoveries received by MCOs outside of their claims system. Such expenditures or recoveries are generally incurred on a lump sum basis (e.g., TPRs, provider incentive payments, pharmacy rebates) or on a fixed PMPM basis (e.g., fixed premiums paid to MCOs' subcontractors for capitated benefits like vision). Common industry practice is to reallocate such expenditures equitably by risk group when they are included in the final base data to reflect the expected utilization and cost variations among different risk groups. The Commission does not currently address such equitable cost reallocation at the risk group level in the existing base data development approach. The general approach used by the Commission is to calculate the average PMPM across all risk groups and include the same PMPM in the base data for all risk groups, regardless of the inherent utilization and cost differences at the risk group level for each itemized non-lag expenditure. Without equitable reallocation of such costs in the base data development, the Commission's resulting capitation rates may be over or under funded at a risk group level relative to the actual cost profile of the risk group.

We retained this observation from the FY 2023 review because the Commission did not change how they allocate certain non-lag expenditures to risk groups on a PMPM basis.

TREND

We gained a detailed understanding of the Commission's FY 2024 medical and pharmacy trend development approach through underlying data provided by the Commission, as well as responses to our specific trend review questions.

As noted in the Risk Level Classification section, the NEMT service grouping component comprises a small and lower-risk portion of the overall capitation rates. As such, we performed a high-level review of the Commission's FY 2024 NEMT trend development methodology to become comfortable in the context of overall rate soundness.

Within the scope of our review, we reviewed the data and processes used by the Commission to develop trend assumptions. It is outside the scope of our review to independently develop capitation rates. Therefore, ***we did not request more granular data to produce our own estimates of trend assumptions***. We present our conclusions based on our review of the Commission's data and methods.

Reasonableness of Resulting Trend Assumptions

Trend assumptions represent estimates of future experience. Trend assumptions cannot technically be classified as "right" or "wrong" since no two actuaries are likely to completely agree on what they believe will happen in the future – and future experience is unlikely to exactly match any actuary's assumptions. Therefore, our assessments of the reasonableness of the Commission's trends are intended to provide context and considerations pertaining to the Commission's trend assumptions.

We did not evaluate the drivers of the historical trends relied upon by the Commission to develop prospective trends because this type of evaluation would require substantially more granular data than we requested within the scope of our review. Many factors contribute to observed trends, including the availability of new treatments, the introduction of alternative treatments for existing conditions, and changes in average member demographics and acuity.

In some instances, we have recommendations or observations regarding the Commission's methodology or other factors even though we may not have concerns with the final FY 2024 trend assumptions. These recommendations and observations are driven by potential issues that could arise due to the Commission's methodology or other factors, but they may not necessarily produce unreasonable results in the selected trend assumptions for the FY 2024 rates.

Medical Trends (including LTC services for applicable programs)

The Commission's overall annual prospective PMPM trends for STAR and STAR Health appear to be somewhat high based on our experience working with other states. However, the Commission's overall annual prospective PMPM trends for the other programs appear reasonable. Methodology adjustments incorporated by the Commission for the trends used to develop FY 2024 capitation rates improved the reasonableness of the trend assumptions versus the FY 2023 trends, particularly for STAR+PLUS and STAR Kids.

We also reviewed the stability of the observed historical trends using the Commission's trend calculation methodology. Exhibits 13 through 18 display the volatility in observed annual trends in the medical data provided for our FY 2024 review by program and risk group. These exhibits are provided solely to illustrate the volatility that can result from the Commission's reliance on historical trends, versus using the historical trends to inform projected trends, and should not be interpreted as an evaluation of the reasonableness of the final trend assumptions.

Program-specific concerns and unique considerations are described below.

STAR

The Commission's overall annual prospective PMPM trend at the program level of 4.1% appears to be somewhat high based on our experience working with other states, especially given that the provider reimbursement and other program changes are included in separate programmatic adjustments. However, the historical trends for the STAR program were high in the few years prior to the PHE, so the selected trend may be reasonable based on the unique characteristics of the populations and services included in the program. The Commission indicated that enrollment declines prior to the PHE appeared to increase the average acuity of the STAR population, which resulted in higher trends. Without conducting an independent trend analysis, we do not have insight into whether the drivers of those trends are likely to persist.

STAR Health

The Commission's overall annual prospective PMPM trend at the program level of 4.7% appears to be somewhat high based on our experience working with other states, especially given that the provider reimbursement and other program changes are included in separate programmatic adjustments. However, the historical trends for the STAR Health program were high in the last two years prior to the PHE, so the selected trend may be reasonable based on the unique characteristics of the populations and services included in the program. The Commission noted that the high trends observed in in FY 2019 and the first part of FY 2020 were driven by decreasing enrollment and increases in private duty nursing utilization. Without conducting an independent trend analysis, we do not have insight into whether the drivers of those higher trends are likely to persist.

Dental

Dental trends can vary across programs and states due to a variety of underlying differences, such as program eligibility parameters and coverage differences that can affect utilization mix. However, the Commission's overall annual prospective PMPM trend at the program level of 0.5% per year is generally consistent within a range of observed trends for similar populations based on our experience working with other states. Depending on expected changes in service mix and utilization, it may be reasonable for the FY 2024 dental trends to be higher or lower than previous observed dental trends.

STAR+PLUS

The Commission's overall annual prospective LTC services PMPM trend at the program level of 2.4% appears to be reasonable based on our experience working with other states. We also observed that trend assumptions have decreased significantly between the FY 2023 rate development and FY 2024 rate development. However, the historical trends for LTC services in the STAR+PLUS program prior to the PHE were higher than what we have seen in other States for similar programs. Without conducting an independent trend analysis, we do not have insight into the drivers of those trends to evaluate whether they are likely to persist post-PHE.

During our FY 2023 rate review, we asked the Commission to share any analysis they performed to understand the historical trends and any of their insights about the local market's trend dynamics. The Commission explained that historically there have been two major drivers of the observed historical trends:

1. The driver of the observed LTC trend for the four OCC and HCBS risk groups is almost entirely due to increased utilization of Personal Attendant Services (PAS). From FY 2016 to FY 2019 average PAS units for the four risk groups increased by 4% per year.

2. The driver of the observed LTC trend for the two NF risk groups is primarily due to the overall changing acuity of the population. Nursing facilities are reimbursed based on the RUG score of the members being served. Members with a higher RUG score receive a higher reimbursement rate. According to the Commission, the historical data indicates a consistent increase of overall acuity as measured by RUG for NF populations in the historical periods.

The Commission's responses noted above appear to provide reasonable explanations for the relatively high historical trend experience prior to the PHE; however, we did not perform an independent analysis to confirm these trend drivers.

STAR Kids

The Commission's overall annual prospective PMPM trend at the program level of 5.3% appears to be somewhat high based on our experience working with other states, but more in line with our expectations versus the 6.9% annual trend assumption used in the development of FY 2023 rates. However, the historical trends were high in both the FFS environment prior to the start of the STAR Kids program and in managed care thereafter through the beginning of the PHE. Without conducting an independent trend analysis, we do not have insight into the drivers of those trends to evaluate whether they are likely to persist post-PHE.

During our FY 2023 rate review, we asked the Commission to share any analysis they performed to understand the historical trends and any of their insights about the local market's trend dynamics. The Commission explained that historically there have been two major drivers of the observed historical trends:

1. The limited supply of Children's hospitals and high demand for these facilities from this population resulted in an unfavorable contracting environment from the MCO's perspective.

2. Private duty nursing (PDN) services comprise 30% of medical costs for this population, although it has been used by a relatively smaller portion of the population. Prior to COVID-19, the annual cost increase had been consistently high from FY 2018 to the first half of FY 2020. In many cases the member requires full-time care thus limiting the MCOs ability to manage this expense.

The Commission's responses noted above appear to provide reasonable explanations for the relatively high historical trend experience prior to the PHE, however we did not perform an independent analysis to confirm these trend drivers.

Dual Demonstration

In addition to the commentary on the Commission's overall annual prospective LTC services PMPM trend in the STAR+PLUS program noted above, the annual acute care trend of approximately 1.4% appears to be reasonable compared to similar programs in other states. Trends are displayed for the dual demo program in Exhibit 18.

In addition, the acute care trends used for the Medicaid Only populations in the STAR+PLUS program, as shown in Table 6, are materially lower than the trends used for dual eligible OCC and HCBS risk groups in the Dual Demonstration program for OCC and HCBS groups. Most acute care costs paid by Medicaid for dual eligible members is the member cost sharing that Medicare does not cover, which is typically a percentage of costs (coinsurance). Therefore, we would expect a similar level of trend compared to these risk groups that are only covered by Medicaid, where the full cost of services is included.

Table 6
Texas Medicaid Managed Care Rate Review
Dual Demonstration Program
Acute Care Trend Assumptions

Risk Group	Dual Demo	STAR+PLUS Medicaid Only
OCC	2.3%	1.1%
HCBS	2.1%	1.0%
Nursing Facility	1.4%	2.7%

Pharmacy Trends

Pharmacy trends can be difficult to compare across programs and states due to a variety of underlying differences, such as program eligibility parameters and PDL differences that can affect utilization mix. However, we provide general comparisons to pharmacy trends for similar populations for context.

An evaluation of the drivers of the historical trends would require substantially more granular data than we requested within the scope of our review. Many factors contribute to observed trends, including the availability of new treatments, new alternatives to existing treatments, changes in manufacturer pricing strategies, changes in pharmacy contracted pricing, and changes in average member demographics and acuity.

We also reviewed the stability of the observed historical trends using the Commission's trend calculation methodology. Depending on expected changes in drug mix and utilization, it may be reasonable for the FY 2024 pharmacy trends to be higher or lower than previous observed pharmacy trends. Exhibits 19 through 22 display the volatility in observed annual trends in the pharmacy data provided for our review by program and risk group. These exhibits are provided solely to illustrate the volatility that can result from the Commission's reliance on historical trends and should not be interpreted as an evaluation of the reasonableness of the final trend assumptions.

Program-specific concerns and unique considerations are described below.

STAR

The Commission's PMPM pharmacy trend assumptions for the FY 2024 rate development are the same as the assumptions for the FY 2023 rate development, except that the trend assumption for TANF Adult decreased by 0.1% due to rounding applied at an intermediate step of the trend calculation. The Commission's overall annual prospective PMPM trend at the program level of 1.2% per year, based on the information in Exhibit 19, is generally consistent with a range of observed trends for similar populations based on our experience working with other states.

The pharmacy experience for populations such as STAR have generally been heavily impacted throughout the PHE, but we do not expect this impact to persist. Therefore, we believe it is reasonable for the Commission not to use historical PMPM trends since the beginning of the PHE.

STAR Health

The Commission's overall annual prospective program PMPM trend at the program level of 1.6% per year, shown in Exhibit 20, is generally consistent with a range of observed trends for similar populations based on our experience working with other states.

The pharmacy experience for populations such as STAR Health have generally been heavily impacted throughout the PHE, but we do not expect this impact to persist. Therefore, we believe it is reasonable for the Commission not to use historical PMPM trends since the beginning of the PHE.

Dental

The Dental program does not cover pharmacy benefits.

STAR+PLUS

The Commission's overall annual prospective PMPM trend at the program level of 4.6% per year, based on the information in Exhibit 21, is generally consistent with a range of observed trends for similar populations based on our experience working with other states.

As part of our review of the FY 2024 rate development, we compared the projected FY 2024 statewide pharmacy PMPMs in the trend analysis to historical statewide pharmacy PMPMs provided in the trend analysis for the FY 2023 rate review (from the later of September 2012 or the addition of the population to the STAR+PLUS program through February 2022) at the risk group level. The Commission's projected FY 2024 pharmacy PMPM is approximately 35% higher than any historical pharmacy PMPMs for the MBCCP risk group. During the FY 2023 rate review, the Commission explained that the high historical trends for the MBCCP risk group during FY 2019 and FY 2020 were primarily driven by the drug Ibrance. The Commission explained that they reviewed Ibrance experience to validate these trends, but actual trends in subsequent years do not support that this significant increase has continued or is expected to continue through FY 2024. The more recent trends for the MBCCP population in Exhibit 21 suggest this significant increase driven by Ibrance subsided in more recent years. With Ibrance experience now in the base period data, the percentage impact of future treatments with similar experience as Ibrance may be smaller since incremental costs from new treatments are growing from a larger base period cost. Although the disparity between the projected pharmacy PMPM and historical pharmacy PMPMs for the MBCCP risk group is less pronounced in the FY 2024 rate development than it was in FY 2023, the Commission's continued reliance on the historical trend still may not be reasonable for this population.

Although the PHE likely had some impact on pharmacy trends, we believe it is reasonable for the Commission to consider emerging PMPM pharmacy trends since the beginning of the PHE. The pharmacy experience for populations similar to STAR+PLUS has generally been less impacted throughout the PHE for several reasons, including:

- Acuity of these populations has remained more stable, which is expected for STAR+PLUS eligible members
- Many of the drug costs are attributable to conditions that require timely adherence

STAR Kids

The Commission's overall annual prospective PMPM trend at the program level of 3.8% per year, based on the information in Exhibit 22, is generally consistent with a range of observed trends for similar populations based on our experience working with other states.

We compared the projected FY 2023 statewide pharmacy PMPMs in the trend analysis to historical statewide pharmacy PMPMs provided in the trend analysis (from September 2012 through February 2022) at the risk group level. The Commission's projected FY 2023 pharmacy PMPMs were within the range of monthly historical PMPMs for several risk groups. However, the projected FY 2024 pharmacy PMPMs are approximately 10% higher than any historical pharmacy PMPMs for the MCDP risk group. The Commission's rate certification and the work files do not include any explanation to support the FY 2024 pharmacy PMPMs for some risk groups being materially higher or lower than historical experience. Although the disparities between the projected pharmacy PMPMs and historical pharmacy PMPMs are more reasonable for other risk groups in the FY 2024 rate development than they were in FY 2023, the Commission's continued reliance on the historical trend still may not be reasonable for the MCDP population.

Although the PHE likely had some impact on pharmacy trends, we believe it is reasonable for the Commission to consider emerging PMPM pharmacy trends since the beginning of the PHE. The pharmacy experience for populations similar to STAR Kids have generally been less impacted throughout the PHE for several reasons, including:

- Acuity of these populations has remained more stable, which is expected for STAR Kids eligible members
- Many of the drug costs are attributable to conditions that require timely adherence

Dual Demonstration

The overall program PMPM trend of 3.0% per year is generally consistent with a range of observed trends for similar populations in other states.

NEMT Trends

As noted in the Risk Level Classification section, our review of the NEMT trend assumption focused on the Commission's general methodology for developing the assumption. We did not perform a detailed technical check or a review of the reasonableness of the Commission's NEMT trend assumption due to the relatively low risk associated with this assumption. However, the Commission's NEMT PMPM trend of 3.3% per year is reasonable based on our experience working with other states.

Trend Assumptions Recommendations

We note the following recommendations related to trend:

Recommendation G: Develop medical trend assumptions at more detailed service category level
Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids
This recommendation is unchanged from FY 2023 review.

Due to differences in reimbursement methodologies, the provider contracting environment, and managed care initiatives among various detailed medical service categories, we recommend the Commission develop medical trends at the major service category level to be in line with common practices. At a minimum, medical trend analysis is typically performed at the following service category level in Medicaid capitation rate development. Many states use even more granular categories of service.

- Hospital inpatient services
- Hospital outpatient services
- Emergency room services
- Physician services
- Significant drivers of trend (e.g., Private Duty Nursing for STAR Kids)
- Other medical services

In the capitation rate setting process, such level of granularity for medical trend analysis helps the actuary gain a valuable understanding of primary trend drivers at the service category level. It also helps the State and MCOs monitor whether the service category level trend is in line with expectations for the managed care environment. For example, a typical program goal in a managed care environment is to hold MCOs accountable for the optimization of their enrolled members' service utilization among service categories. Specifically, MCOs may be expected to reduce or manage utilization trend for emergency room services and hospital inpatient services by promoting appropriate uses of physician services. Without this granular level of medical trend analysis, it is difficult to gain visibility and understanding of what has been driving the program expenditure changes and how the managed care program performed in historical time periods.

Additionally, developing and applying trends at a more granular service grouping allows for recognition of service delivery mixes over time, such as inpatient hospital services decreasing but being replaced by outpatient hospital services.

Although the Commission has indicated there are credibility concerns post-PHE with regard to developing trends at the more detailed service category level of detail, we retained this recommendation from the FY 2023 review because of the importance of examining the changes in mix of service within medical trends, especially during the PHE. We acknowledge that the Commission said it will re-evaluate whether to incorporate the category of service level detail into their trend development in future rate setting cycles after the credibility of the data improves sufficiently; however, understanding the shifting unit costs and utilization of various services as a result of major external factors (such as the PHE) is an important facet of accurately estimating trend assumptions in capitation rate development.

Recommendation H: Develop medical and pharmacy trend assumptions separately by utilization and unit cost components

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids
*This recommendation is **modified** from the FY 2023 review.*

In addition to analyzing medical trends at major service category level, we also recommend the Commission develop both medical and pharmacy trend assumptions separately for utilization and unit cost components. This approach will provide insights about the provider contracting dynamics at the major service category level. It will also provide an understanding of the drivers of recent observed experience trends (e.g., utilization, unit cost, or both) and the expected frequency of the observed trends (e.g., due to one-time changes in the delivery system, random catastrophic claims events, or recurring trend dynamics). All these insights and understandings are critical to capturing the key prospective trend forces in trend development.

The Commission produced an analysis of historical utilization and unit cost trends for medical services, but this analysis was not explicitly used to develop distinct utilization and unit cost trends for FY 2024. Other states often select distinct utilization and unit cost trends. This more granular approach allows for trends that are better aligned with each population's projected costs and program goals. The Commission added an interim step to the FY 2024 trend development for pharmacy services to calculate separate utilization and unit cost trends; however, this interim step is a mechanical change and not a methodological change. The Commission uses identical weighting formulas and identical time periods to calculate the pharmacy utilization and unit cost trends. This process produces an identical result as if the Commission developed pharmacy trends at the PMPM level, except for the impact of rounding applied to the intermediate trend assumptions.

This recommendation is retained from the FY 2023 rate review because the Commission did not make any material changes to the medical and pharmacy trend assumptions. We modified this recommendation to address the Commission's mechanical change to split the pharmacy trend calculation into two components: one for utilization and one for unit cost. This change by the Commission is an algebraic change only and does not address the intent of the recommendation that utilization and unit cost trends be reviewed and developed separately.

The Commission's response to the FY 2023 recommendation asserted that a more granular view of trends would not increase the credibility or accuracy of the trend projection. Based on the Commission's current trend development approach that relies solely on historical trends, we generally agree with the Commission's assertion. However, distinct development of utilization and unit cost trend assumptions would allow the Commission additional flexibility to reflect emerging or anticipated changes in projected utilization or unit cost trends that differ from historical experience. Trend assumptions for smaller programs or populations in other states sometimes rely on composite PMPM trend assumptions, as the impact of more granular analysis may not warrant the potential additional cost of consulting services required to perform a more granular analysis. However, trend assumptions for larger programs and populations, such as those in the Texas Medicaid Managed Care program, are commonly developed based on more granular components because these assumptions can have a significant impact on the estimation of future costs.

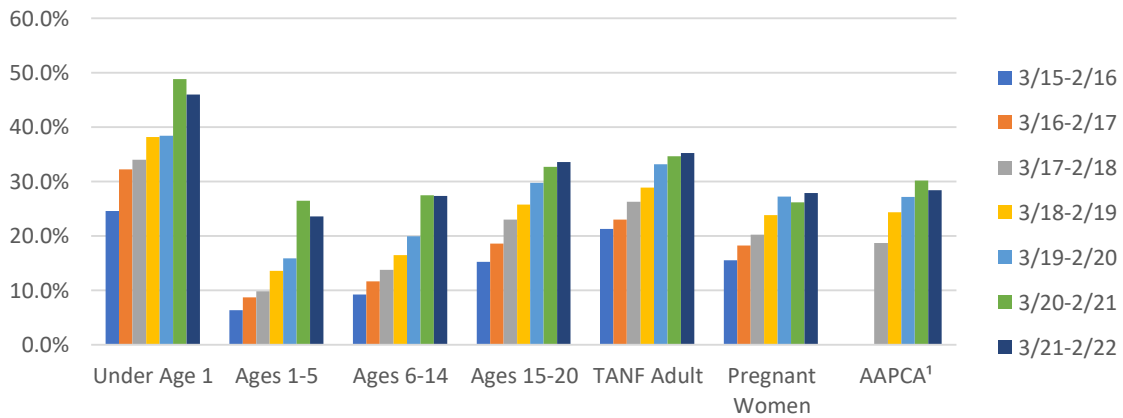
Recommendation I: Develop and apply pharmacy trends by drug type (i.e., Specialty and Non-Specialty)

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids
This recommendation is unchanged from the FY 2023 review.

The historical PMPM trends used by the Commission to develop pharmacy trends reflect the historical mix by drug type (i.e., generic, brand, and specialty) rather than the current mix by drug type. These historical trends represent the actual experience between the two periods; however, the mix by drug type has changed materially in many populations due to increases in FDA approvals of specialty drugs over the past several years.

The Commission did not include historical experience by drug type in the rate development analysis for the FY 2024 rates. Therefore, our analysis of the impact of this recommendation is based on data the Commission provided for the FY 2023 rate review. Figures 4 through 7 show the historical change in the specialty PMPM for 12-month periods, from March 2015 through February 2022 (except as otherwise noted), included in the trend analysis as a percentage of the total pharmacy PMPM included in the FY 2023 trend analysis (net of the exclusions, as noted in the appendices) for each rate cell by program.

Figure 4
Texas Medicaid Managed Care Rate Review
STAR Program - Trend Development
Specialty PMPM as a Percentage of Pharmacy PMPM



[1] Based on six-month periods from September through February.

Figure 5
Texas Medicaid Managed Care Rate Review
STAR Health Program - Trend Development
Specialty PMPM as a Percentage of Pharmacy PMPM

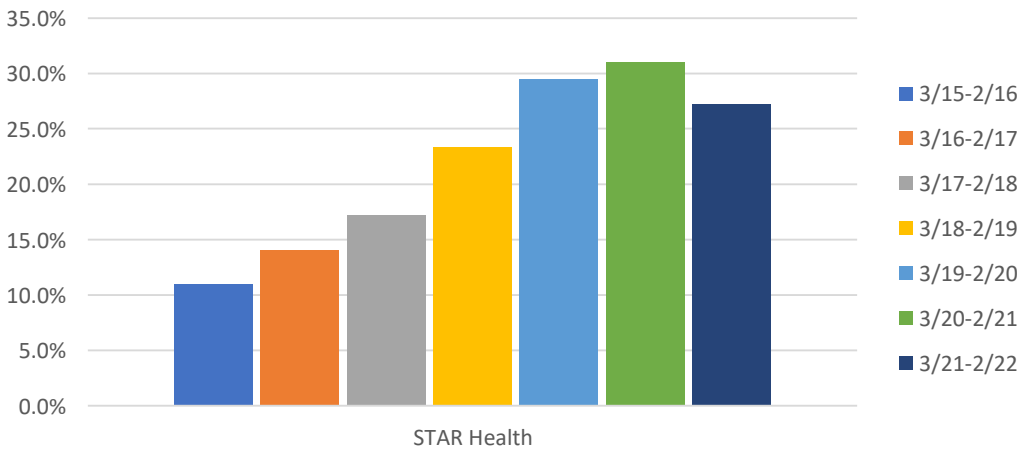
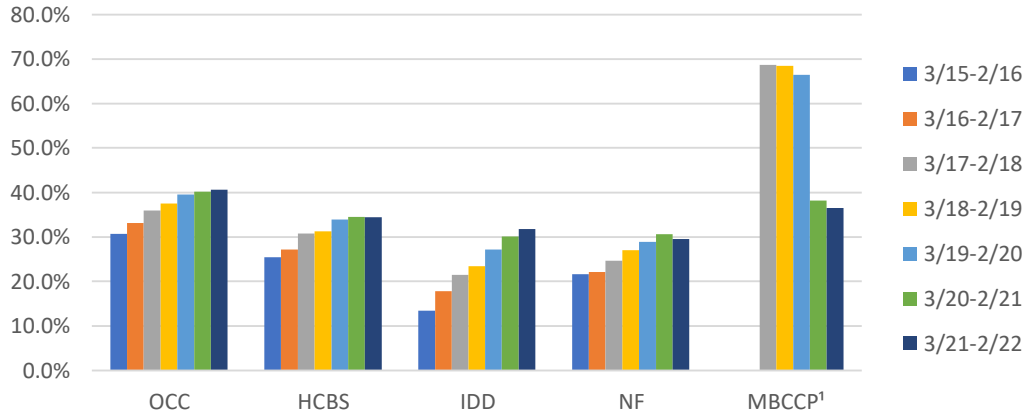
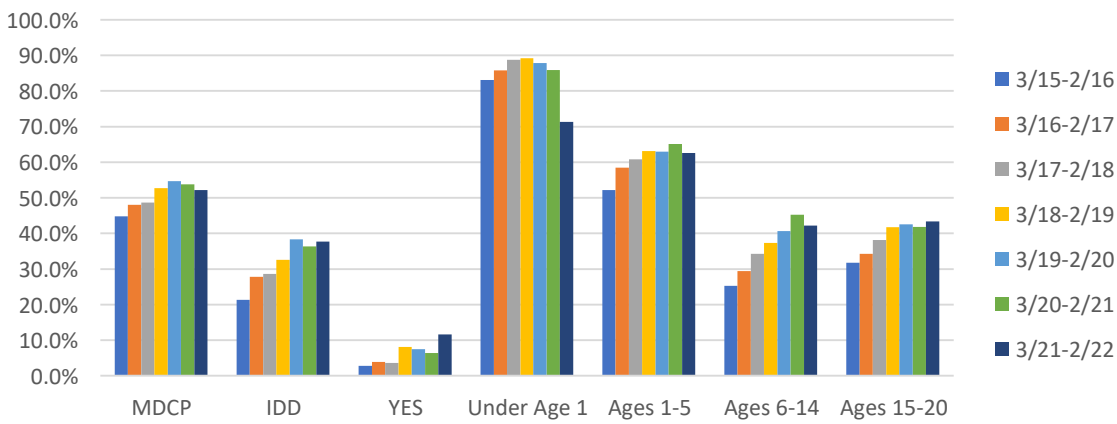


Figure 6
Texas Medicaid Managed Care Rate Review
STAR+PLUS Program - Trend Development
Specialty PMPM as a Percentage of Pharmacy PMPM



[1] Based on six-month periods from September through February.

Figure 7
Texas Medicaid Managed Care Rate Review
STAR Kids Program - Trend Development
Specialty PMPM as a Percentage of Pharmacy PMPM



Given the general increase in specialty drug mix in recent years, the Commission's reliance on historical aggregate trends may not accurately represent future trends because it undervalues the impact of specialty drug trends on the drug mix included in the base period. For example, if specialty drugs make up 40% of pharmacy costs in the base period data but the average across the time period included in the trend calculation is only 30%, the trend assumption inherently places a higher weight on trends observed for traditional drugs (which generally have a lower observed trend rate) and understates the overall PMPM trend rate. The Commission is using pre-PHE pharmacy trends in the trend calculation for all risk groups, and the percentage of pharmacy PMPMs attributable to specialty drugs has continued to increase throughout the PHE for almost all risk groups. Therefore, the impact of drug mix changes on pharmacy trend is likely increasing.

To illustrate this recommendation, we reviewed the Commission's selected FY 2024 pharmacy trends for STAR and STAR Health programs, and the Age 15 to 20 risk group in the STAR Kids program. The Commission's FY 2024 trend support files did not include historical breakouts for specialty and non-specialty drugs. However, we were able to rely on the FY 2023 rate development materials provided by the Commission for the selected populations because the

Commission used the same time periods and weights to develop their FY 2024 pharmacy trends as were used for FY 2023. We calculated the annual trends for each risk group based on separate specialty / non-specialty trends composited using the FY 2023 base period mix. Table 7 shows the comparison of these two trend approaches, with STAR trends aggregated based on FY 2022 pharmacy costs. This issue also impacts STAR+PLUS and the other STAR Kids risk groups, but possibly to a lesser degree since the Commission applies 20% weight to more recent historical trends which capture the emerging mix of specialty and traditional costs.

Table 7
Texas Medicaid Managed Care Rate Review
Trend Development
Estimated Impact of Applying Distinct Trends to Specialty and Traditional Pharmacy Costs

Program	Commission's FY 2024 Trend	Estimated Composite Trend Based on Distinct Trends[1]	(Under) / Over-Statement of Historical Weighted Trend
STAR	1.7%	2.7%	-1.0%
STAR Health	1.6%	3.9%	-2.3%
STAR Kids Ages 15 to 20	4.5%	4.9%	-0.4%

Table 7 is provided solely to illustrate the impact of developing and applying separate specialty and non-specialty trends, assuming all other aspects of the Commission's pharmacy trend methodology remain the same. This analysis should not be interpreted as an evaluation of the reasonableness of the final trend assumption.

Most other states set distinct pharmacy trends for specialty drug costs and non-specialty drug costs. States often further identify separate trends for brand and generic drug types, although the trends for brand and generic drug types are often intertwined due to shifting between brand and generic drugs to treat the same conditions.

The Commission developed separate trends for brand, generic, and specialty drugs prior to FY 2023 capitation rates, but they modified their trend development methodology to be calculated on a total basis to be able to reflect recent PDL changes that had a significant impact. The Commission indicated their PDL trend adjustment analysis does not isolate how utilization shifts between brand and generic drugs and does not lend itself to separate factors by drug type; however, the Commission also noted that the PDL changes typically do not affect specialty drugs. To calculate the estimated composite trend based on distinct trends in Table 7, we combined the brand and generic drug types and reallocated the PDL adjustment factor to the combined non-specialty drug type. Therefore, we believe the Commission's current process can be modified to accommodate separate trend assumptions for specialty and non-specialty drugs.

We recommend incorporating distinct trends for specialty and *non-specialty* drugs since specialty pharmacy costs are generally growing at a faster rate than non-specialty pharmacy costs. Based on our experience with other states, this growth is attributable to both increasing utilization and increasing unit costs.

We retained this recommendation from the FY 2023 review because the Commission's current approach does not reflect the emerging shifts in drug utilization and costs between specialty and non-specialty drugs. The Commission explained that they did not incorporate this recommendation because they do not believe their PDL adjustment analysis lends itself to separate factors. However, we believe the benefits of developing separate specialty and non-specialty pharmacy trends outweigh the risks of estimating the allocation of PDL changes, particularly since PDL changes are significantly skewed toward non-specialty drugs.

Recommendation J: Consider the impact of recently approved and upcoming pipeline drugs for each population

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids
This recommendation is unchanged from the FY 2023 review.

The pharmacy landscape is changing much more rapidly than many other types of healthcare cost categories. This rapid change is partially driven by the rate of new drug approvals, and many of these drug approvals treat conditions for which no prior drugs were available. Many new generic drugs and biologics, which generally decrease pharmacy costs, are also becoming available. Although historical trends may provide a reasonable guide for certain service categories, historical pharmacy trends tend to be less reliable as a predictor of future pharmacy trends in the current environment.

The Commission set pharmacy trends for FY 2024 based purely on a formulaic weighting of historical aggregate trends. While historical trends can provide useful information, a purely historical trend approach introduces unique risks in the rapidly changing pharmacy landscape. A significant number of new drugs have been approved and existing drugs have been granted expanded indications in recent years. In many cases, these drugs offer new treatments, so these drugs may add pharmacy costs rather than replace existing costs. Each of these drugs alone may not materially impact trends, but the combined impact of these drug approvals has materially increased utilization in other states, particularly for specialty drugs.

Many states evaluate the pharmacy pipeline and develop trends at a more detailed level, such as the therapeutic class and population level, to incorporate future expectations based on new drugs and anticipated future drug approvals through the rate year. Evaluating pharmacy trends at a population level (risk group or broader population definitions, such as adults / children and disabled / non-disabled) allows states to consider the impact of drugs that affect specific demographics, resulting in more targeted trends at the risk group level. The claim detail necessary to evaluate the impact of new drugs and expanded indications on pharmacy costs was not included within the scope of our review.

The Commission indicated that they adjust the capitation rates mid-year if and when material PDL changes occur that were not anticipated when the initial rates were certified. The scope of our review does not include retrospective review of past rate certifications, so we did not review how the Commission performs these mid-year rate adjustments.

The Commission also indicated that they consider new drug approvals and pipeline drugs to inform the trend assumptions. However, based on our experience, pipeline drugs typically have disproportionate impacts on different populations. This disproportionate impact cannot be accurately reflected by setting the trend assumption using the same weighting of historical trends across all risk groups.

We recommend the Commission review drug approvals (including expanded indications expected to materially impact a drug's utilization) between the beginning of the base period and end of the rate year and identify how these drugs are (or are anticipated to be) reimbursed to MCOs. For drugs that are likely to be covered by MCOs through the capitation payments, the Commission should evaluate the expected impact of the new drugs on utilization and / or costs at the risk group level and incorporate these expectations into the pharmacy trends. Similarly, the Commission should evaluate how the emerging experience differs from historical experience and adjust the pharmacy trends accordingly.

We retained this recommendation from the FY 2023 rate review because the impact of pharmacy pipeline drugs changes from year to year and varies by risk group, although the impact on FY 2024 may be smaller than the impact on FY 2023 due to the shorter time – and thus likely fewer new drugs – between the base period and the rate year. The Commission assesses the materiality of some drugs based on fiscal estimates to determine which drugs should be added to the non-risk list, which mitigates some of the pipeline risk. Although the Commission may deem the pipeline drugs that remain in the capitation rates to be less material on an individual drug basis, they could cumulatively become material to the program. However, the Commission's current approach may not account for this cumulative impact.

Recommendation K: Evaluate pharmacy trends at the therapeutic class level
Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids
This recommendation is unchanged from the FY 2023 review.

In conjunction with Recommendation J, we recommend evaluating trends at the therapeutic class level. A therapeutic class level analysis of historical costs provides additional granularity which would allow the Commission to evaluate the degree to which new drugs may offset, increase, or decrease historical utilization and costs.

We retained this recommendation from the FY 2023 rate review because the impact of therapeutic class level trends often varies by risk group. The Commission's response to this recommendation in the FY 2023 rate review suggested that this level of review would increase the variance of the result without any material improvement. We believe emerging utilization and unit cost changes can be more accurately identified at the therapeutic class level, but the Commission's current pharmacy trend approach does not allow for consideration of anticipated variances based on therapeutic class level developments.

Trend Assumptions Observations

The following approaches used by the Commission for the development of prospective trend assumptions are consistent with general rate setting practices in other states, and these approaches comply with Medicaid managed care rate setting guidance.

- The use of historical program trends from multiple years to inform prospective trend assumptions specific to population and service groupings (i.e., medical, pharmacy, NEMT)

- The use of statewide medical trends rather than historical SDA level observed trends to address observed volatility at the SDA level
- Normalizing historical experience in the trend analysis to remove program and PDL changes
- Incorporating industry trends for NEMT services

We note the following observations related to trend:

Observation G: Prospective medical trends are developed using a purely formulaic approach
Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids
This observation is unchanged from the FY 2023 review.

As described above, the Commission calculated historical trends for multiple years and then formulaically blended the years to develop a singular medical trend for rate development. Actuarial best practice is to set trend assumptions based on multiple data points, including but not limited to, a review of historical observed trends, emerging program experience, industry knowledge of observed trends in similar states and programs, and industry research on upcoming changes in medical care that may not be reflected in historical data. Using a purely formulaic approach to select trend assumptions assumes that future experience will conform exactly with historical experience, which has the potential to incorporate abnormally high or low historical trends into forward-looking trend assumptions that may not be indicative of anticipated changes between the base period and FY 2024.

We retained this observation from the FY 2023 rate review because the Commission's purely formulaic approach does not account for emerging trends that may cause future experience to differ from historical experience.

Observation H: Medical trends are not consistently applied to sub-capitated and service coordination cost
Applicable program(s): STAR, STAR+PLUS, STAR Kids
This observation is unchanged from the FY 2023 review.

All services are subject to PMPM changes over time due to utilization changes and unit cost changes. However, the Commission did not apply medical trend assumptions to sub-capitated (i.e., fixed monthly premium per member from the MCO to a third party to cover specific services) or service coordination costs in the FY 2024 rate development. The STAR program does not have service coordination costs, so this observation applies only to sub-capitated costs in the STAR program.

For sub-capitated services, appropriate trends are expected to be applied to the base data in the rate development to account for expected underlying cost and utilization changes from the base period to the rating period unless there are specific reasons to justify no cost changes. In certain cases, the Commission used the most recent actual contracted sub-capitated amounts provided by the MCOs, which may remove the need to apply trend. However, this is not a consistent practice across all MCOs or all programs because actual contracted amounts are not always provided by the MCOs.

We retained this observation from the FY 2023 rate review because the Commission's approach may not capture anticipated changes in sub-capitated and service coordination costs between the base data and FY 2024.

Observation I: The data source used for quantitative medical trend analysis does not enable more granular analyses
Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids
This observation is unchanged from the FY 2023 review.

Encounter data provides increased granularity for conducting in-depth trend analyses, which is particularly important in situations where the observed experience trends are unusually high or low. The Commission's trend analysis is based on MCO reported monthly expenditure data with limited opportunity for more robust trend analysis. The data used by the Commission does not appear to provide assurance that reported expenditures are categorized consistently at the detailed service category level across all MCOs participating in the program. This data also does not appear to provide assurance that the reported units are defined accurately and consistently across all MCOs. Absent such assurances, the extent and depth of the Commission's trend analysis will be very limited. To the extent that complete and accurate encounter data is available in Texas, encounter data is a preferred primary trend data source for quantitative analysis. More detailed trend analysis does not guarantee more accurate trend assumptions in any rate setting cycle given the prospective nature of trend development and the potential inhere variability of trend experience, but it empowers actuaries to better understand the drivers of historical trends and determine the appropriate adjustments to apply this information to prospective projections.

We retained this observation from the FY 2023 rate review because the monthly expenditure data reported by MCOs is summarized at a level that precludes the Commission from implementing some of the recommendations included in this report.

Observation J: Historical CPI trend calculation used for NEMT trends varies from common trend calculation approaches

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids
This observation is ***modified*** *from the FY 2023 review.*

The Commission calculated the 10-year historical CPI trend for transportation services as one input into their selection of NEMT trend assumptions. The approach used by the Commission to calculate the CPI trend is not consistent with typical methods for using CPI data to calculate trend.

Average annual trend calculations based on CPI are typically calculated by measuring the change in the index between given months (i.e., the starting month and the ending month) and converting the result to an annual change, if applicable. Using the CPI indices included in the files provided by the Commission's actuary, the annualized trend over the 10 years ending February 2020 (from February 2010 to February 2020, based on this typical approach) is 0.9%. The Commission calculated the annual trend as of each of the most recent 120 months (e.g., from March 2009 to March 2010, from April 2009 to April 2010, …, and from February 2019 to February 2020) prior to the PHE (through February 2020) and then averaged all 120 of the annual trends, resulting in an average annual trend of 1.6%.

We retained this observation from the FY 2023 rate review because the Commission's methodology for calculating the CPI component of the NEMT trend assumption is not consistent with common trend calculation approaches. We modified the observation to remove the concern that the trend does not capture actual observed CPI changes from the base period to present day because the base period used for FY 2024 rates reflects the impact of recent market conditions.

PROGRAMMATIC ADJUSTMENTS

We gained a detailed understanding of the Commission's FY 2024 programmatic adjustment development approach based on a review and analysis of data provided by the Commission in conjunction with the Commission's responses to our review questions. Our review approach varied based on the assessed risk of each adjustment.

As noted in the Risk Level Classification section, the NEMT service grouping component comprises a small and lower-risk portion of the overall capitation rates. As such, we performed a review of the Commission's FY 2024 NEMT programmatic adjustments to become comfortable in the context of overall rate soundness.

Within the scope of our review, we reviewed the data and processes used by the Commission to develop programmatic adjustments. It is outside the scope of our review to independently develop capitation rates. Therefore, ***we did not produce our own estimates of programmatic adjustments***. We present our conclusions based on our review of the Commission's data and methods.

Reasonableness of Resulting Programmatic Adjustment Assumptions

Exhibits 23 through 27 summarize the programmatic adjustment factors used by the Commission to develop the FY 2024 capitation rates for each program and our level of review for each adjustment. The adjustments are grouped by rate component and then sorted in descending order based on the statewide impact for that component (positive or negative).

These exhibits show the statewide adjustment factors for informational purposes to demonstrate the overall impact of each programmatic change. Many of the programmatic adjustments are attributable to changes that are typically simple to isolate and measure. Although some of these adjustments can be material at the risk group level, they have little risk of error or concerns regarding the Commission's methodology. Some programmatic adjustments introduce more actuarial judgement or risk of error; however, their impact is small.

Within the scope of our review, we did not gather the claim detail necessary to independently develop programmatic adjustment factors for each program. Therefore, we cannot offer a definitive assessment of the programmatic adjustments used by the Commission to develop the FY 2024 capitation rates. We did review how the following characteristics of the programmatic adjustment factors aligned with the description of each change provided by the Commission:

- The overall impact of the change to the program
- The magnitude of the change relative to expectations based on our collective experience, as applicable, in other states
- The internal consistency of each programmatic change's impact across risk groups and SDAs, where applicable (e.g., the adjustment factor for Rural Hospital Outpatient should disproportionately impact SDAs in more rural areas of the state)

In some instances, we have recommendations or observations regarding the Commission's methodology or other factors even though we may not have concerns with the final FY 2024 programmatic adjustment factors. These recommendations and observations are driven by potential issues that could arise due to the Commission's methodology or other factors, but they may not necessarily produce unreasonable results in the programmatic adjustments in the FY 2024 rates.

Programmatic Adjustments Recommendations

We note the following recommendations related to programmatic adjustments:

Recommendation L: Remove member months periods for members ages 21 through 64 who have an IMD stay in excess of 15 days during any month

Applicable program(s): STAR, STAR+PLUS
This recommendation is unchanged from the FY 2023 review.

In 42 CFR § 438.6(e),[75] the State may make a monthly capitation payment to MCOs for a member aged 21 to 64 who receives inpatient treatment in an IMD, so long as the member's length of stay in the IMD is for no more than 15 days during the period of the monthly capitation payment. The commonly accepted approach to comply with CMS requirements is to deduct the related costs from the base data and remove the associated member months from the base period, either in the base data development or as a programmatic adjustment. The description of the Commission's IMD cost removal adjustment indicates the removal of IMD costs for stays in excess of 15 days during any month but does not incorporate the removal of the member months.

The impact is not material to the program overall based on our experience with other states and input from the Commission. However, the Commission is slightly understating the capitation rates for affected risk groups by removing the IMD costs from the numerator of the capitation rate calculation but not reducing the member months in the denominator.

Additionally, although the impact of the IMD adjustment is small, adherence to guidance has recently been subject to scrutiny by CMS in many states. It is important to calculate this adjustment consistent with CMS requirements to avoid the risk that CMS will determine program costs are out of compliance and not eligible for federal matching funds.

We retained this recommendation from the FY 2023 rate review because the Commission's current approach not consistent with the CMS requirement to remove the member months for members ages 21 through 64 who had an IMD stay in excess of 15 days during the month as part of the IMD cost removal adjustment. The Commission has not formalized a decision to reimburse MCOs for IMD stays in excess of 15 days, which must be done using General Revenue funds. Because of this State policy limitation, the State keeps these members enrolled in managed care. Therefore, the Commission does not remove these member months from the capitation rate development.

[75] 42 CFR § 438.6(e) – Special contract provisions related to payment, Payments to MCOs and PIHPs for enrollees that are a patient in an institution for mental disease, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.6.

Recommendation M: Adjust the NEMT rate component to account for the anticipated impact of disenrollment related to the expiration of the PHE

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids
*This recommendation is **new** from the FY 2023 review.*

The average acuity of members who remain in Medicaid is expected to change as the state disenrolls members who are no longer eligible for Medicaid but who maintained enrollment due to the PHE. The Commission applied an adjustment to the medical and pharmacy components of the FY 2024 capitation rates to account for this expected change in average acuity; however, the Commission did not apply a PHE adjustment to the NEMT component to the FY 2024 rates.

The Commission explained that the PHE adjustment was not applied to the NEMT component for the following reasons:

- NEMT costs for MCOs who subcapitate these services will not change after the end of the PHE.
- Method 1 of the Commission's PHE adjustment methodology for the medical and pharmacy components is based on how much the average PMPM costs decreased between the 12 months immediately before the PHE and FY 2022. Average NEMT PMPMs in FY 2022 are generally higher than average NEMT PMPMs prior to the PHE, likely due to factors related to the transition of NEMT services from MTOs to MCOs effective July 2021. Therefore, method 1 of the Commission's PHE adjustment methodology for the medical and pharmacy components would produce an adjustment factor of 1.0 for most risk groups.
- Method 2 of the Commission's PHE adjustment methodology for the medical and pharmacy components is based on differences in the proportion of non-utilizers between the 12 months immediately before the PHE and FY 2022. Due to the transition of NEMT services from MTOs to MCOs effective July 2021, the Commission concluded a comparison of non-utilizers between these two time periods would be inappropriate since the NEMT carve-in may have impacted utilization patterns for reasons unrelated to the PHE.

We agree with the Commission that the methodology used to calculate the PHE adjustment factor for the medical and pharmacy components would not be appropriate for the NEMT component, for reasons explained in the second and third points above. However, based on our experience in other states and discussions with NEMT providers, we believe NEMT subcapitated vendors will likely renegotiate their rates with MCOs to account for the impact of disenrollment – particularly because NEMT services are expected to be used much less by members who are no longer eligible for Medicaid than for those who will remain enrolled. In addition, some subcapitated vendors included risk mitigation, such as risk corridors, in their existing contracts which will likely calibrate the total payments to subcapitated vendors based on changes in PMPM costs due disenrollment. In the absence of consistent data before and after the PHE, which is understandable due to the timing of the NEMT carve-in, a factor based on broad actuarial judgement would be more reasonable than no adjustment at all. Therefore, we recommend the Commission apply a PHE adjustment to the NEMT component using an alternate approach from the methodology used to develop the medical and pharmacy PHE adjustment factors.

Because the NEMT component comprises a small portion of overall costs, we do not believe this recommendation impacts the overall actuarial soundness of the FY 2024 capitation rates. The impact of this recommendation in future years may decrease as more information regarding disenrollments becomes available and as the Commission adjusts their approach to accounting for PHE-related adjustments in the rates.

Programmatic Adjustments Observations

The following approaches used by the Commission for development of prospective programmatic adjustment assumptions are reasonable and acceptable. These approaches are consistent with general rate setting practices in other states, and these approaches comply with Medicaid managed care rate setting guidance.

- Accounting for any known or anticipated changes of eligibility and / or covered services between the base period and the rating period through programmatic adjustments
- Accounting for any known or anticipated changes in provider reimbursement levels between the base period and the rating period through programmatic adjustments

- Use of detailed encounters and enrollment data to quantify changes of provider reimbursement, eligibility and / or covered services between the base period and the rating period through programmatic adjustments

  Comparing base period experience to pre-PHE experience and reviewing the state's expected disenrollments to estimate the PHE related impact.

- Developing programmatic adjustments at the appropriate risk group and SDA level, based on the program

We note the following observations related to programmatic adjustments:

Observation K: Reimbursement changes are included as programmatic adjustments, regardless of their materiality

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids
This observation is unchanged from the FY2023 review.

In the projection of benefit costs, trends and programmatic changes are the two components used to collectively capture anticipated cost and utilization changes from the base period to the rating period. In the current approach the Commission explicitly quantifies every provider reimbursement change with a resulting programmatic adjustment factor applied in the rate development. In general, immaterial or recurring provider reimbursement program changes can be accounted for through trends rather than programmatic changes to gain a certain level of rate setting efficiency. The Commission's approach also introduces a risk of potential double counting between trends and programmatic adjustments in the rate development if every programmatic adjustment is not normalized for in the Commission's historical trend analysis.

In our review the Commission does not normalize for small programmatic adjustments in their trend analysis, due to their immaterial impact, and therefore some double counting is occurring. However, we do not think this has a material impact on the overall capitation rates. In addition, the additional layer of complexity could introduce risk into future rate setting results.

Observation L: The FQHC wrap payment removal relies on base data aggregation using projected enrollment

Applicable program(s): STAR, Dental, STAR+PLUS, STAR Kids
This observation is unchanged from the FY2023 review.

As described in the Base Data Development section of the appendices for each of the applicable programs, the Commission excluded FQHC wrap payment costs from the capitation rate development because MCOs and DHMOs are not at-risk for these costs. The Commission calculated the FQHC wrap payment removal adjustment for the community rates based on projected enrollment, consistent with the base data PMPMs. It is appropriate that the Commission performed this calculation in the same manner as the base data. However, the Commission's approach deviates from the common actuarial approach of accounting for base period data in a way that represents the actual experience at the program level for a specific risk group in a specific SDA (or statewide for Dental), as noted in the Base Data Development review conclusions (Recommendation E). As with the base data PMPMs, the financial impact on the community rate can go both ways, but this approach introduces risks to the capitation rate development and payment at the community level.

Observation M: Programmatic adjustments are not developed at a service category level

Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids
This observation is unchanged from the FY2023 review.

The Commission generally calculated the programmatic adjustment factors by dividing the estimated impact of the adjustment by the aggregate base period data at the risk group and SDA level, or by the aggregate statewide base period data for STAR Health. Many of the programmatic adjustments are applicable to a specific service category, such as inpatient experience. To the extent the service mix for an MCO or DHMO is materially different than the service mix at the SDA level, the MCO or DHMO's projected FY 2024 costs may not accurately reflect the adjustment for a particular programmatic change. This risk of misalignment is lessened in the STAR Health program since there is only one MCO. However, applying programmatic adjustments at the service category level does allow for more granular analysis of emerging experience, which can facilitate better program management.

This method of calculating the programmatic adjustment factors is consistent with the level of granularity applied in the Commission's current approach to developing trends at the aggregate service grouping level (i.e., medical, pharmacy, and NEMT). If the Commission changes the approach for trend to be more granular, it is important that the programmatic adjustments also be developed and applied at the same level.

As discussed in the Trend recommendations, one of the benefits of introducing this level of granularity in the development of the capitation rates is to help the State, MCOs, and DHMOs monitor actual costs at the service category level compared to the estimated costs in the capitation rates. For example, using the costs and assumptions from the "Age 6 to 14" risk group in Bexar in the STAR program, if the trend assumptions and programmatic adjustments are developed and applied at a detailed category of service level, Table 8 shows there can be material differences in the estimated service category PMPMs between the two different approaches while the overall PMPM is unaffected. An enhanced level of granularity included in the rate development can be an important tool in tracking and monitoring program costs and understanding the drivers of actual to expected differences to refine the development of future capitation rates.

Table 8
Texas Medicaid Managed Care Rate Review
STAR Program – Programmatic Adjustment Development
Illustrative Programmatic versus Trend Assumptions Granularity
Bexar Age 6-14 Risk Group

Scenario 1: Current Approach: Aggregate Trend and Programmatic Assumptions

Category of Service	Base Period PMPM[1]	Annual Trend Assumption	Removal of FQHC Wrap	FY 2024 PMPM[4]
Professional	$37.85	1.051	0.9188	$38.41
Emergency Room	$5.32	1.051	0.9188	$5.39
Outpatient Facility	$10.48	1.051	0.9188	$10.63
Inpatient Facility	$9.90	1.051	0.9188	$10.04
Other	$10.87	1.051	0.9188	$11.03
Total	$74.40			$75.51

Scenario 2: Detailed Category of Service Trend and Programmatic Assumptions (Illustrative to show the potential impact of more granular assumptions)

Category of Service	Base Period PMPM[1]	Annual Trend Assumption[2]	Removal of FQHC Wrap[3]	FY 2024 PMPM[4]	Difference to Scenario 1
Professional	$37.85	1.060	0.8430	$35.85	($2.56)
Emergency Room	$5.32	1.040	1.0000	$5.75	$0.36
Outpatient Facility	$10.48	1.070	1.0000	$11.99	$1.36
Inpatient Facility	$9.90	1.020	1.0000	$10.30	$0.26
Other	$10.87	1.035	1.0000	$11.64	$0.61
Total	$74.40			$75.51	$0.00

Illustrative FY 2024 PMPMs = Base Period PMPM x [Annual Trend Assumption Factor ^ 2 years] x Removal of FQHC Wrap Factor

[1] *Matches the Commission's value; categories of service may not add to total due to rounding.*
[2] *Illustrative trend assumptions at a detailed category of service level that aggregate to the overall PMPM medical trend assumption in FY 2024.*
[3] *Removal of FQHC Wrap if the full adjustment is applied to the Professional category of service.*
[4] *Does not include all programmatic adjustments; only reflects FQHC for illustrative purposes.*

As noted by the Commission and illustrated in Table 8, applying trends and programmatic adjustments at the service category level would be budget neutral. However, we retained this observation from the FY 2023 review because the additional granularity can enhance program monitoring capabilities.

Observation N: The weighting factor for the PHE adjustment reflects disenrollment net of new entrants
Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids
This observation is ***new*** *from the FY2023 review.*

The Commission applied a weighting adjustment to the calculated PHE acuity adjustment to reflect that membership will be disenrolled throughout the upcoming rate year. The Commission developed the weighting factor based on the monthly enrollment forecast from May 2023 through August 2024, as described in more detail in the appendices. The monthly enrollment forecast reflects expected PHE-related disenrollments, as well as expected enrollment changes unrelated to the PHE, such as new entrants. We have two observations related to this methodology:

- The projected enrollment used is not consistent between the calculation of the weighting adjustment and the PHE adjustment calculation using the cohort method, which assumes that final post-redetermination enrollment is equal to pre-PHE enrollment. This difference may create inconsistencies between how the PHE adjustment was developed (blended adjustment factors) and how it is applied (application of weighting adjustment).

- The Commission's approach inherently assumes that the average acuity of new entrants is the same as the average acuity of members who are being disenrolled due to the expiration of the PHE. However, disenrolled members are generally expected to have lower acuity than ongoing Medicaid members.

  As an example, Table 9 illustrates that the Commission's methodology may not account for acuity differences for an estimated 2,700 new entrants in the STAR Health program during the rate year.

Table 9
Texas Medicaid Managed Care Rate Review
STAR Health Program - Programmatic Adjustment Development
PHE Weighting Factor Example for STAR Health

A	**Commission's cumulative net enrollment change from May 2023 to August 2024**	**-12,087**
B	Commission's estimated new entrants between May 2023 and August 2023	581
C	Commission's estimated new entrants between September 2023 and October 2023	319
D	Estimated new entrants November 2023 through August 2024 (10 months) [1]	1,800
e = (c + d)	Estimated FY 2024 new entrants	2,119
f = (b + e)	Total estimated new entrants from May 2023 to August 2024	2,700
g = (a - f)	**Estimated total gross disenrollments**	**-14,787**

[1] Based on average monthly enrollment growth between May 2023 and October 2023 (i.e., (b + c) / 5 months). The Commission indicated disenrollments in the STAR Health program are expected to being November 2023.

We include these comments regarding the weighting factor as an observation, as opposed to a recommendation, because there is no established actuarial best practice for evaluating the impact of the PHE or related disenrollments on capitation rates. Due to the overall uncertainty of the timing and acuity impact of the PHE-related disenrollments, we do not have material concerns regarding the impact of this observation on the overall actuarial soundness of the capitation rates. We did not review the PHE adjustment calculations at the level of granularity needed to evaluate whether these observations are likely to overstate or understate the final PHE adjustment factor because the effort to do so would be significant, and it would not have materially impacted our review conclusions due to the general uncertainty and ambiguity of the PHE impact. Furthermore, the Commission stated they are planning to review emerging disenrollment information as of a yet-to-be determined date to compare emerging experience to the assumptions reflected in the rates.

Observation O: Some programmatic adjustments vary by at least 5% among risk group / SDA combinations, but appear reasonable

Applicable program(s): STAR, STAR Kids
This observation is unchanged from the FY2023 review.

This observation acknowledges some adjustments have material variances and explains why we do not have concerns about them. We include this as an observation because some of these programmatic adjustments have a material impact on specific risk groups or SDAs, but we did not feel a more detailed review was required because the magnitude and direction of these adjustment factors seems appropriate.

As shown in Exhibits 23 and 27, we reviewed many of the programmatic adjustments for reasonableness. The following adjustments vary by a notable amount among populations but have reasonable explanations as to why these variations exist.

STAR

- Standard dollar amount adjustment:[76] The biggest impact from changes to this inpatient hospital add-on payment is for the Pregnant Women risk group in certain rural SDAs. The description of the Delivery Supplemental Payment case rate which covers costs related to childbirth provided in the rate certification suggests delivery cost reimbursement adjustments are impacted by changes in the standard dollar amount, which aligns with the Pregnant Women risk groups.

- Insulin reimbursement change: This adjustment primarily varies by risk group since it mostly impacts adults. Although we did not review drug-level detail, the impact by risk group is reasonable.

[76] "Standard Dollar Amount (SDA) Add-on Status Verification," Texas Health and Human Services, Retrieved from: https://pfd.hhs.texas.gov/hospitals-clinic/hospital-services/standard-dollar-amount-sda-add-status-verification.

- Makena formulary adjustment: This adjustment primarily varies by risk group since it impacts pregnant women. Although we did not review drug-level detail, the impact by risk group is reasonable.

- Related party adjustment: This adjustment primarily varies by SDA, which is expected since the adjustment only applies to specific MCOs. Although we did not review claim-level detail, the impact by SDA is reasonable.

STAR Kids

- Related party adjustment: This adjustment primarily varies by SDA, which is expected since the adjustment only applies to specific MCOs. Although we did not review claim-level detail, the impact by SDA is reasonable.

- Attendant Care reimbursement change: This adjustment primarily varies by risk group. Although we did not review claim-level detail, the impact by risk group is reasonable.

STAR+PLUS

- Attendant Care reimbursement change: This adjustment primarily varies by risk group. Although we did not review claim-level detail, the impact by risk group is reasonable with a large impact for those risk groups using attendant care (e.g., HCBS) and a small impact for those who do not (e.g., Nursing Facility).

- Insulin reimbursement change: This adjustment primarily varies by risk group since it mostly impacts adults. Although we did not review drug-level detail, the impact by risk group is reasonable.

We retained this observation from the FY 2023 rate review, but we updated the observation to reflect programmatic adjustments with at least 5% variance in FY2024 rates.

NON-BENEFIT EXPENSES

We examined the Commission's FY 2024 non-benefit expense development approach by reviewing data and analysis provided by the Commission, as well as responses to our specific non-benefit expense review questions.

As noted in the Risk Level Classification section, the NEMT service grouping component comprises a small and lower-risk portion of the overall capitation rates. As such, we performed a review of the Commission's FY 2024 NEMT non-benefit expense development methodology to become comfortable in the context of overall rate soundness.

Within the scope of our review, we assessed the data and processes used by the Commission to develop non-benefit expense assumptions. It is outside the scope of our review to independently develop capitation rates. Therefore, ***we did not produce our own estimates of non-benefit expense assumptions***. We present our conclusions based on our review of the Commission's data and methods.

Reasonableness of Resulting Non-Benefit Expense Assumptions

To evaluate the reasonableness of the administrative component of the non-benefit expense assumption, we reviewed the Commission's comparison of the program-wide average FY 2024 administrative expense load for the medical and pharmacy components to historical program-wide administrative expenses PMPM reported by the MCOs / DHMOs.

MCOs / DHMOs in many states are reporting emerging increases in administrative costs due to increases in wages and general inflation. In addition, the projected disenrollments due to the expiration of the PHE over the course of FY 2024 may increase PMPM administrative costs since the aggregate costs will be spread over fewer beneficiaries.

The Commission reviewed historical MCO administrative expenses from FY 2019 through FY 2023 trended with inflation to FY 2024. The Commission noted that the FY 2024 administrative cost assumptions result in PMPMs within the range of inflation-adjusted historical costs for each program. Table 10 below shows the historical administrative expenses PMPMs projected to FY 2024 with inflation as documented by the Commission in the FY 2024 rate certifications and the Commission's FY 2024 program-wide administrative allowance (net of margin, taxes, and fees). However, the administrative functions and demands required in the STAR, STAR Health, STAR+PLUS, and STAR Kids programs changed during the historical period evaluated by the Commission. The Commission's historical MCO administrative costs prior to FY 2022 for STAR, STAR Health, STAR+PLUS, and STAR Kids do not reflect the current level of administrative expenses attributed to NEMT services because NEMT was first carved into managed care during

the last quarter of FY 2021.[77] The Commission's historical MCO administrative costs prior to FY 2022 for STAR, STAR+PLUS, and STAR Kids also do not reflect the current level of administrative expenses attributed to directed payments because the number and complexity of directed payments increased in FY 2022. The Commission's FY 2024 administrative allowances include administrative costs for NEMT and directed payments.

The FY 2023 data included in the Commission's historical administrative expense analysis represents the first six months of the fiscal year (September 2022 through February 2023).

Table 10
Texas Medicaid Managed Care Rate Review
Non-Benefit Expense Development
Commission's Historical Administrative Expense PMPM Adjusted with Inflation to FY 2024

	STAR	STAR Health	Dental[1]	STAR+PLUS[2]	STAR Kids[2]
FY 2019	$25.83	$56.88	$2.05	$144.53	$216.33
FY 2020	24.81	59.62	2.11	136.25	210.24
FY 2021	24.50	60.86	2.08	125.86	173.36
FY 2022	24.79	54.16	1.78	122.58	173.84
FY 2023	22.09	45.81	n/a	126.66	179.63
FY 2024 Administrative Allowance from rate certification	$26[3]	$57.84	$1.75	$131.64	$175[3]
FY 2024 Administrative Allowance net of Service Coordination	$26[3]	$57.84	$1.75	$81.20	$112.50[3]

[1] Based on Method 2 as described in the Commission's FY 2024 rate report; the Commission did not include FY 2023 experience in the historical analysis in the rate certification.
[2] The Commission's FY 2024 and historical administrative PMPMs for STAR+PLUS and STAR Kids include service coordination.
[3] The Commission provided approximate program-wide administrative allowance PMPMs in the rate certifications for the STAR and STAR Kids programs rather than the exact amounts.

The Commission's FY 2024 administrative allowances from rate certifications in Table 10 include an average service coordination PMPM of $50.44 for STAR+PLUS and $62.50 for STAR Kids. Similarly, the Commission included service coordination PMPM expenses reported by the MCOs in the historical administrative expense PMPMs for these two programs. Table 10 also includes the Commission's FY 2024 administrative allowances for these two programs net of the Commission's average service coordination PMPM. The Commission's FY 2024 administrative allowance for STAR Health in Table 10 does not include the FY 2024 service coordination PMPM of $60.00, and the Commission removed estimated service coordination expenses from the historical administrative expense PMPMs reported by the STAR Health MCO.

Administrative expenses can vary among states, programs, and populations for many reasons, including differences in operational requirements, reporting requirements, taxes, and labor markets. The Milliman Medicaid managed care financial results for 2022 research report[78] shows the actual administrative PMPMs net of taxes and fees for calendar year 2022 across the country by MCO. These PMPMs include all types of managed care programs, including those with higher and lower acuity populations than the Texas Medicaid managed care programs subject to this review. These PMPMs are also calculated at the MCO level, so they may represent the average aggregate administrative PMPMs across multiple populations with a wide variety of acuity, health care needs, and program requirements. The actual administrative PMPMs net of taxes and fees for calendar year 2022 for 80% of managed care organizations included in the report (between the 10th and 90th percentiles) were between $24.38 and $58.10. We benchmarked the Commission's FY 2024 administrative allowances net of service coordination, shown in the last row of Table 10, for reasonableness against the range of administrative PMPMs from the Milliman research report, as noted below:

- *STAR:* We would expect the STAR program to be near the lower end of the range due to the average expected acuity of enrollees.
- *STAR Health:* It is not unreasonable that the STAR Health program's administrative expenses are near the top 10th percentile due to the expected acuity of enrollees. A significant majority of managed care enrollees have lower acuity than STAR Health, so the experience reflected in the research report is heavily weighted toward lower-cost enrollees.

[77] A partial year of NEMT administrative expenses would have been reported in FY 2021 MCO experience, but this experience would not be representative of current annual costs.

[78] "Medicaid Managed Care Financial Results for 2022," Milliman Research Report, Retrieved from: https://www.milliman.com/-/media/milliman/pdfs/2023-articles/6-29-23_medicaid-managed-care-financial-results-2022-final.ashx.

- *Dental:* The administrative PMPMs summarized in the Milliman Medicaid managed care financial results for 2022 research report are not appropriate for comparison to a stand-alone dental program.

- *STAR+PLUS:* We would expect the STAR+PLUS program's administrative expenses net of service coordination costs to be near the higher end of the range due to the average expected acuity of enrollees. Based on the average acuity of STAR+PLUS beneficiaries, we do not have concerns that the historical costs and the Commission's FY 2024 administrative expense assumption (net of service coordination) are above the 90th percentile of the average PMPMs in the Milliman research report.

- *STAR Kids:* It is not unreasonable that the STAR Kids program's administrative expenses net of service coordination costs are in the top 10th percentile due to the expected acuity of enrollees. A significant majority of managed care enrollees have lower acuity than STAR Kids, so the experience reflected in the research report is heavily weighted toward lower-cost enrollees. Based on the average acuity of STAR Kids beneficiaries, we do not have concerns that the historical costs and the Commission's FY 2024 administrative expense assumption (net of service coordination) are roughly twice as high as the 90th percentile of the average PMPMs in the Milliman research report as the research report includes a broader range of populations.

The Commission's premium tax and maintenance tax assumptions are consistent with the most current state requirements.

The explicit risk margin component of the non-benefit expense assumption is intended to account for the underwriting risks taken by MCOs / DHMOs to cover the uncertain costs related to provide defined benefits and administration duties as specified in the MCO / DHMO contracts under fixed capitation rates. Nationally, the risk margin assumptions range from 1.0% to 2.0% for most comprehensive Medicaid managed care programs and stand-alone dental programs. The Commission's explicit risk margins of 1.5% for STAR, STAR Health and Dental and 1.75% for STAR+PLUS and STAR Kids are within the reasonable range and deemed to be appropriate for the covered populations and covered benefits within these programs.

The overall adequacy of administrative PMPMs for FY 2024 will depend on the actual timing of disenrollments since MCOs will collect administrative PMPM revenue for more beneficiaries earlier in FY 2024 and for fewer beneficiaries as disenrollments occur, particularly for the STAR, STAR Health, and Dental programs which are expected to be more heavily impacted by disenrollments.

The experience rebate adjustments discussed in the Rate Structure section of the appendices provide some protection to the Commission if actual experience in FY 2024 deviates substantially from projected costs reflected in the capitation rates. Despite the uncertainty regarding the PHE-related disenrollments and current market conditions, we do not have material concerns regarding the FY 2024 non-benefit expense assumptions given the existence of broader risk mitigation mechanisms (e.g., the experience rebate adjustments).

In some instances, we have recommendations or observations regarding the Commission's methodology or other factors even though we may not have concerns with the final FY 2024 non-benefit expense assumptions. These recommendations and observations are driven by potential issues that could arise due to the Commission's methodology or other factors, but they may not necessarily produce unreasonable results in the selected non-benefit expense assumptions for the FY 2024 rates.

Program-specific concerns and unique considerations are described below.

STAR

The FY 2024 program-wide assumption appears to be slightly higher than average MCO experience from FY 2019 through FY 2023 trended to FY 2024, as noted by the Commission. The Commission's administrative expense PMPM is approximately the same as the FY 2019 MCO experience trended to FY 2024 with inflation and slightly higher than MCO experience during the years when enrollment was increasing due to the PHE.

STAR Health

The Commission added a $60 service coordination PMPM to the FY 2024 rates. The Commission estimated that half of this PMPM would cover new requirements effective for FY 2024, and the other half is reflective of quality improvement costs that were included in administrative costs prior to FY 2024. Therefore, we expect the FY 2024 administrative expense net of service coordination to be roughly $30 PMPM less than FY 2023 administrative costs before consideration of other factors, such as inflation and enrollment changes. Consistent with our expectation, the FY 2024

administrative expense PMPM is approximately $26 less than the FY 2023 administrative expense PMPM. The analysis of historical MCO administrative costs in the Commission's rate certification reflects administrative costs net of quality improvement costs. The FY 2024 assumption appears to be generally consistent with average MCO experience from FY 2019 through FY 2022, adjusted for inflation. However, FY 2022 MCO experience was approximately 10% lower than FY 2021 experience, possibly driven by significant PHE-related enrollment increases that are expected to be reversed during FY 2024. The FY 2024 administrative expense PMPM is less than the average inflation-adjusted MCO experience from FY 2019 through FY 2021, but NEMT services have been added to the program since then which we would expect to increase the administrative expense PMPM. The Commission modeled the impact of enrollment changes to evaluate the impact on STAR Health administrative expense PMPMs, but this analysis does not directly address why administrative expenses increased through FY 2021 or whether the increases could have been driven by underlying changes in the STAR Health acuity (e.g., increased utilization of private duty nursing services).

Dental

The Commission noted that MCNA reported significantly higher PMPM administrative costs than DentaQuest, driven by administrative functions outsourced to a related party. Therefore, the Commission evaluated historical administrative costs based on adjustments to MCNA's reported costs. The Commission's Method 1 excludes all of MCNA's outsourced administrative expenses, and Method 2 assumes MCNA's outsourced administrative expense PMPM is the same as DentaQuest's external administrative expense PMPM. We do not believe Method 1 provides a reasonable lower bound for analysis because it assumes MCNA's expenses would be materially lower than DentaQuest's expenses (from 3% to 12% lower, varying by year). The FY 2024 program-wide assumption is approximately 12% less than DHMO average experience from FY 2019 through FY 2022, adjusted for inflation to FY 2024, based on the Commission's adjustment that assumes MCNA's administrative costs PMPM are the same as DentaQuest's administrative costs PMPM. However, PMPM costs are expected to increase throughout FY 2024 as enrollment decreases due to redeterminations.

STAR+PLUS

The FY 2024 program-wide assumption appears to be slightly lower than average MCO experience from FY 2019 through FY 2020 trended to FY 2024, which does not include costs related to NEMT or directed payments, as noted by the Commission. The administrative expense PMPM decrease from FY 2020 to FY 2021 is less expected in the STAR+PLUS program than in other programs because of the limited impact of the PHE on enrollment in this program. The projected FY 2024 program-wide assumption is slightly higher than average MCO experience from FY 2021 through FY 2023, which is in line with our expectations due the program losing some membership because of the PHE, resulting in some loss in economies-of-scale.

STAR Kids

The FY 2024 program-wide assumption appears to be generally consistent with average MCO experience across the five years of historical information reviewed. The administrative expense PMPM decreased in FY 2021 through FY 2023, which is consistent with the increase in enrollment during the PHE that resulted in fixed costs being spread over many more members.

Non-Benefit Expense Recommendations

We do not have any recommendations related to the Commission's development of non-benefit expenses.

Non-Benefit Expense Observations

The following approaches used by the Commission for the development of prospective non-benefit expense assumptions are consistent with general rate setting practices in other states, and these approaches comply with Medicaid managed care rate setting guidance.

- Evaluation of historical program administrative expenses from multiple years to inform prospective administrative expense assumptions specific to populations
- Considering input from MCOs regarding changes in future administrative expenses relative to historical administrative expenses
- Use of explicit assumptions for each major component including administration, risk margin, premium tax, and other taxes and fees to provide transparency as desired by other stakeholders
- Adding risk margin to the capitation rates to account for uncertainty in the projection of future costs

We note the following observations related to non-benefit expenses:

Observation P: Administrative expense assumptions are developed separately for the medical, pharmacy, and NEMT rate components

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids
This observation is unchanged from the FY 2023 review.

In most states, administrative expense assumptions are developed at the risk group level across all services. The Commission's more granular approach adds complexity but does not necessarily improve the reliability of the non-benefit expense assumptions. We do not have any material concerns with the Commission's approach.

We retained this observation from the FY 2023 rate review because there is opportunity for improved efficiency, particularly now that all three rate components are represented in the MCO base period experience.

Observation Q: The service coordination component is applied to each risk group on a uniform PMPM basis rather than being appropriately varied to account for the potential service coordinator staffing ratio variances among risk groups

Applicable program(s): STAR+PLUS, STAR Kids
This observation is unchanged from the FY 2023 review.

Service coordination plays a critical role in achieving the overall success of managed care for a complex population, like those covered in this program. It accounts for approximately 39% of total assumed non-benefit expenses net of risk margin, premium tax, and maintenance tax based on the summary information as provided by the Commission in the STAR+PLUS program and approximately 36% of these expenses in the STAR Kids program. Due to the nature of service coordination, there can be material PMPM cost variances at risk group level within this program to the extent that the service coordinator staffing ratios are materially different by risk group. When service coordination is applied to each risk group on a uniform PMPM basis rather than in a more equitable way to reflect the underlying staffing ratio differences, the administrative costs may be over- or under-funded by risk group.

Financially, this uniform PMPM funding approach for service coordination at risk group level can disadvantage those MCOs with higher mix of risk groups requiring more intensive service coordination. This approach may create unintended behavior changes to MCO operation as they might be financially incentivized to understaff the needed service coordinators for those most acute risk groups or strategically avoid those more acute risk groups since these groups are under-funded for this essential non-benefit expense component under the current methodology.

The Commission stated that they have attempted to collect and review the information by risk group in the past, but they have not been able to gather reliable data stratified at the risk group level of detail. We retained this observation from the FY 2023 rate review because this issue introduces risk to the MCOs based on their covered member mix and the inherent differences in service coordination costs for those populations. In the absence of reliable data, the Commission may be able to rely on industry standards or other published resources.

Observation R: The non-benefit expense PMPM for pharmacy services in the Dual Demo program is from 2015 without trend applied

Applicable program(s): Dual Demo
This observation is unchanged from the FY 2023 review.

The Commission noted that the current amount for administering pharmacy services under the TMHP contract is not representative of costs absent the Dual Demonstration program. However, the PMPM included is from 2015 and may be outdated. The Commission could consider applying a trend assumptions representative of general administrative costs increases to adjust for increases in the cost of administering benefits, such as employee salaries, from 2015 to FY 2024.

We retained this observation from the FY 2023 rate review because the Commission continues to use the PMPM from 2015; however, the magnitude of non-benefit expenses for pharmacy services in the Dual Demo program is immaterial.

CMS COMPLIANCE AND DOCUMENTATION

We reviewed the Commission's FY 2024 rate certification for compliance with the CMS 2023-2024 Medicaid managed care rate setting guidance.[79] While we are not conducting a compliance review on CMS' behalf, we reviewed the rate certification to ensure that the Commission provided information for all portions of the CMS 2023-2024 Medicaid managed care rate setting guidance and provided sufficient documentation to comply with actuarial standards of practice. We reviewed the CMS 2023-2024 Medicaid managed care rate setting guidance and compared them against what the Commission submitted in their Medicaid managed care capitation rate certification for each program: (1) Section I. Medicaid Managed Care Rates, Data, Projected Benefit Costs and Trends, Special Contract Provisions Related to Payment, Projected Non-Benefit Costs, and Risk Adjustment and Acuity Adjustments; (2) Section II. Medicaid Managed Care Rates with Long-Term Services and Supports; and (3) Section III. New Adult Group Capitation Rates.

CMS Compliance and Documentation Recommendations

We note the following recommendation related to CMS compliance and documentation:

Recommendation N: Include supporting documentation for the development of the administrative costs
Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids, Dual Demo
*This recommendation is **modified** from the FY 2023 review.*

The rate certifications include the following information to support the administrative costs included in the FY 2024 capitation rates:

- Fixed and variable administrative costs assumptions by rate component (e.g., medical, pharmacy, and NEMT) for all programs except Dental, which only has a single fixed PMPM administrative cost assumption
- The total administrative costs in the total program on a PMPM basis calculated by adding the amounts for each rate component
- Historical PMPM program administrative costs, including inflation-adjusted projections to FY 2024
- Adjustments to historical PMPM program administrative costs for the Dental program based on administrative functions outsourced to a related party

The Commission noted in the rate certifications that the administrative costs are developed from historical Financial Statistic Reports and the Commission believes the resulting administrative costs for FY 2024 are reasonable compared to historical program experience. However, the rate certifications do not include documentation on how the administrative cost assumptions were developed from this data source. We recommend the Commission expand their documentation to include additional documentation so that CMS or another actuary could reasonably understand the development of these assumptions, including but not limited to:

- Population adjustments, if applicable
- Changes in administrative components (e.g., NEMT, directed payments) between the years in the historical comparison and FY 2024
- Allocation methodology between fixed and variable administrative cost assumptions (i.e., PMPM and percent of claims)
- Allocation methodology between service groupings with separately defined administrative assumptions (i.e., medical, pharmacy, and NEMT)
- Any other adjustments applied
- Changes in methodology from prior rating period

[79] 2022-2023 Medicaid Managed Care Rate Development Guide, Centers for Medicare & Medicaid Services, April 2022, Retrieved from: 2022-2023 Medicaid Managed Care Rate Development Guide.

The Commission's rate development work files include estimates and analysis of the historical medical component PMPM costs for the STAR, STAR Health, STAR+PLUS, and STAR Kids programs and the historical total PMPM costs for the Dental program. However, the sources of some of the assumptions reflected in the work files were not clearly documented. Additionally, the work files demonstrate that the Commission analyzed historical experience in different ways, but the rate certification does not explain whether or how these analyses were considered in the final administrative expense assumptions. We recognize that the Commission provided additional information related to their analysis of the administrative expense assumption, but the additional information does not fully address our recommendation.

We retained this recommendation from the FY 2023 rate review because the Commission's documentation in the rate certification is missing some key information. We modified this recommendation to reflect some changes made by the Commission (e.g., adjusting historical experience for inflation to improve the comparability across years) and some new observations for FY 2024.

Recommendation O: Include documentation in the rate certification that clearly identifies which MCO final rates are based on 108% of individual MCO experience and how the 8% is allocated between benefit and non-benefit costs

Applicable program(s): STAR, STAR Kids
*This recommendation is **new** from the FY 2023 review.*

The Commission does not indicate how the 108% factor is allocated between benefit costs and non-benefit costs, which makes it difficult to evaluate the actual administrative allowance paid to MCOs. Since actuarial soundness is based on the total rate, this allocation is not critical to the rate development process. However, transparent cost allocations will improve the Commission's and the MCOs' abilities to analyze program experience and manage the program.

The non-benefit expenses paid to MCOs under 108% of the MCO-specific rate cannot be easily replicated based on the assumptions included in Section V of the rate certification. In order to perform this calculation, another actuary would need to know whether the final rate was based on 108% of the MCO-specific rate and how the 8% is allocated to the rate components. The information shared with MCOs identifies which rates are based on 108% of the MCO-specific rate, but the rate certification does not clearly state this information. The importance of documenting how the 8% increase is allocated is described in Observation B.

We recommend two changes to the Commission's documentation in the rate certification:

- Identify which final rates are based on 108% of the individual MCO experience rate
- Identify how the additional 8% revenue above projected costs for these rates is allocated to benefit and non-benefit costs

This recommendation is new for FY 2024 as a refinement to the FY 2023 observation that final non-benefit expense assumptions are not clearly identified in the rate certification.

Recommendation P: Reconcile actual patient liability amounts compared to rating assumptions for each MCO

Applicable program(s): STAR+PLUS, Dual Demo
*This recommendation is **modified** from the FY 2023 review.*

The Medicaid Rating Checklist, Section AA.3.13[80] states:

> *"Client participation should not be used to reduce total costs for all participants. Client participation should be assessed individually, reducing the individual rate paid to the capitated entity, not computed in aggregate and reducing all capitation payments."*

Given the patient liability amount (a form of client participation) is unique to each member due to their social security income, managed LTC program capitation rates are typically developed one of two ways, so that MCOs are not at risk for the difference between the average estimated amount of patient liability at a risk group level and the actual patient liability amount for the members enrolled in their plan.

[80] "Appendix A. PAHP, PIHP and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Rate setting," Item number sub-section AA.3.13, July 22, 2003, Retrieved from: Medicaid Rating Checklist (soa.org).

1) Gross of patient liability: Capitation rates are developed gross of patient liability, and the State adjusts capitation rates paid to the MCOs to reflect each individual's specific patient liability. This approach works best in States that have robust and timely patient liability data in order to apply the patient liability adjustment in real time.

2) Net of patient liability: Capitation rates are developed net of patient liability by including an estimate of what the average patient liability will be in the contract period for each risk group. The State then performs a reconciliation after the contract period to adjust for the difference between actual and expected patient liability at the MCO level. This approach is typically used in States that do not have robust and timely patient liability data.

The base data used to develop the STAR+PLUS capitation rates is net of patient liability, which results in capitation rates being net of patient liability, consistent with approach 2 above. However, the Commission stated they do not intend to perform a reconciliation of the patient liability amounts, which introduces risk into the program that the capitation rates overall could be over or under funded (if the overall amount of patient liability is not equal to the estimated amount), as well as disparities by MCO due to the mix of members they enroll with unique patient liability amounts.

The Commission applied a separate cost-of-living adjustment to the average base period patient liability PMPMs in the FY 2024 rate development, which mitigates some of the risk of the capitation rates being over or under funded. However, this risk is not eliminated because the actual amount of FY 2024 patient liability is likely to differ from the base period as individual members enter and leave the program. Furthermore, the FY 2024 patient liability for each MCO is unlikely to exactly align with the average patient liability amounts removed from the capitation rates.

The Commission indicated they continue to evaluate the impact of patient liability, but they do not intend to perform a reconciliation of patient liability. The Commission stated the patient liability percentage of gross cost has demonstrated very little variation between MCOs within each SDA. However, the data provided by the Commission shows the FY 2022 patient liability by MCO and SDA ranges from 3.0% to 7.2% for Medicaid Only beneficiaries and from 11.0% to 19.9% for Dual eligible beneficiaries. Although patient liability has a narrower range within specific SDAs, Milliman observed that patient liability percentages can vary by as much as 3.6% for Medicaid only enrollees and by as much as 1.7% for dual eligible members within individual SDAs.

We recommend the Commission perform a reconciliation of patient liability after the contract period to adjust for the difference between actual and expected patient liability at the MCO level.

We retained this recommendation from the FY 2023 rate review because the Commission's aggregate computation of patient liability in the FY 2024 rates is inconsistent with the CMS Medicaid Rating Checklist, and the MCOs are still at risk for random differences in average patient liability for their members versus the average patient liability used to develop the rates.

CMS Compliance and Documentation Observations

We note the following observations related to CMS compliance and documentation:

Observation S: Supporting documentation does not clearly indicate that IMD costs are removed and associated member months remain

Applicable program(s): STAR, STAR+PLUS
This recommendation is unchanged from the FY 2023 review.

In 42 CFR § 438.6(e),[81] the State may make a monthly capitation payment to MCOs for a member aged 21 through 64 who receive inpatient treatment in an IMD, so long as the member has a length of stay in the IMD is for a short term stay of no more than 15 days during the period of the monthly capitation payment. The commonly accepted approach to comply with CMS requirements is to deduct the related costs from the base data and remove the associated member months from the base period, either in the base data development or as a programmatic adjustment. The description of the Commission's IMD cost removal adjustment indicates the removal of IMD costs for stays in excess of 15 days during any month but does not incorporate the removal of the member months.

[81] 42 CFR § 438.6(e) – Special contract provisions related to payment, Payments to MCOs and PIHPs for enrollees that are a patient in an institution for mental disease, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.6.

The impact is likely not material to the program overall based on our experience with other states. However, the Commission is slightly understating the capitation rates for affected risk groups by removing the IMD costs from the numerator of the capitation rate calculation, but not reducing the member months in the denominator.

Additionally, although the impact of the IMD adjustment is small, adherence to guidance has recently been subject to scrutiny by CMS in many states. It is important to calculate this adjustment consistent with CMS requirements to avoid the risk that CMS will determine program costs are out of compliance and not eligible for federal matching funds.

We retained this observation from the FY 2023 rate review because the rate certification is not transparent regarding the inconsistencies between the Commission's IMD adjustment and CMS requirements.

Observation T: Supporting documentation does not clearly describe the PHE weighting factor development

Applicable program(s): STAR, STAR Health, Dental, STAR Kids, STAR+PLUS
*This observation is **new** from the FY 2023 review.*

The rate certification describes the PHE weighting factor as being based on the "percentage of cumulative disenrollments expected each month." However, the Commission's calculation is based on enrollment projections that include all projected enrollment changes, including new entrants. The rate certification also does not document that the total number of disenrollments, which the Commission uses in the denominator of the percentage of cumulative disenrollments, is calculated as the decrease in total enrollment between May 2023 and August 2024.

This observation is new for FY 2024 because the Commission used a new PHE adjustment methodology in FY 2024, and the Commission's FY 2023 PHE adjustment did not utilize this calculation. We include this as an observation, as opposed to a recommendation, because the Commission is likely to change this methodology in future rate setting cycles as more data becomes available regarding actual changes in membership due to redeterminations.

EXHIBITS

Exhibit 1
Texas Managed Medicaid Capitation Rate Review
Summary of FY 2024 Recommendations

		Applicable Program(s)						Recommendation Basis			Directional Impact of Current Methodology on Capitation Rates
Recommendation	FY 2023 Recommendation?	STAR	STAR Health	Dental	STAR+ PLUS	STAR Kids	Dual Demo	Introduces Actuarial Soundness Risk	Does not Follow Common Actuarial Practices	Regulation Compliance	(+) Over-funding (-) Under-funding Unknown = Not quantifiable Potential Risk Group or SDA Impact[1] No Financial Impact
Rate Structure											
A: Consider consolidating SDAs for the purpose of rate development	Yes	X			X	X		X			Potential Risk Group or SDA Impact
B: Consider combining risk groups to enhance credibility and reduce annual volatility	Yes					X		X			Potential Risk Group or SDA Impact
Base Data Development											
C: Use state encounter data as the primary base data source for expenditure data	Yes	X	X	X	X	X		X			Potential Risk Group or SDA Impact
D: Use the state capitation payment file as the primary base data source for enrollment data	Yes	X		X	X	X	Relies on base data from STAR+PLUS	X			Potential Risk Group or SDA Impact
E: Develop base period for each SDA by weighting each MCO's experience with actual enrollment instead of projected enrollment	Yes	X			X	X		X	X		Potential Risk Group or SDA Impact
F: Include supporting documentation for the development of the base period data	Yes (modified)	X	X	X	X	X				X	No Financial Impact
Trend Assumptions											
G: Develop medical trend assumptions at more detailed service category level	Yes	X	X		X	X	Relies upon STAR+PLUS medical trend analyses	X	X		Unknown
H: Develop medical and pharmacy trend assumptions separately by utilization and unit cost component	Yes (modified)	X	X		X	X		X	X		Unknown
I: Develop and apply pharmacy trends by drug type (i.e., Specialty and Non-Specialty)	Yes	X	X		X	X		X	X		(-)
J: Consider the impact of recently approved and upcoming pipeline drugs for each population	Yes	X	X		X	X		X	X		Unknown
K: Evaluate pharmacy trends at the therapeutic class level	Yes	X	X		X	X		X	X		Unknown
Programmatic Adjustments											
L: Remove member months periods for members ages 21 through 64 who have an IMD stay in excess of 15 days during any month	Yes	X			X			X	X	X	(-)
M: Adjust the NEMT rate component to account for the anticipated impact of disenrollment related to the expiration of the PHE	No	X	X		X	X	Relies on STAR+PLUS		X		(-)
Non-Benefit Expenses											
CMS Compliance											
N: Include supporting documentation for the development of the administrative costs	Yes (modified)	X	X	X	X	X	X			X	No Financial Impact
O: Include documentation in the rate certification that clearly identifies which MCO final rates are based on 108% of individual MCO experience and how the 8% is allocated between benefit and non-benefit costs	No	X				X				X	No Financial Impact
P: Reconcile actual patient liability amounts compared to rating assumptions for each MCO	Yes (modified)				X		X			X	Unknown

[1] *Current methodology may under- or over-fund a certain risk group or SDA but the total funding across the entire program is not impacted.*

Exhibit 2
Texas Managed Medicaid Capitation Rate Review
Summary of FY 2024 Observations

		Applicable Program(s)					
Observation	**FY 2023 Observation?**	**STAR**	**STAR Health**	**Dental**	**STAR+ PLUS**	**STAR Kids**	**Dual Demo**
Rate Structure							
A: Rates are developed individually by MCO rather than across all MCOs	Yes	X				X	
B: Allocation of benefit and non-benefit expenses in final rates to MCOs are not clearly identified	Yes (modified)	X				X	
C: LTC rates developed separately for nursing facility and community residents	Yes				X		Relies on STAR+PLUS
Base Data Development							
D: Summary-level enrollment data and expenditure data are gathered from separate sources	Yes	X	X	X	X	X	Relies on base data from STAR+PLUS
E: Net reinsurance costs should not be included in the base data	Yes	X			X	X	
F: Certain non-lag expenditures are allocated to risk groups on a PMPM basis instead of reflecting inherent utilization and cost differences	Yes	X			X	X	
Trend Assumptions							
G: Prospective medical trends are developed using a purely formulaic approach	Yes	X	X	X	X	X	Relies on STAR+PLUS
H: Medical trends are not consistently applied to sub-capitated and service coordination cost	Yes	X			X	X	
I: The data source used for quantitative medical trend analysis does not enable more granular analysis	Yes	X	X		X	X	
J: Historical CPI trend used for NEMT trends is not calculated using a typical CPI trend calculation approach	Yes (modified)	X	X		X	X	
Programmatic Adjustments							
K: Reimbursement changes are included as programmatic adjustments, regardless of their materiality	Yes	X	X		X	X	Relies on STAR+PLUS
L: The FQHC wrap payment removal relies on base data aggregation using projected enrollment	Yes	X		X	X	X	
M: Programmatic adjustments are not developed at a service category level	Yes	X	X	X	X	X	
N: The weighting factor for the PHE adjustment reflects disenrollment net of new entrants	No	X	X	X	X	X	
O: Some programmatic adjustments vary by at least 5% among risk group / SDA combinations but appear reasonable	Yes	X				X	
Non-Benefit Expenses							
P: Administrative expense assumptions are developed separately for the medical, pharmacy, and NEMT rate components	Yes	X	X		X	X	Relies on STAR+PLUS
Q: The service coordination component is applied to each risk group on a uniform PMPM basis rather than being appropriately varied to account for the potential service coordinator staffing ratio variances among risk groups	Yes				X	X	
R: The non-benefit expense PMPM for pharmacy services in the Dual Demo program is from 2015 without trend applied	Yes						X
CMS Compliance							
S: Supporting documentation does not clearly indicate that IMD costs are removed and associated member months remain	Yes	X			X		
T: Supporting documentation does not clearly describe the PHE weighting factor development	No	X	X	X	X	X	

Exhibit 3
Texas Medicaid Managed Care Rate Review
STAR Program – Rate Structure
FY 2022 Average Enrollment

SDA	Age <1	Age 1 to 5	Age 6 to 14	Age 15 to 20	TANF - Adults	Pregnant Women	Adoption Assistance
Bexar	18,916	87,482	137,313	65,679	23,645	35,439	11,807
Dallas	29,772	141,664	220,060	104,738	20,437	48,103	7,416
El Paso	7,524	36,142	61,473	33,681	7,721	14,249	1,009
Harris	54,746	258,472	408,407	193,040	45,867	87,187	12,142
Hidalgo	22,140	104,496	179,659	95,762	18,572	36,289	1,430
Jefferson	6,296	29,223	46,678	20,559	7,211	11,485	1,866
Lubbock	6,047	25,646	39,991	18,357	5,975	11,730	3,131
Nueces	6,181	28,105	45,772	22,571	7,654	12,328	1,783
Tarrant	21,963	101,082	157,171	72,276	18,419	38,755	6,220
Travis	12,050	54,337	82,544	38,390	10,485	19,047	5,581
MRSA Central	10,546	48,077	76,162	34,382	11,290	19,890	4,912
MRSA Northeast	13,100	58,890	94,139	43,185	12,565	24,602	5,099
MRSA West	13,038	56,416	85,059	38,278	12,179	24,471	4,687

Exhibit 4 Texas Medicaid Managed Care Rate Review STAR Health Program – Rate Structure FY 2022 Average Enrollment
Total
45,268

Exhibit 5 Texas Medicaid Managed Care Rate Review Dental Program – Rate Structure FY 2022 Average Enrollment (Medicaid Only)				
Age <1	**Age 1 to 5**	**Age 6 to 14**	**Age 15 to 18**	**Age 19 to 20**
172,186	1,057,209	1,756,238	678,381	228,755

Exhibit 6
Texas Medicaid Managed Care Rate Review
STAR+PLUS Program – Rate Structure
FY 2022 Average Enrollment

SDA	Medicaid Only - OCC	Medicaid Only - HCBS	Dual Eligible - OCC	Dual Eligible - HCBS	Medicaid Only - NF	Dual Eligible - NF	IDD	MBCCP
Bexar	19,365	2,389	18,043	2,607	553	2,986	1,769	487
Dallas	26,100	3,691	23,168	4,772	861	4,122	2,327	639
El Paso	6,004	814	12,432	1,221	98	591	523	327
Harris	43,995	3,360	50,061	4,831	863	4,673	4,035	1,119
Hidalgo	14,627	2,643	31,719	9,613	226	2,186	1,010	628
Jefferson	8,005	636	7,767	1,109	183	1,496	370	191
Lubbock	4,793	358	5,682	586	175	1,292	586	140
Nueces	7,219	858	8,206	2,149	171	1,517	452	350
Tarrant	17,205	1,567	16,097	2,271	628	3,553	2,187	499
Travis	9,805	635	10,536	1,429	351	2,757	1,221	344
Central	12,325	695	12,293	1,194	440	3,498	843	264
Northeast	17,839	1,309	17,231	3,379	525	4,536	1,066	351
West	11,538	943	15,663	2,191	477	3,819	1,041	365

Exhibit 7
Texas Medicaid Managed Care Rate Review
STAR Kids Program – Rate Structure
FY 2022 Average Enrollment

SDA	MDCP	IDD	YES*	Under Age 1*	Ages 1 to 5	Ages 6 to 14	Ages 15 to 20
Bexar	595	327	122	97	1,464	6,478	5,823
Dallas	976	565	129	97	2,276	10,255	8,317
El Paso	120	75	20	19	532	2,318	1,944
Harris	1,406	868	221	146	3,967	18,093	14,457
Hidalgo	279	209	212	51	1,942	11,139	8,631
Jefferson	152	64	69	17	508	2,377	1,964
Lubbock	138	74	11	10	406	1,592	1,285
Nueces	88	69	40	24	490	2,399	2,268
Tarrant	768	551	132	77	1,558	6,891	5,489
Travis	409	411	177	45	791	3,215	2,723
Central	252	175	47	43	906	4,436	3,653
Northeast	396	268	68	34	1,052	5,177	4,258
West	225	162	58	25	748	3,152	2,755

**YES and Under Age 1 capitation rates are developed on a statewide basis.*

Exhibit 8
Texas Medicaid Managed Care Rate Review
STAR Program - Base Data Review
Reconciliation of Travis SDA Across All MCOs

Table 1: Raw Base Period (9/1/2021 - 8/31/2022) Enrollment and Expenditure Data As Reported

Risk Group	Enrollment	Medical	NEMT	Rx	Capitation	Net Reinsurance	Other Medical Expenditures	TPR (Medical)	TPR (Rx)	Total Benefit Cost
Under Age 1	144,601	$143,224,352	$30,798	$2,565,823	$912,177	$29,955	-$6,369,319	$375,092	-$12,031	$140,756,847
Age 1 to 5	652,045	$109,603,056	$94,822	$7,074,077	$3,954,602	$154,105	-$12,068,458	$1,068,799	-$57,108	$109,823,895
Age 6 to 14	990,533	$104,227,333	$86,148	$25,555,221	$5,563,251	$250,634	-$13,323,401	$817,072	-$98,174	$123,078,084
Age 15 to 18	356,712	$56,695,926	$37,532	$11,323,883	$1,992,976	$85,564	-$5,256,255	$482,554	-$37,808	$65,324,371
Age 19 to 20	103,969	$13,422,433	$15,527	$3,058,107	$586,883	$24,294	-$1,373,698	$106,532	-$11,915	$15,828,164
TANF Adult	125,820	$45,073,287	$122,320	$14,225,085	$859,728	$26,416	-$2,687,616	$671,258	-$36,190	$58,254,287
Pregnant Women	228,565	$91,578,863	$128,030	$5,362,327	$1,533,711	$31,674	-$5,289,096	$1,915,058	-$38,484	$95,222,082
Adoption Assistance	66,966	$12,304,972	$30,992	$3,867,945	$352,929	$22,557	-$684,264	$311,125	-$7,621	$16,198,635
Total	**2,669,211**	**$576,130,223**	**$546,170**	**$73,032,468**	**$15,756,257**	**$625,199**	**-$47,052,109**	**$5,747,488**	**-$299,331**	**$624,486,365**

Table 2: Data Adjustments

Risk Group	Enrollment	Medical	NEMT	Rx	Capitation	Net Reinsurance	Other Medical Expenditures	TPR (Medical)	TPR (Rx)	Total Benefit Cost
Under Age 1		-$56,935,669	$8	$22	-$174,875		$7,242,117	-$568,488	$81	-$50,436,804
Age 1 to 5		-$23,172,754	$1	$56	-$775,984		$12,242,295	-$1,131,093	$710	-$12,836,769
Age 6 to 14		-$26,881,843	$0	$185	-$1,220,987		$12,165,564	-$851,745	$2,082	-$16,786,744
Age 15 to 18		-$20,101,081	$1,412	$92	-$450,808		$4,051,324	-$500,212	-$470	-$16,999,743
Age 19 to 20		-$4,303,458	$1	$21	-$129,465		$1,028,630	-$111,802	$704	-$3,515,369
TANF Adult		-$16,093,842	$5	$105	-$139,340		$2,043,523	-$709,992	$160	-$14,899,380
Pregnant Women		-$31,756,503	$404	$37	-$294,892		$5,496,147	-$2,097,376	$5	-$28,652,177
Adoption Assistance		-$2,959,421	$1,424	$25	-$27,757		$550,021	-$315,262	$51	-$2,750,918
Total		**-$182,204,571**	**$3,256**	**$544**	**-$3,214,107**		**$44,819,622**	**-$6,285,971**	**$3,323**	**-$146,877,905**

Table 3: Final Base Period Enrollment and Expenditure Data With All Adjustments

Risk Group	Enrollment	Medical	NEMT	Rx	Capitation	Net Reinsurance	Other Medical Expenditures	TPR (Medical)	TPR (Rx)	Total Benefit Cost
Under Age 1	144,601	$86,288,683	$30,806	$2,565,846	$737,302	$29,955	$872,798	-$193,397	-$11,950	$90,320,043
Age 1 to 5	652,045	$86,430,302	$94,823	$7,074,133	$3,178,618	$154,105	$173,837	-$62,294	-$56,399	$96,987,126
Age 6 to 14	990,533	$77,345,490	$86,148	$25,555,406	$4,342,264	$250,634	-$1,157,837	-$34,674	-$96,092	$106,291,340
Age 15 to 18	356,712	$36,594,844	$38,944	$11,323,975	$1,542,168	$85,564	-$1,204,931	-$17,658	-$38,278	$48,324,628
Age 19 to 20	103,969	$9,118,975	$15,529	$3,058,129	$457,419	$24,294	-$345,069	-$5,271	-$11,211	$12,312,795
TANF Adult	125,820	$28,979,445	$122,325	$14,225,190	$720,388	$26,416	-$644,093	-$38,735	-$36,030	$43,354,907
Pregnant Women	228,565	$59,822,360	$128,434	$5,362,364	$1,238,819	$31,674	$207,051	-$182,319	-$38,479	$66,569,905
Adoption Assistance	66,966	$9,345,551	$32,416	$3,867,970	$325,171	$22,557	-$134,243	-$4,137	-$7,570	$13,447,717
Total	**2,669,211**	**$393,925,652**	**$549,425**	**$73,033,012**	**$12,542,150**	**$625,199**	**-$2,232,487**	**-$538,483**	**-$296,008**	**$477,608,461**

Footnotes:

1. In Table 1, enrollment data was summarized based on the March 2023 caseload file provided by the Commission.
2. In Table 1, expenditure data was calculated based on the MCO supplemental expenditure data as reported by MCOs to the Commission using the Commission's prescribed MCO supplemental data reporting template.
3. In Table 1, base period lag expenditure data (Medical, NEMT, and Rx) was calculated based on the monthly expenditure data as reported in SFY22 MCO supplemental data report with runout through February 2023.
4. In Table 1, base period non-lag expenditure data (Capitation, Net Reinsurance Cost, Other Medical Expenditure, and TPR) was calculated using the expenditure data as reported in the SFY22 (9/1/2021-8/31/2022) MCO. supplemental data report with runout through February 2023
5. in Table 1, 'Other Medical Expenditures' is net of reported quality improvement and service coordination.
6. In Table 2, the primary drivers of the data adjustments are FQHC wrap payments and State directed payments.
7. In Table 2, IBNR is meant to account for any unpaid amounts for claims incurred in the base period as of February 2023.
8. The NEMT expenditures reflected in Tables 1 through 3 are based on July 2022 through December 2022 data, which is the base period used by the Commission for the NEMT rate component.

Exhibit 9
Texas Medicaid Managed Care Rate Review
STAR Health Program - Base Data Review
Reconciliation Statewide

Table 1: Raw Base Period (9/1/2021 - 8/31/2022) Enrollment and Expenditure Data As Reported

	Enrollment	Medical	Rx	NEMT	Capitation	Net Reinsurance	Other Medical Expenditures	TPR	Total Benefit Cost
Total	**543,219**	**$296,453,828**	**$35,023,717**	**$380,648**	**$24,154,854**	**$28,791**	**-$2,294,734**	**-$77,376**	**$353,669,727**

Table 2: Data Adjustments

	Enrollment	Medical	Rx	NEMT	Capitation	Net Reinsurance	Other Medical Expenditures	TPR	Total Benefit Cost
Total				**$27,857**	**-$1,660,144**	**-$28,791**	**$4,842,432**	**$28,486**	**$3,209,840**

Table 3: Final Base Period Enrollment and Expenditure Data With All Adjustments

	Enrollment	Medical	Rx	NEMT	Capitation	Net Reinsurance	Other Medical Expenditures	TPR	Total Benefit Cost
Total	**543,219**	**$296,453,828**	**$35,023,717**	**$408,505**	**$22,494,709**	**$0**	**$2,547,698**	**-$48,890**	**$356,879,567**

Footnotes:

1. *In Table 1, enrollment data was summarized based on the March 2023 caseload file provided by the Commission.*
2. *In Table 1, expenditure data was calculated based on the MCO supplemental expenditure data as reported by MCOs to the Commission using the Commission's prescribed MCO supplemental data reporting template.*
3. *In Table 1, base period lag expenditure data (Medical, NEMT, and Rx) was calculated based on the monthly expenditure data as reported in SFY22 MCO supplemental data report with runout through February 2023.*
4. *In Table 1, base period non-lag expenditure data (Capitation, Net Reinsurance Cost, Other Medical Expenditure, and TPR) was calculated using the expenditure data as reported in the SFY22 (9/1/2021-8/31/2022) MCO. supplemental data report with runout through February 2023*
5. *in Table 1, 'Other Medical Expenditures' is net of reported quality improvement.*
6. *In Table 2, the primary drivers of the data adjustments are FQHC wrap payments and related party adjustments to subcapitated vision expenditures.*
7. *The NEMT expenditures reflected in Tables 1 through 3 are based on July 2022 through December 2022 data, which is the base period used by the Commission for the NEMT rate component.*

Exhibit 10
Texas Medicaid Managed Care Rate Review
Dental Program - Base Data Review
Reconciliation Statewide Across All DHMOs

Table 1: Raw Base Period (9/1/2021 - 8/31/2022) Enrollment and Expenditure Data As Reported

Risk Group	Enrollment	Dental_FFS	Other Non-FFS Expenses	Total Benefit Cost
Under Age 1	2,066,231	$17,506,186	$1,493,626	$18,999,812
Ages 1 to 5	12,686,509	$301,032,729	$5,566,658	$306,599,387
Ages 6 to 14	21,074,856	$548,380,549	$9,391,931	$557,772,481
Ages 15 to 18	8,140,573	$204,526,298	$4,513,241	$209,039,540
Ages 19 to 20	2,745,059	$44,532,895	$2,232,083	$46,764,978
Total	**46,713,229**	**$1,115,978,658**	**$23,197,540**	**$1,139,176,198**

Table 2: Data Adjustments

Risk Group	Enrollment	Dental_FFS	Other Non-FFS Expenses	Total Benefit Cost
Under Age 1		$24,995	$3,555	$28,550
Ages 1 to 5		$138,412	$1,789	$140,201
Ages 6 to 14		$191,180	-$11,649	$179,531
Ages 15 to 18		$76,081	-$7,078	$69,003
Ages 19 to 20		$15,271	-$2,234	$13,036
Total		**$445,938**	**-$15,617**	**$430,321**

Table 3: Final Base Period Enrollment and Expenditure Data With All Adjustments

Risk Group	Enrollment	Dental_FFS	Other Non-FFS Expenses	Total Benefit Cost
Under Age 1	2,066,231	$17,531,181	$1,497,182	$19,028,362
Ages 1 to 5	12,686,509	$301,171,141	$5,568,447	$306,739,588
Ages 6 to 14	21,074,856	$548,571,729	$9,380,283	$557,952,012
Ages 15 to 18	8,140,573	$204,602,379	$4,506,163	$209,108,543
Ages 19 to 20	2,745,059	$44,548,166	$2,229,849	$46,778,015
Total	**46,713,229**	**$1,116,424,596**	**$23,181,923**	**$1,139,606,519**

Footnotes:

1. In Table 1, historical enrollment data was summarized based on the SFY 2024 databook.

2. In Table 1, expenditure data was calculated based on the MCO supplemental expenditure data as reported by MCOs to the Commission using the Commission's prescribed MCO supplemental data reporting template.

3. In Table 1, base period lag expenditure data (Dental_FFS) was calculated based on the monthly expenditure data as reported in SFY22 MCO supplemental data report with runout through February 2023.

4. In Table 1, base period non-lag expenditure data was calculated using the expenditure data as reported in the SFY22 (9/1/2021-8/31/2022) MCO supplemental data report with runout through February 2023.

5. in Table 1, 'Other Non-FFS Expenses' is net of reported quality improvement.

6. In Table 2, the primary driver of the data adjustments is IBNR, which accounts for any unpaid amounts for claims incurred in the base period as of February 2023.

Exhibit 11
Texas Medicaid Managed Care Rate Review
STAR+PLUS Program - Base Data Review
Reconciliation of Bexar SDA Across All MCOs

Table 1: Raw Base Period (9/1/2021 - 8/31/2022) Enrollment and Expenditure Data As Reported

Risk Group	Enrollment	Acute	LTC	NEMT	Rx	Capitation	Net Reinsurance	Other Medical Expenditures	Other Pharmacy Expenditures	TPR (Medical)	TPR (Rx)	Total Benefit Costs	TPR Included in Lag Data TPR - Medical
Dual Eligible - HCBS	31,281	$1,293,243	$60,886,524	$744,185	$0	$174,461	$2,668	$1,597,543	-$8,070	-$4,990	-$38,717	$64,678,128	-$235,078
Dual Eligible - OCC	216,518	$1,587,194	$74,070,429	$1,497,074	$0	$65,884	$17,860	$5,936,651	-$59,682	-$7,429	-$235,310	$83,089,189	-$1,890,053
Dual Eligible - Nursing Facility	35,836	$394,354	$157,155,220	$114,728	$0	$12,025	$4,475	$4,571,571	-$11,334	-$27,175	-$52,583	$162,197,117	-$276,024
IDD >21	21,234	$8,797,737	$220,929	$19,211	$14,247,241	$12,867	$697	$538,942	-$5,416	-$386	-$30,190	$23,822,866	-$133,958
MBCCP	5,838	$11,695,119	$262,013	$23,236	$4,483,000	$18,073	$263	$90,477	-$3,683	-$901	-$9,273	$16,564,164	-$23,600
Medicaid Only - HCBS	28,664	$54,189,717	$53,847,571	$676,415	$33,132,408	$282,885	$1,800	$1,656,850	-$26,724	-$6,220	-$41,600	$143,741,766	-$173,715
Medicaid Only - OCC	232,375	$185,372,107	$47,003,362	$1,829,641	$113,623,991	$692,951	$12,403	$7,402,289	-$98,837	-$13,419	-$304,471	$355,752,391	-$1,692,887
Medicaid Only - Nursing Facility	6,633	$13,505,413	$34,069,174	$16,222	$4,824,655	$11,206	$722	$1,245,998	-$20,762	-$5,745	-$10,872	$53,642,644	-$49,820
Total	**578,378**	**$276,834,884**	**$427,515,222**	**$4,920,712**	**$170,311,296**	**$1,270,352**	**$40,888**	**$23,040,323**	**-$234,507**	**-$66,266**	**-$723,016**	**$903,488,265**	**-$4,475,134**

Table 2: Data Adjustments

Risk Group	Enrollment	Acute	LTC	NEMT	Rx	Capitation	Net Reinsurance	Other Medical Expenditures	Other Pharmacy Expenditures	TPR (Medical)	TPR (Rx)	Total Benefit Costs
Dual Eligible - HCBS		-$1,293,243	$1,249,169	$2,337	$0	-$171,048	$0	-$1,044,935	$570	$26	$38,717	-$1,257,151
Dual Eligible - OCC		-$1,587,194	$1,505,863	$27,120	$0	-$43,041	$0	-$4,750,110	$834	-$47	$235,310	-$4,846,527
Dual Eligible - Nursing Facility		-$394,354	$694,812	$12,980	$0	-$6,301	$0	-$4,268,115	$2,784	$12	$52,583	-$3,958,194
IDD >21		-$1,542,183	-$220,929	$436	$8,129	$3,740	$0	-$394,058	-$2,886	-$3	-$25,543	-$2,147,751
MBCCP		-$1,663,040	$0	$0	$3,226	$825	$0	-$111,721	$1,420	$1	-$6,975	-$1,769,290
Medicaid Only - HCBS		-$13,325,538	$6,945	$23,015	$16,532	-$188,553	$0	-$1,187,695	$10,657	-$17	-$30,054	-$14,644,638
Medicaid Only - OCC		-$49,134,706	$4,574	$33,515	$59,183	$46,810	$0	-$6,250,989	-$28,390	-$137	-$260,421	-$55,270,003
Medicaid Only - Nursing Facility		-$4,670,010	$54,923	$1,458	$2,148	$1,441	$0	-$1,183,257	$14,915	$0	-$3,368	-$5,778,381
Total		**-$73,610,268**	**$3,295,356**	**$100,861**	**$89,219**	**-$356,127**	**$0**	**-$19,190,880**	**-$95**	**-$164**	**$248**	**-$89,671,935**

Table 3: Final Base Period Enrollment and Expenditure Data With All Adjustments

Risk Group	Enrollment	Acute	LTC	NEMT	Rx	Capitation	Net Reinsurance	Other Medical Expenditures	Other Pharmacy Expenditures	TPR (Medical)	TPR (Rx)	Total Benefit Costs
Dual Eligible - HCBS	31,281	$0	$62,135,692	$746,521	$0	$3,413	$2,668	$552,608	$0	-$4,964	$0	$63,435,939
Dual Eligible - OCC	216,518	$0	$75,576,292	$1,524,195	$0	$22,844	$17,860	$1,186,541	$0	-$7,476	$0	$78,320,255
Dual Eligible - Nursing Facility	35,836	$0	$157,850,032	$127,707	$0	$5,724	$4,475	$303,457	$0	-$27,163	$0	$158,264,232
IDD >21	21,234	$7,255,554	$0	$19,648	$14,255,370	$16,607	$697	$144,884	-$13,144	-$389	-$55,733	$21,623,494
MBCCP	5,838	$10,032,079	$262,013	$23,236	$4,486,226	$18,898	$263	-$21,243	-$3,145	-$900	-$16,248	$14,781,180
Medicaid Only - HCBS	28,664	$40,864,179	$53,854,516	$699,430	$33,148,940	$94,331	$1,800	$469,154	-$22,501	-$6,237	-$71,655	$129,031,959
Medicaid Only - OCC	232,375	$136,237,401	$47,007,935	$1,863,156	$113,683,175	$739,761	$12,403	$1,151,299	-$188,056	-$13,556	-$564,892	$299,928,626
Medicaid Only - Nursing Facility	6,633	$8,835,403	$34,124,097	$17,681	$4,826,803	$12,647	$722	$62,742	-$7,653	-$5,745	-$14,241	$47,852,456
Total	**578,378**	**$203,224,616**	**$430,810,578**	**$5,021,573**	**$170,400,514**	**$914,225**	**$40,888**	**$3,849,442**	**-$234,498**	**-$66,430**	**-$722,769**	**$813,238,140**

Footnotes:

1. In Table 1, enrollment data was summarized based on the March 2023 caseload file provided by the Commission.

2. In Table 1, expenditure data was calculated based on the MCO supplemental expenditure data as reported by MCOs to the Commission using the Commission's prescribed MCO supplemental data reporting template.

3. In Table 1, base period lag expenditure data (Acute, LTC, NEMT, and Rx) was calculated based on the monthly expenditure data as reported in SFY22 MCO supplemental data reported with runout through February 2023.

4. In Table 1, base period non-lag expenditure data (Capitation, Net Reinsurance Cost, Other Medical Expenditure, and Other Pharmacy Expenditure) was calculated using the expenditure data as reported in the SFY22 (9/1/2021-8/31/2022) MCO. supplemental data report with runout through February 2023

5. In Table 1, 'Other Medical Expenditures' is net of reported quality improvement expenditures to the extent applicable as we will review this component together with the service coordination component and the administrative cost component of the rate.

6. In Table 2, MCOs are not at risk for outpatient pharmacy expenditures for dual members and therefore are excluded from the base expenditure.

7. In Table 2, FQHC wrap payments will be accounted in non-base component of the capitation rates and are therefore excluded from the base expenditure.

8. In Table 2, IBNR is meant to account for any unpaid amounts for claims incurred in the base period as of February 2023.

9. In Table 2, UHRIP, UHRIP-QIF, QIPP, TIPPs, RAPPs and BHS DPP are State directed provider add-on payments which are not accounted for in the main capitation rates and therefore are excluded from the base expenditure.

10. The NEMT expenditures reflected in Tables 1 through 3 are based on July 2022 through December 2022 data, which is the base period used by the Commission for the NEMT rate component.

Exhibit 12
Texas Medicaid Managed Care Rate Review
STAR Kids Program - Base Data Review
Reconciliation of Harris SDA Across All MCOs

Table 1: Raw Base Period (9/1/2021 - 8/31/2022) Enrollment and Expenditure Data As Reported

Risk Group	Enrollment	Med	NEMT	Rx	Capitation	Net Reinsurance	Other Medical Expenditures (net of quality improvement)	Other Pharmacy Expenditures	TPR - Medical*	TPR - Rx	Total Benefit Cost	TPR Included in Lag Data TPR-Medical and Rx Combined*
MDCP	16,871	$190,818,551	$32,582	$22,274,195	$48,541	$4,458	$3,039,351	-$348,526	-$212,255	$0	$215,869,152	-$212,255
IDD	10,419	$22,772,180	$18,629	$5,144,390	$28,286	$2,500	$542,813	-$97,002	-$1,087,205	$0	$28,411,796	-$1,087,205
YES	2,646	$4,032,433	$2,117	$884,160	$7,617	$672	$719,177	-$1,243	-$996,213	$0	$5,644,934	-$996,213
Under Age 1	1,748	$10,413,532	$896	$1,526,858	$4,038	$303	$159,483	-$453	-$44,940	$0	$12,104,657	-$44,940
Age 1 to 5	47,607	$119,688,452	$38,374	$12,113,978	$142,645	$10,511	$2,309,547	-$24,431	-$37,932	$0	$134,279,076	-$37,932
Age 6 to 14	217,117	$153,518,686	$111,078	$46,201,788	$655,457	$50,816	$5,776,271	-$186,294	-$7,715	$0	$206,127,801	-$7,715
Age 15 to 20	173,485	$90,213,745	$62,871	$40,522,210	$524,978	$35,721	$4,716,771	-$152,595	-$8,216	$0	$135,923,701	-$8,216
Total	**469,893**	**$591,457,579**	**$266,547**	**$128,667,579**	**$1,411,561**	**$104,982**	**$17,263,413**	**-$810,543**	**-$4,187,032**	**$0**	**$738,361,118**	**-$4,187,032**

Table 2: Data Adjustments

Risk Group	Enrollment	Med	NEMT	Rx	Capitation	Net Reinsurance	Other Medical Expenditures	Other Pharmacy Expenditures	TPR - Medical	TPR - Rx	Total Benefit Cost
MDCP		$279,105	$14,532	$63	-$14,347	$0	-$2,330,383	$350,839	$212,255	-$350,956	-$1,700,191
IDD		$1,921	$8,968	$14	-$8,660	$0	-$452,927	$95,732	$1,087,205	-$95,757	-$354,952
YES		-$400,486	$2,527	$5	-$2,490	$0	-$682,229	$1,184	$996,213	-$1,177	-$1,081,490
Under Age 1		-$8,210	$1,996	$6	-$1,349	$0	-$106,442	$223	$44,940	-$227	-$113,776
Age 1 to 5		-$29,375	$48,763	$39	-$45,015	$0	-$1,620,535	$24,387	$37,932	-$24,701	-$1,621,736
Age 6 to 14		$26,311	$171,361	$122	-$163,265	$0	-$4,478,370	$172,775	$7,715	-$172,775	-$4,271,066
Age 15 to 20		-$28,815	$165,910	$121	-$159,817	$0	-$3,850,743	$127,015	$8,216	-$127,703	-$3,746,328
Total		**-$159,549**	**$414,057**	**$370**	**-$394,943**	**$0**	**-$13,521,629**	**$772,156**	**$2,394,476**	**-$773,296**	**-$12,889,539**

Table 3: Final Base Period Enrollment and Expenditure Data With All Adjustments

Risk Group	Enrollment	Med	NEMT	Rx	Capitation	Net Reinsurance	Other Medical Expenditures	Other Pharmacy Expenditures	TPR - Medical	TPR - Rx	Total Benefit Cost
MDCP	16,871	$191,097,656	$47,114	$22,274,258	$34,193	$4,458	$708,968	$2,313	$0	-$350,956	$214,168,960
IDD	10,419	$22,774,101	$27,597	$5,144,404	$19,626	$2,500	$89,886	-$1,269	$0	-$95,757	$28,056,844
YES	2,646	$3,631,948	$4,644	$884,165	$5,126	$672	$36,948	-$59	$0	-$1,177	$4,563,445
Under Age 1	1,748	$10,405,322	$2,892	$1,526,865	$2,689	$303	$53,041	-$230	$0	-$227	$11,990,881
Age 1 to 5	47,607	$119,659,077	$87,136	$12,114,017	$97,630	$10,511	$689,012	-$44	$0	-$24,701	$132,657,340
Age 6 to 14	217,117	$153,544,997	$282,439	$46,201,909	$492,192	$50,816	$1,297,901	-$13,519	$0	-$172,775	$201,856,735
Age 15 to 20	173,485	$90,184,930	$228,781	$40,522,331	$365,161	$35,721	$866,028	-$25,580	$0	-$127,703	$132,177,373
Total	**469,893**	**$591,298,030**	**$680,604**	**$128,667,949**	**$1,016,618**	**$104,982**	**$3,741,784**	**-$38,387**	**$0**	**-$773,296**	**$725,471,579**

Footnotes:

1. In Table 1, enrollment data was summarized based on the SFY 2022 MCO supplemental data report.
2. In Table 1, expenditure data was calculated based on the MCO supplemental expenditure data as reported by MCOs to the Commission using the Commission's prescribed MCO supplemental data reporting template.
3. In Table 1, base period lag expenditure data (Med, NEMT, Rx) was calculated based on the monthly expenditure data as reported in SFY22 MCO supplemental data reported with runout through February 2023.
4. In Table 1, base period non-lag expenditure data (Capitation, Net Reinsurance Cost, Other Medical Expenditure, and Other Pharmacy Expenditure) was calculated using the expenditure data as reported in the SFY22 (9/1/2021-8/31/2022) MCO. supplemental data report with runout through February 2023
5. In Table 1, 'Other Medical Expenditures' is net of reported quality improvement expenditures to the extent applicable as we will review this component together with the service coordination component and the administrative cost component of the rate.
6. In Table 2, FQHC wrap payments will be accounted in non-base component of the capitation rates and are therefore excluded from the base expenditure.
7. In Table 2, IBNR is meant to account for any unpaid amounts for claims incurred in the base period as of February 2023.
8. In Table 2, TIPPs, RAPPs and BHS DPP are State directed provider add-on payments which are not accounted for in the main capitation rates and therefore are excluded from the base expenditure.
9. In Table 2, Capitated NEMT paid amounts are removed from the Capitation data and added into the NEMT base data.
10. The NEMT expenditures reflected in Tables 1 through 3 are based on July 2022 through December 2022 data, which is the base period used by the Commission for the NEMT rate component.
**NOTE: Totals do not tie out with the sum of each risk group because TCHP provided TPR in aggregate for the entire SDA (no risk group level information was submitted).*

Exhibit 13
Texas Managed Medicaid Capitation Rate Review
STAR Program - Trend Development
Historical Annual Trend in Total Medical PMPM (Adjusted for Programmatic Changes)

	Risk Groups						
Year Ending	**Under Age 1**	**1 to 5**	**6 to 14**	**15 to 20**	**TANF Adults**	**Pregnant Women**	**AAPCA[1]**
FY2017*	2.8%	-2.2%	2.3%	2.8%	4.4%	0.3%	
FY2018*	5.5%	5.6%	4.7%	2.9%	1.5%	-0.3%	
FY2019*	4.4%	6.3%	5.3%	6.1%	8.5%	0.9%	6.9%
9/2019 to 2/2020*	7.4%	11.0%	11.1%	9.9%	6.6%	2.0%	2.3%
FY2022	14.1%	15.0%	9.2%	-4.3%	-10.9%	-24.5%	4.4%
9/2022 to 12/2022	15.4%	14.0%	10.1%	-2.4%	-5.5%	-15.3%	0.7%
Selected Trend	**4.7%**	**4.3%**	**5.1%**	**4.8%**	**5.1%**	**0.5%**	**5.4%**

** Data included in selected trend.*

[1] Final trend weighted based on FY2019 and 9/19-2/20 trends only.

Exhibit 14
Texas Managed Medicaid Capitation Rate Review
STAR Health Program - Trend Development
Historical Annual Trend in Total Medical PMPM (Adjusted for Programmatic Changes)

Year Ending	Annual Trend
FY2017*	-2.8%
FY2018*	5.2%
FY2019*	9.3%
FY2020 (9/2019 to 2/2020)*	9.7%
FY2020	1.2%
FY2021	-16.7%
FY2022	-11.4%
9/2022 to 12/2022	-5.3%
Selected Trend	**4.7%**

** Data included in selected trend.*

Exhibit 15
Texas Managed Medicaid Capitation Rate Review
Dental Program - Trend Development
Historical Annual Trend in Total PMPM

Year Ending	Total
3/2017 to 2/2018*	0.3%
3/2018 to 2/2019*	0.9%
3/2019 to 2/2020*	0.3%
Selected Trend	**0.5%**

** Data included in selected trend.*

Exhibit 16
Texas Managed Medicaid Capitation Rate Review
STAR+PLUS Program - Trend Development - LTC
Historical Annual Trend in Total Medical PMPM (Adjusted for Programmatic Changes)

	Risk Groups						
Year Ending	Medicaid Only - OCC	Medicaid Only - HCBS	Dual Eligible - OCC	Dual Eligible - HCBS	Medicaid Only - Nursing Facility	Dual Eligible - Nursing Facility	MBCCP[1]
FY2017*	8.9%	6.7%	5.5%	6.4%	1.1%	1.8%	
FY2018*	3.3%	3.8%	2.3%	3.9%	1.7%	2.3%	
FY2019*	4.5%	5.9%	1.9%	4.0%	3.2%	3.2%	38.5%
9/2019 to 2/2020*	3.3%	3.0%	0.6%	1.7%	1.6%	2.2%	18.2%
FY2022*	-3.0%	3.8%	-2.0%	2.5%	0.5%	-0.3%	-4.7%
9/2022 to 12/2022*	0.4%	2.6%	2.7%	2.1%	-2.3%	-0.4%	-2.5%
Selected Trend	**4.2%**	**4.8%**	**2.3%**	**3.9%**	**1.6%**	**1.9%**	**3.3%**

** Data included in selected trend.*

[1] MBCCP average Pre-PHE trend set equal to the weighted average of other risk groups excluding nursing facility services due to small sample size in LTC services.

Exhibit 17
Texas Managed Medicaid Capitation Rate Review
STAR Kids Program - Trend Development
Historical Annual Trend in Total Medical PMPM (Adjusted for Programmatic Changes)

	Risk Groups						
Year Ending	**MDCP**	**IDD**	**YES**	**Under Age 1**	**Ages 1 to 5**	**Ages 6 to 14**	**Ages 15 to 20**
FY2015*	8.2%	11.0%	-1.9%	-3.2%	5.9%	4.0%	1.5%
FY2016*	5.2%	8.9%	14.9%	0.3%	8.3%	8.7%	2.5%
FY2019*	10.2%	7.6%	7.6%	26.1%	4.6%	2.4%	7.1%
9/2019 to 2/2020*	8.4%	4.2%	2.7%	-21.6%	7.3%	4.4%	8.6%
FY2022*	4.1%	-0.5%	5.4%	17.4%	-1.6%	0.9%	-9.4%
9/2022 to 12/2022*	3.3%	-6.4%	0.5%	-1.1%	-1.1%	1.0%	-7.9%
Selected Trend	**7.1%**	**6.8%**	**5.9%**	**5.4%**	**5.1%**	**4.1%**	**4.4%**

** Data included in selected trend, except Ages 15-20 included only pre-PHE trends (i.e., did not use FY2022 or 9/2022 to 12/2022 trends).*

Exhibit 18
Texas Managed Medicaid Capitation Rate Review
Dual Demonstration Program
Historical Annual Acute Care Trend

	Risk Groups		
Year Ending	**OCC**	**HCBS**	**Nursing Facility**
3/2017 to 2/2018*	2.6%	3.0%	1.5%
3/2018 to 2/2019*	6.9%	5.0%	2.1%
3/2019 to 2/2020*	4.2%	3.0%	0.7%
9/2021 to 8/2022*	-4.5%	-2.4%	1.2%
Selected Trend	**2.3%**	**2.1%**	**1.4%**

** Data included in selected trend.*

Exhibit 19
Texas Managed Medicaid Capitation Rate Review
STAR Program - Trend Development
Historical Annual Trend in Total Pharmacy PMPM (Adjusted for Programmatic Changes)

	Risk Groups						
Year Ending	Under Age 1	1 to 5	6 to 14	15 to 20	TANF Adults	Pregnant Women	AAPCA[1]
3/2016 to 2/2017	-6.5%	-8.5%	-2.2%	-1.7%	9.4%	17.0%	
3/2017 to 2/2018*	3.9%	1.3%	0.3%	1.4%	8.0%	4.8%	
3/2018 to 2/2019*	-6.5%	-1.3%	-1.0%	0.2%	10.0%	-2.3%	2.1%
3/2019 to 2/2020*	-1.5%	-0.1%	1.0%	3.8%	5.0%	-0.4%	-3.0%
3/2020 to 2/2021							-23.3%
3/2021 to 2/2022							0.7%
9/2022 to 2/2023							10.0%
Selected Trend	**-2.3%**	**-0.3%**	**0.2%**	**2.2%**	**7.1%**	**-0.2%**	**-1.3%**

** Data included in selected trend.*

[1] Based on six-month periods from September through February; Final trend based on different weighted average.

Exhibit 20
Texas Managed Medicaid Capitation Rate Review
STAR Health Program - Trend Development
Historical Annual Trend in Total Pharmacy PMPM (Adjusted for Programmatic Changes)

Year Ending	Annual Trend
3/2016 to 2/2017	-5.4%
3/2017 to 2/2018*	-1.2%
3/2018 to 2/2019*	3.8%
3/2019 to 2/2020*	0.9%
Selected Trend	**1.6%**

** Data included in selected trend.*

Exhibit 21
Texas Medicaid Managed Care Rate Review
STAR+PLUS Program - Trend Development
Historical Annual Trend in Total Pharmacy PMPM (Adjusted for Programmatic Changes)

	Risk Groups				
Year Ending	**OCC**	**HCBS**	**IDD**	**NF**	**MBCCP[1]**
3/2016 to 2/2017	6.7%	4.9%	1.4%	-2.2%	
3/2017 to 2/2018*	6.5%	6.5%	1.9%	0.9%	
3/2018 to 2/2019*	5.1%	3.8%	7.9%	2.2%	34.7%
3/2019 to 2/2020*	3.6%	3.9%	3.8%	-1.0%	14.5%
3/2020 to 2/2021	-1.8%	-2.2%	-2.2%	-8.9%	2.9%
3/2021 to 2/2022	-2.4%	-0.3%	3.9%	0.2%	1.2%
3/2022 to 2/2023*	2.8%	4.0%	4.1%	1.8%	10.6%
Selected Trend	**4.2%**	**4.2%**	**4.7%**	**0.7%**	**19.1%**

** Data included in selected trend.*

[1] Based on six-month periods from September through February; Final trend based on different weighted average.

Exhibit 22
Texas Medicaid Managed Care Rate Review
STAR Kids Program - Trend Development
Historical Annual Trend in Total Pharmacy PMPM (Adjusted for Programmatic Changes)

	Risk Groups						
Year Ending	**MDCP**	**IDD**	**YES**	**Under Age 1**	**Ages to 5**	**Ages 6 to 14**	**Ages 15 to 20**
3/2016 to 2/2017	6.3%	2.7%	-16.2%	2.5%	10.3%	0.0%	-5.0%
3/2017 to 2/2018*	11.1%	5.1%	-5.8%	41.3%	11.8%	4.7%	9.8%
3/2018 to 2/2019*	21.4%	6.7%	0.0%	3.9%	9.8%	2.4%	5.4%
3/2019 to 2/2020*	4.4%	9.1%	-2.9%	-14.5%	-5.0%	-1.3%	2.2%
3/2020 to 2/2021	7.6%	-4.3%	-33.1%	-5.0%	-10.5%	-12.6%	-4.2%
3/2021 to 2/2022	6.8%	2.0%	0.7%	32.2%	1.7%	4.1%	-1.0%
3/2022 to 2/2023*	3.3%	1.4%	13.4%	-5.9%	-7.1%	5.6%	1.4%
Selected Trend	**9.4%**	**6.4%**	**0.8%**	**-0.8%**	**0.8%**	**1.8%**	**4.5%**

** Data included in selected trend, except Ages 15 to 20 included only pre-PHE trends (i.e., did not use 3/2022 to 2/2023 trend).*

Exhibit 23
Texas Medicaid Managed Care Rate Review
STAR Program - Programmatic Adjustment Development
Summary of FY 2024 Programmatic Adjustments

Adjustment Description	Adjustment Category	Statewide Adjustment Factor	Minimum Adjustment Factor (at SDA / Risk Group level)	Maximum Adjustment Factor (at SDA / Risk Group level)	Adjustment Factor Variance (Largest minus Smallest)	Level of Review
Medical Rate Component Programmatic Adjustments						
PHE Related Cost Adj*	Public Health Emergency	21.75%	0.00%	108.12%	108.12%	Methodology review
Removal of FQHC Wrap	Wrap and Carve-Out Removal	-3.21%	-16.48%	-0.13%	16.36%	Reconciliation to MCO submissions
Evaluation and Mgt Reim	Provider Reimbursement Adj	0.77%	0.00%	1.41%	1.41%	Reasonableness
Rural Hospital OP	Provider Reimbursement Adj	0.29%	-0.03%	2.90%	2.93%	Reasonableness
Standard Dollar Amount	Inpatient Reimbursement Adj	0.24%	-0.30%	5.11%	5.41%	Reasonableness
Vaccine Administration	Other Rating Adjustments	0.23%	0.01%	0.72%	0.71%	Reasonableness
Related Parties	Inpatient Reimbursement Adj	-0.14%	-5.62%	0.00%	5.62%	Reasonableness
Noninvasive Prenatal Screening Reimbursement Adjustment	Provider Reimbursement Adj	0.09%	0.00%	1.13%	1.13%	Reasonableness
Birth and Womens Health Related Surgery Reimbursement Adjustments	Provider Reimbursement Adj	0.08%	0.00%	0.54%	0.54%	Reasonableness
QI - PPR Reduction	Inpatient Reimbursement Adj	-0.08%	-0.41%	-0.01%	0.40%	Reasonableness
OP BH Reimbursement	Provider Reimbursement Adj	0.07%	0.00%	0.48%	0.48%	Reasonableness
Ground Ambulance Reimbursement Adjustment	Provider Reimbursement Adj	0.04%	0.01%	0.15%	0.14%	Reasonableness
PPC Adjustment	Inpatient Reimbursement Adj	-0.03%	-1.12%	0.76%	1.88%	Reasonableness
Invalid CAD Encounters	Other Rating Adj	-0.03%	-0.40%	0.00%	0.40%	Reasonableness
Private Duty Nursing (PDN)	Provider Reimbursement Adj	0.02%	0.00%	0.52%	0.52%	Reasonableness
PPR Reduction	Inpatient Reimbursement Adj	0.02%	-0.29%	0.42%	0.71%	Reasonableness
Prescribed Pediatric Extended Care Centers Reimbursement Adjustment	Provider Reimbursement Adj	0.01%	0.00%	0.30%	0.30%	Reasonableness
Removal of IMD	Other Rating Adj	-0.01%	-0.28%	0.03%	0.31%	Reasonableness
Pharmacy Rate Component Programmatic Adjustments						
PHE Related Cost Adj*	Public Health Emergency	12.67%	0.00%	63.29%	63.29%	Methodology review
Insulin Reimbursement Change	Other reimbursement changes	-2.57%	-7.11%	0.00%	7.11%	Reasonableness
Makena Formulary Adjustment	Other reimbursement changes	-1.29%	-17.79%	0.00%	17.79%	Reasonableness
IMD Adjustment	Other reimbursement changes	0.00%	-0.10%	0.00%	0.10%	Reasonableness
NEMT Rate Component Programmatic Adjustments						
Mileage Reimbursement	Other reimbursement changes	0.85%	0.05%	4.28%	4.23%	General Review

** The Commission did not include statewide adjustment factors for these programmatic adjustments in the rate certification. The statewide factors shown in this table were calculated by Milliman based on the SDA and risk group level factors and base period incurred claims distribution as provided by the Commission in the review process.*

Exhibit 24
Texas Managed Medicaid Capitation Rate Review
STAR Health Program - Programmatic Adjustment Development
Summary of FY 2024 Programmatic Adjustments

Adjustment Description	Statewide Adjustment Factor	Level of Review
Medical Rate Component Programmatic Adjustments		
PHE Related Cost Adjustment	16.58%	Methodology review
Provider Reimbursement Adjustment	0.38%	Reasonableness
Hospital Reimbursement Adjustment	-0.47%	Reasonableness
Pharmacy Rate Component Programmatic Adjustments		
PHE Related Cost Adjustment	15.63%	Methodology review
Insulin Reimbursement Change	-0.74%	Reasonableness
Makena Formulary Change	-0.03%	Reasonableness
NEMT Rate Component Programmatic Adjustments		
Mileage Reimbursement	2.11%	General review

Exhibit 25
Texas Medicaid Managed Care Rate Review
Dental Program - Programmatic Adjustment Development
Summary of FY 2024 Programmatic Adjustments

Adjustment Description	Minimum Adjustment Factor (at SDA / Risk Group level)	Maximum Adjustment Factor (at SDA / Risk Group level)	Adjustment Factor Variance (Largest minus Smallest)	Level of Review
PHE Related Cost Adjustment	0.00%	8.64%	8.64%	Methodology review
FQHC Wrap Payment Rate Adjustment	-1.38%	-0.51%	0.87%	Reconciliation to DHMO submissions

Exhibit 26
Texas Medicaid Managed Care Rate Review
STAR+PLUS Program - Programmatic Adjustment Development
Summary of FY 2024 Programmatic Adjustments

Adjustment Description*	Statewide Adjustment Factor	Minimum Adjustment Factor (at SDA / Risk Group level)	Maximum Adjustment Factor (at SDA / Risk Group level)	Adjustment Factor Variance (Largest minus Smallest)	Level of Review
Medical Rate Component Programmatic Adjustments					
Attendant Care Reimbursement	10.59%	0.00%	24.14%	24.14%	Reasonableness
IMD Adjustment - Medical	-0.95%	-2.31%	0.00%	2.31%	Reasonableness
PHE Cost Adjustment - Acute Care and Long Term Care**	0.90%	0.00%	16.96%	16.96%	Methodology Review
FQHC Wrap Removal	-0.85%	-4.95%	0.00%	4.95%	Reasonableness
Nursing Facility Patient Liability	-0.85%	-2.48%	0.00%	2.48%	Methodology Review
QI - PPR	-0.37%	-0.98%	0.00%	0.98%	Reasonableness
Rural Hospital OP Reimbursement	0.32%	-0.55%	1.89%	2.44%	Reasonableness
Standard Dollar Amount	0.20%	-0.51%	2.18%	2.69%	Reasonableness
Leap Year	0.12%	0.00%	0.27%	0.27%	Reasonableness
Ground Ambulance	0.09%	0.00%	0.28%	0.28%	Reasonableness
Invalid CAD Encounters	-0.08%	-1.22%	0.00%	1.22%	Reasonableness
Nursing Facility Reimbursement	0.07%	-1.07%	1.39%	2.46%	Reasonableness
OP BH Reimbursement	0.06%	0.00%	0.30%	0.30%	Reasonableness
MAT Reimbursement	0.03%	0.00%	0.35%	0.35%	Reasonableness
PPC Reimbursement Reduction	-0.02%	-0.38%	0.54%	0.92%	Reasonableness
Vaccine Administration	0.02%	0.00%	0.06%	0.06%	Reasonableness
PPR Reimbursement Reduction	-0.01%	-0.30%	0.27%	0.57%	Reasonableness
Birth and Women's Related Health Surgery	0.01%	0.00%	0.03%	0.03%	Reasonableness
Non-Invasive Perinatal Screening	0.00%	0.00%	0.01%	0.01%	Reasonableness
Pharmacy Rate Component Programmatic Adjustments					
Insulin	-3.04%	-8.24%	0.00%	8.24%	Reasonableness
PHE Cost Adjustment - Rx**	2.34%	0.00%	12.44%	12.44%	Methodology Review
IMD Adjustment - Rx	-0.13%	-0.72%	0.00%	0.72%	Reasonableness
Makena Formulary Change	-0.01%	-0.06%	0.00%	0.06%	Reasonableness
NEMT Rate Component Programmatic Adjustments					
Mileage Reimbursement	0.35%	0.00%	3.90%	3.90%	Reasonableness

** The adjustment descriptions are consistent with the titles of the Comission's exhibits included in the FY 2024 rate certification.*

*** The Commission did not include statewide adjustment factors for these programmatic adjustments in the rate certification. The statewide factors shown in this table were calculated by Milliman based on the SDA and risk group level factors and base period incurred claims distribution as provided by the Commission in the review process.*

Exhibit 27
Texas Medicaid Managed Care Rate Review
STAR Kids Program - Programmatic Adjustment Development
Summary of FY 2024 Programmatic Adjustments

Adjustment Description*	Statewide Adjustment Factor	Minimum Adjustment Factor (at SDA / Risk Group level)	Maximum Adjustment Factor (at SDA / Risk Group level)	Adjustment Factor Variance (Largest minus Smallest)	Level of Review
Medical Rate Component Programmatic Adjustments					
PHE Related Cost Adjustment**	2.15%	0.00%	7.94%	7.94%	Methodology Review
Attendant Care Reimbursement	1.73%	0.00%	5.57%	5.57%	Reasonableness
Private Duty Nursing Reimbursement	0.67%	0.00%	1.35%	1.35%	Reasonableness
FQHC Wrap Removal	-0.42%	-3.10%	0.00%	3.10%	Reasonableness
Evaluation and Management Reimbursement	0.19%	0.04%	1.03%	0.99%	Reasonableness
QI - PPR	-0.15%	-2.08%	0.00%	2.08%	Reasonableness
Related Party Removal	-0.08%	-7.51%	0.00%	7.51%	Reasonableness
PPEC Reimbursement	0.07%	0.00%	0.81%	0.81%	Reasonableness
Ground Ambulance	0.05%	0.00%	2.08%	2.08%	Reasonableness
Standard Dollar Amount	-0.04%	-2.02%	0.94%	2.96%	Reasonableness
PPC Reimbursement Reduction	-0.04%	-1.66%	0.56%	2.22%	Reasonableness
Rural Hospital OP Reimbursement	0.04%	-0.02%	0.75%	0.77%	Reasonableness
OP BH Reimbursement	0.03%	0.00%	0.37%	0.37%	Reasonableness
Invalid CAD Encounters	-0.02%	-0.68%	0.00%	0.68%	Reasonableness
Vaccine Administration	0.02%	0.00%	0.11%	0.11%	Reasonableness
PPR Reimbursement Reduction	0.00%	-0.23%	0.24%	0.47%	Reasonableness
Non-Invasive Perinatal Screening	0.00%	0.00%	0.04%	0.04%	Reasonableness
Pharmacy Rate Component Programmatic Adjustments					
PHE Related Cost Adjustment - Rx**	3.96%	0.00%	8.87%	8.87%	Methodology Review
Insulin Reimbursement Change	-0.74%	-4.50%	0.00%	4.50%	Reasonableness
Makena Non-Formulary Adjustment	0.00%	-0.05%	0.00%	0.05%	Reasonableness
NEMT Rate Component Programmatic Adjustments					
Mileage Reimbursement	1.65%	0.00%	4.13%	4.13%	Reasonableness

** The adjustment descriptions are consistent with the titles of the Comission's exhibits included in the FY 2024 rate certification.*

*** The Commission did not include statewide adjustment factors for these programmatic adjustments in the rate certification. The statewide factors shown in this table were calculated by Milliman based on the SDA and risk group level factors and base period incurred claims distribution as provided by the Commission in the review process.*

APPENDIX A

STAR

APPENDIX A: STAR

PROGRAM OVERVIEW

The STAR managed care program, which consists of 16 MCOs across 13 SDAs, covers the greatest number of Texans with Medicaid.[1] The STAR population includes low-income children, pregnant women, and families.[2] Members in the STAR program, who select their health plan from one of the approved MCOs,[3] have access to acute care Medicaid benefits, such as:

- Regular checkups with the doctor
- Prescription drugs and vaccines
- Hospital care and services
- X-rays and lab tests
- Vision and hearing care
- Access to medical specialists and mental health care
- Treatment of special health needs and pre-existing conditions[4]

Some STAR members with special health care needs may receive additional service management to assist with the coordination of Medicaid and non-Medicaid benefits.[5]

The STAR managed care program is estimated to cover roughly 3.5 million beneficiaries in FY 2024 at a program cost of roughly $10.8 billion (excluding directed payments).

[1] STAR Medicaid Managed Care Program, Texas Health and Human Services, Retrieved from: STAR Medicaid Managed Care Program | Texas Health and Human Services.
[2] Ibid.
[3] Ibid.
[4] Ibid.
[5] Ibid.

APPENDIX A: STAR

RATE STRUCTURE

We evaluated the Commission's rate structure for the FY 2024 capitation rate development for the STAR program by reviewing the actuarial report and rate development model created by the Commission.

Description of State Fiscal Year (FY) 2024 Rate Structure

In general, the Commission developed MCO specific capitation rates at a risk group and service delivery area (SDA) level for the STAR population.

Risk Groups

The Commission segmented members into one of eight risk groups as part of the rate structure based on their anticipated risk acuity and cost differences based on the member's following characteristics:

- Children Under Age 1
- Children Ages 1 to 5
- Children Ages 6 to 14
- Children Ages 15 to 18
- Children Ages 19 to 20
- Temporary Assistance for Needy Families (TANF) Adults
- Pregnant Women
- Adoption Assistance or Permanency Care Assistance (AAPCA)

The Commission noted that Children Ages 19 to 20 are combined with Children Ages 15 to 18 for rate development due to the small number of members and significant cost variation in the older age group, so the FY 2024 capitation rates are developed for a total of seven risk groups.

Service Delivery Areas (SDAs)

The Commission segmented the state into the following 13 county and regional-based SDAs as part of the rate structure to account for regional cost variations:

- Bexar County Service Area - San Antonio
- Dallas County Service Area - Dallas
- El Paso County Service Area - El Paso
- Harris County Service Area - Houston
- Hidalgo County Service Area - Brownsville
- Jefferson County Service Area - Beaumont
- Lubbock County Service Area - Lubbock
- Nueces County Service Area - Corpus Christi
- Tarrant County Service Area - Fort Worth
- Travis County Service Area - Austin
- Medicaid Rural Service Area - Central (MRSA Central)
- Medicaid Rural Service Area - Northeast (MRSA Northeast)
- Medicaid Rural Service Area - West (MRSA West)

Rate Development Process

The Commission followed the following steps to develop all FY 2024 rates:

- Step One: Develop MCO-specific FY 2024 capitation rates using each MCO's projected experience by SDA, risk group, and the following service groupings:
  - Medical
  - Pharmacy
  - Non-emergency transportation (NEMT)

  The capitation rate developed by the Commission for each service grouping includes service costs and non-benefit expenses (e.g., administrative costs). This step encompasses the majority of the rate development process and is described throughout the remainder of the report.

- Step Two: Aggregate the MCO specific capitation rates for each service grouping into community rates (the average capitation rate across all MCOs) for each SDA and risk group based upon the projected MCO enrollment mix. The Commission used their judgement to determine if the underlying data at a risk group and SDA level was fully credible to calculate capitation rates.

  - For the STAR program, the AAPCA risk group was defined as not credible at the SDA level for NEMT services due to the small amount of claims experience. Therefore, the NEMT rates are developed at a statewide level without SDA level variations.

- Step Three: Adjust the community rates for each MCO using risk adjustment to reflect the expected acuity differences by MCO due to the underlying health conditions of the members in each plan. Risk scores were applied to the community rate for each service grouping as follows:

  - Medical: The Commission removes delivery costs (i.e., costs related to childbirth) from the capitation rates, since these costs are reflected in Delivery Service Payments (DSP) developed at the SDA level that are intended to be budget neutral to the STAR program (i.e., the total projected cost of the program is unaffected). The DSPs are paid to the MCOs for each delivery, as opposed to capitation rates, which are paid on a per member basis. The Commission engages the University of Florida's Institute for Child Health Policy (ICHP) to develop MCO risk scores using the Chronic Illness and Disability Payment System (CDPS), which are applied to the capitation rates net of delivery costs.

  - Pharmacy: The same risk scores applied to the medical community rate are applied to the pharmacy community rate.

  - NEMT: No risk adjustment is applied to the NEMT community rate.

  The Commission applied risk scores on a budget neutral basis at the risk group level across the MCOs in a given SDA, ensuring that additional funding is not introduced or removed from the program due to the application of the risk scores.

  A review of the risk adjustment methodologies, including the DSPs, is not included in the scope of our review of the FY 2024 Texas Medicaid managed care capitation rates, since risk adjustment and DSP adjustments are applied on a budget neutral basis, meaning they do not increase or decrease the total program funding, just the allocation of payments across MCOs within a risk group***.***

- Step Four: Calculate the final adjusted premium rate by combining the medical and pharmacy service groupings at the SDA and risk group level separately for individual MCO projected experience (Step One) and risk-adjusted community projected experience (Step Three). The Commission set each MCO's specific capitation rate (across all service groupings) for a risk group in a given SDA as the NEMT community rate plus the minimum of a) 108% of the total MCO-specific capitation rate for the medical and pharmacy service groupings and (b) the total risk adjusted community rate for the medical and pharmacy service groupings.

- Step Five: Add MCO specific amounts to the capitation rates by risk group and SDA for the following directed payment programs in the STAR program.

  - Network Access Improvement Program (NAIP)
  - Comprehensive Hospital Increase Reimbursement Program (CHIRP)
  - Texas Incentives for Physicians and Professional Services (TIPPS)
  - Directed Payment Program for Behavioral Health Services (DPP BHS)
  - Rural Access to Primary and Preventative Services (RAPPS)

  A review of the development of directed payment programs is not included in the scope of our review of the FY 2024 Texas Medicaid managed care capitation rates since directed payment programs are separately developed, reviewed, and funded outside the standard capitation rate development process.

- Step Six: Apply experience rebates to each MCO across all managed care programs and SDAs based on the Financial Statistical Reports (FSRs).

  - For FY 2024, each MCO is subject to an experience rebate based on the MCO's Financial Statistical Reports (FSRs) across all managed care programs and SDAs using the following parameters. The experience rebate limits the amount of profit (i.e., pre-tax income) an MCO can retain to no more than 7.2% of revenues.

APPENDIX A: STAR

Table 1 Texas Medicaid Managed Care Rate Review STAR Program – Rate Structure FY 2024 Experience Rebate Parameters		
Pre-Tax Income as a % of Revenues	**MCO Share**	**Commission's 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%

APPENDIX A: STAR

BASE DATA DEVELOPMENT

We reviewed the base data component of the FY 2024 capitation rates based on the underlying data provided by the Commission and our understanding of the Commission's FY 2024 base data development approach, as described below. The Commission provided all information we requested.

Description of State Fiscal Year (FY) 2024 Base Data Development

For a more detailed description of what base data is and why it matters, please see the Review Process section of the Main Report. Our detailed understanding of the base data development is summarized below for each major component of the FY 2024 capitation rate setting process:

Base Data Selection

- The Commission selected FY 2022 (September 2021 through August 2022) as the base period for both the enrollment data and the service expenditure data for the medical and pharmacy rate components. The Commission selected July 2022 through December 2022 as the base period for both the enrollment and service expenditure data for the NEMT rate component. The populations and services covered by the STAR program during FY 2024 are generally the same as those covered by the STAR program during the selected base period.

- The Commission provided a monthly enrollment file, which was used as the primary data source for base period enrollment data. This file summarizes monthly enrollment counts at an SDA, risk group, and MCO level, but does not provide individual membership records for each beneficiary.

- The managed care organizations ("MCOs") reported supplemental medical and pharmacy expenditure data in a prescribed reporting template, as designed by the Commission, which the Commission used as the primary data source for base period expenditure data. The data in this submission is not provided at a detailed claim level, but rather includes summarized monthly expenditure amounts by SDA and risk group for the following categories of service:

  - Professional
  - Outpatient Facility Emergency Room ("ER")
  - Outpatient Facility Non-ER
  - Inpatient Facility
  - Other Acute Care
  - Pharmacy
  - Non-Emergency Medical Transportation ("NEMT")

  For the categories of service above, the MCOs provided the data to the Commission in a "lag" format, which reports claim costs by the combination of the month the service was performed ("incurred month") and the month in which payment was made to the provider ("paid month"). Additional "non-lag" information was provided by the MCOs in the supplementary reporting for the following costs:

  - Monthly utilization metrics for the same categories of service in the lag data
  - Monthly capitation payments made from the MCO to a sub-capitated provider at a risk group level
  - Large claim reports for members with costs exceeding $500,000
  - Reinsurance arrangements
  - Monthly third party reimbursement by risk group
  - Monthly other direct service expenses by risk group

Base Data Validation

The Commission performed the following validations of the MCO supplemental data prior to relying on this data for the development of the base data for FY 2024.

- The Commission reconciled MCO reported supplemental data to the MCO reported Financial Statistical Reports ("FSR") expenditures for consistency in aggregate and by risk group at the MCO and SDA level for the base period (FY 2022). The FSRs are self-reported data prepared by the MCOs under the terms and conditions of the Uniformed Managed Care Contract and the Uniform Managed Care Manual. For more information on the FSRs please refer to the Texas Health and Human Services website.[6]

[6] Medicaid & CHIP Financial Statistical Reports: Fiscal Year 2022: Sept. 1, 2021, to Aug. 31, 2022, Texas Health and Human Services, Retrieved from: Medicaid & CHIP Financial Statistical Reports | Texas Health and Human Services.

- The Commission reconciled the MCO reported supplemental lag expenditure data and the FSR data to the Commission's encounter data at the risk group level for FY 2022 separately for all MCO and SDA combinations.

Multiple entities audit the data sources used to validate the MCO supplemental data.

- University of Florida's Institute for Child Health Policy ("ICHP"), the External Quality Review Organization ("EQRO") vendor for Texas, is contracted to reconcile and validate the encounter data prior to releasing the encounter data to the Commission.
- The Office periodically audits the FSRs for a selected MCO and Program. Historically this audit has only been performed for the STAR+PLUS and STAR Kids programs.
- The Commission additionally contracts with external auditors to perform agreed-upon procedure ("AUP") engagements of the FSRs. These AUP engagements occur more than two years after the end of the state fiscal year.

Base Data Adjustments

- For expenditures paid through the claims system, also referred to as "lag expenditures" in this report, the Commission made the following explicit adjustments:
  - The paid expenditures as of February 2023 for the base period (FY 2022) were adjusted for claims that have been incurred but not reported ("IBNR").
  - Special adjustments were applied, as applicable, on an MCO-specific basis for lag expenditures. For example, TCHP in Harris SDA owns and operates its own patient-centered medical home ("PCMH"). The rate development uses a hybrid cost that is weighted 75% on the PCMH cost allocation methodology and 25% on the FFS equivalent cost. Both cost structures are included in the MCO supplemental data submission, and the Commission used the hybrid cost in the rate development.
- For expenditures paid outside claims system, also referred to as "non-lag expenditures" in this report, the Commission made the following adjustments:
  - Sub-capitation expenditures are costs for which the MCO subcontracts with a third party to provide specific services in exchange for a fixed monthly premium per member. The contract between the MCO and the subcontractor defines whether the premiums are the same for all members or if they vary based on risk group, SDA, or other characteristics.
    - When explicitly reported by MCOs, the Commission removed the administrative portion of the sub-capitated expenditures from the base data.
    - When applicable, the Commission replaced actual premiums paid to subcontracted third parties during the base period with the most current premium amounts available.
    - The Commission excluded the fixed month premium payments to a third-party subcontractor from the rate development costs for an MCO that subcontracts with a related party. Instead, the Commission included the actual payments to providers from the MCO lag data in the projected claim costs for this MCO.
  - Net reinsurance cost is the total cost of premiums paid by MCOs to reinsurers less claim payments received from reinsurers. A reinsurer will provide insurance to an MCO to protect the MCO against higher-than-expected claim experience. Some MCOs in the STAR program choose to purchase reinsurance, but reinsurance is not required by the STAR program.
    - The Commission capped reported net reinsurance costs to be no greater than $0.50 per member per month ("PMPM"), as applicable.
  - Other itemized expenditures and / or recoveries:
    - Federally qualified health centers ("FQHCs") receive additional "wrap payments" from the MCOs in addition to their contracted MCO reimbursement rates to ensure total FQHC funding is consistent with statutorily defined minimum funding levels. The MCOs are not at-risk for the wrap payments, so

the wrap payment costs are excluded from the capitation rate development. The Commission accounted for the wrap payment exclusion through the programmatic adjustment component of the rates, so the Commission did not include the FQHC wrap payment adjustment in the base data development.

- The Commission excluded reported state directed payments, which are listed in the Rate Structure section of this appendix. The Commission accounted for these payments outside the main capitation rates as special rate adjustments.

- For third party reimbursements ("TPR"), which are reported in a standalone section of the MCO supplemental data separate from lag expenditures and non-lag expenditures, the Commission removed the TPR from the base data if the reported TPR amounts were confirmed to not be included in other expenses reported in the MCO supplemental data. The Commission validated the MCO reporting of TPR based on reconciliations between the MCO supplemental data and the FSRs.

- The Commission did not adjust the base data to remove costs that are not covered by the program but are included in the data sources. Instead, the Commission removed these costs through programmatic adjustments.

Base Data Aggregation

- Aggregation of MCO-specific base data for community base data development:

  - The Commission's base data used to develop community rates for each risk group within each SDA was calculated by aggregating MCO-specific base period PMPMs as incurred in the base period using each MCO's projected enrollment for FY 2024.

Data Provided for Base Data Development Review

We received the following primary data items from the Commission for the base data development review:

- A copy of the source data used by the Commission to develop the final base data for Travis SDA, as Milliman's selected sample SDA for in-depth base data review and replication for the STAR program:

  - MCO FSRs:

    - FY 2022 90 day (September 2021 through August 2022) with runout through November 2022

  - MCO supplemental expenditure data:

    - September 2019 through February 2023

  - The Commission provided summarized monthly enrollment files by each MCO and risk group:

    - Actual enrollment was provided for the period from September 2012 to February 2023

    - Projected enrollment was provided for the period from March 2023 to August 2028

- A copy of the Commission's base data development working files for all MCO and SDA combinations:

  - Lag expenditure completion and adjustment file, which includes the development of final lag base data at the SDA, MCO, and risk group level for lag expenditures:

    - Estimates of IBNR claims for expenditures reported through payment lags in the MCO supplemental expenditure data

    - Special adjustments, as limited to a few plans on a case-by-case basis, to the expenditures reported through payment lags in the MCO supplemental expenditure data

  - Non-lag expenditure calculation and adjustment file, which includes the development of final non-lag base data at the SDA, MCO, and risk group level for expenditures paid outside lags:

    - The PMPM calculation for each itemized expenditure not reported through payment lags in the MCO supplemental expenditure data
    - Certain reported non-lag expenditures that were excluded from the base data development

- A copy of the Commission's base data expenditure reconciliation files for all MCOs and all SDAs:
    - A comparison of reported total expenditures at the MCO level across all risk groups in each SDA between the MCO FSR and MCO supplemental expenditure data for FY 2022
    - A comparison of reported lag expenditures at the MCO and risk group level in each SDA across the Commission-provided encounters, MCO FSRs, and MCO supplemental expenditure data for FY 2022
- The Commission's documentation of base data development in the FY 2024 actuarial report
- The Commission's responses to ad hoc questions from Milliman

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TREND

We reviewed the trend component of the FY 2024 capitation rates based on the underlying data provided by the Commission and our understanding of the Commission's FY 2024 trend development approach, as described below. The Commission provided all information we requested.

Description of State Fiscal Year (FY) 2024 Trend Development

Our detailed understanding of the trend development for FY 2024 capitation rates is summarized below.

Data Used for Trend Development

The Commission used the following data to support the final trends:

Medical Trends

For all risk groups other than AAPCA:

- Monthly historical PMPM medical claim experience from the 3.5 years of STAR program experience prior to the beginning of the COVID-19 PHE (September 2016 through February 2020) summarized by risk group and SDA. The Commission used PMPM level data without separate utilization and unit cost detail to develop the selected medical trends.
- Annual adjustment factors for material medical programmatic changes from FY 2017 through FY 2020, including:
  - Provider reimbursement changes
  - Other programmatic changes

For AAPCA, the Commission used the data above beginning September 2017 or FY 2018, when the AAPCA risk group coverage became effective under the STAR program.

Pharmacy Trends

For all risk groups other than AAPCA:

- Historical PMPM pharmacy claim experience for the last five 12-month periods prior to the COVID-19 PHE (March 2015 through February 2020) by risk group and month, excluding the following costs:
  - Drugs carved out of managed care for FY 2024 (i.e., costs are reimbursed directly to providers by the State through FFS Medicaid coverage and are not included in the managed care program)
  - Drugs covered under managed care, but reimbursed to MCOs separate from the capitation rates on a non-risk basis (i.e., non-risk arrangements)
  - The drug Orkambi
  - Anti-viral and progestational agent drug classes

  Historical claim payment amounts were adjusted to reflect managed care pharmacy reimbursement provisions. Historical data was summarized separately for utilization and unit cost.
- Adjustment factors for material preferred drug list (PDL) changes from FY 2018 through FY 2020

For AAPCA, the Commission used the data above beginning September 2017 or FY 2018, when the AAPCA risk group coverage became effective under the STAR program.

NEMT Trends

- Historical PMPM NEMT managed transportation organization (MTO)[7] claims for demand response services[8] (i.e., non-fixed route transportation systems that require advanced scheduling by the individual customer) for the last four 12-month periods prior to the COVID-19 PHE (March 2016 through February 2020), adjusted as follows:
  - The Commission excluded MTO Regions 1 and 10 due to changes in MTOs in September 2017.
  - The Commission excluded MTO Region 4 because the NEMT services were provided FFS.
  - The Commission applied adjustments to Regions 6 through 9, 11, and 13 to account for provider reimbursement changes (Regions 6 through 8 and 11), the impact of Hurricane Harvey in 2017 (Regions 9 and 13), and a stretcher service policy change in November 2016 (Region 13).
- Consumer Price Index – All Urban Consumers (CPI) for transportation services from March 2009 through February 2020 published by the Bureau of Labor Statistics (BLS)

Normalization Process

Medical Trends

The Commission performed the following steps to normalize medical trends to adjust for historical programmatic changes:

- The Commission calculated the incurred medical claims PMPM by risk group and SDA for FY 2017 through FY 2019 and for the six-month periods from September 2018 through February 2019 (i.e., the first half of FY 2019, or "FY 2019 H1") and September 2019 through February 2020 ("FY 2020 H1").
- The Commission multiplied the SDA level incurred medical claims PMPM by programmatic change adjustment factors so the year-to-year values could be evaluated on a consistent basis for measuring trend without the influence of other change drivers.
- The Commission calculated SDA-specific PMPM trends as the percentage change in PMPM values (adjusted for programmatic changes) from year 1 to year 2.

Pharmacy Trends

The Commission excluded certain costs covered under the capitation rates from the pharmacy trend analysis because they drove material one-time impacts on costs (e.g., progestational agents) or they are historically volatile and expected to remain volatile on an ongoing basis (e.g., anti-viral treatments that fluctuate based on the intensity of the flu season). In addition, the Commission performed the following steps to normalize pharmacy trends to adjust for historical PDL changes:

- The Commission calculated the statewide incurred pharmacy claims PMPM (inclusive of all drug types, but net of excluded costs mentioned above), allocated to utilization (defined as "days supply") PMPM and unit cost (defined as "incurred claims per days supply"), by risk group for each 12-month period from March 2016 through February 2020.
- The Commission multiplied the statewide incurred pharmacy claims per days supply by the annual PDL adjustment factors. The adjusted incurred claims per days supply estimate the unit costs that would have been incurred based on the PDL in effect prior to March 2017.
  - The Commission assumed costs for drugs that were not assumed to be explicit replacements for other drugs (e.g., emerging therapies that have been added to the PDL) are the same as the actual incurred costs.

[7] NEMT services were provided by MTOs prior to June 1, 2021; services areas under the MTO program were defined differently than under the MCO contracts.
[8] "Demand response" is any non-fixed route system of transporting individuals that requires advanced scheduling by the customer, including services provided by public entities, nonprofits, and private providers. (49 C.F.R Section 604.3(g)). Examples can be found at https://www.transit.dot.gov/sites/fta.dot.gov/files/docs/Demand_Response_Fact_Sheet_Final_with_NEZ_edits_02-13-13.pptx

- The Commission calculated the annual statewide utilization and unit cost trends as the year-over-year percentage change in days supply PMPM and adjusted incurred claims per days supply, respectively.

NEMT Trends

The Commission did not apply any normalization adjustments for the NEMT trend analysis.

Aggregation

Medical Trends

The Commission aggregated all historical SDA specific PMPM trends into one single historical statewide PMPM trend. The Commission calculated the single historical statewide PMPM trend as the dollar weighted average of the thirteen historical SDA specific PMPM trends using adjusted year 1 expenditures as weights. For example, if one trend data point is measured from FY 2018 to FY 2019, the medical costs by SDA in FY 2018 are used to weight the SDA specific trends into the statewide trend.

Pharmacy and NEMT Trends

The Commission does not use SDA-level trends to develop pharmacy or NEMT trends. Therefore, the Commission's trend development for these components does not require additional aggregation steps.

Final Selection of Trend Assumptions

Medical Trends

The Commission calculates the statewide medical annual trend at the risk group level by weighting the historical annual statewide trends for each risk group as follows:

Table 2
Texas Medicaid Managed Care Rate Review
STAR Program - Trend Development
Weighting of Historical Trends for Final Medical Trend Calculation

Trend Denominator	Trend Numerator	Weight in Overall Trend Calculation
All Risk Groups Other than AAPCA		
FY 2016	FY 2017	28.57% = 12 / 42 months
FY 2017	FY 2018	28.57% = 12 / 42 months
FY 2018	FY 2019	28.57% = 12 / 42 months
FY 2019 H1	FY 2020 H1	14.29% = 6 / 42 months
AAPCA		
FY 2018	FY 2019	66.67% = 12 / 18 months
FY 2019 H1	FY 2020 H1	33.33% = 6 / 18 months

Pharmacy Trends

The Commission calculates the statewide pharmacy annual utilization and unit cost trends at the risk group level by weighting the historical annual statewide utilization and unit cost trends for each risk group as follows:

Table 3
Texas Medicaid Managed Care Rate Review
STAR Program – Trend Development
Weighting of Historical Trends for Final Pharmacy Trend Calculation

Trend Denominator	Trend Numerator	Weight in Overall Trend Calculation
All Risk Groups Other than AAPCA		
March 2016 through February 2017	March 2017 through February 2018	16.67% = 1 / 6
March 2017 through February 2018	March 2018 through February 2019	33.33% = 2 / 6
March 2018 through February 2019	March 2019 through February 2020	50.00% = 3 / 6
AAPCA		
September 2017 through February 2018	September 2018 through February 2019	33.33% = 1 / 3
September 2018 through February 2019	September 2019 through February 2020	66.67% = 2 / 3

The Commission then calculates the statewide pharmacy PMPM trend as the cumulative impact of the selected utilization and unit cost trends. The Commission uses the following standard algebraic formula to calculate the PMPM trend:

PMPM trend = (1 + utilization trend) * (1 + unit cost trend) - 1

NEMT Trends

The Commission selected the NEMT annual trend assumption for all risk groups using an equal 50% weight for the experience-based trend assumption developed from MTO historical data and a 50% weight for an industry trend assumption.

- The Commission's experience-based trend assumption is equal to the average of the historical annual statewide trends for the 12-month periods beginning March 2016 through February 2020 using managed care experience.
- The Commission's industry trend assumption is equal to the sum of an inflation trend and a utilization trend:
  - The inflation trend is equal to the average year-over-year trend in CPI for each month over ten years ending February 2020.
  - The utilization trend is selected by the Commission.

Data Provided for Trend Review

We received the following primary data items from the Commission for the trend development review:

- Historical medical claim experience for September 2019 through February 2023 by risk group, SDA, and month:
  - Incurred claims in total and PMPM
- A copy of the Commission's medical trend development working files for all risk group and SDA combinations, including:
  - Summarized FY 2020 – FY 2023 (through February 2023) managed care PMPM trends
  - Programmatic adjustment factors for material changes between FY 2021 and FY 2023
  - Calculation of final trends based on a weighted average of historical annual trends in incurred claims PMPM adjusted for material programmatic changes
- The Commission's documentation of trend development in the FY 2024 actuarial report
- The Commission's responses to ad hoc questions

We also relied on the following additional information provided by the Commission for our FY 2023 rate review:

- Historical medical claim experience for September 2017 through August 2019 by risk group, SDA, and month:
  - Incurred claims in total and PMPM
- Historical pharmacy claim experience for March 2012 through February 2022 by drug type (brand, generic, or specialty), risk group, and month including:
  - Total utilization and utilization PMPM classified by days supply and scripts
  - Total incurred claims and incurred claims PMPM
  - Incurred claims per days supply

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- A copy of the Commission's FY 2023 medical trend development working files for all risk group and SDA combinations, including:
  - Summarized FY 2017 – FY 2019 managed care PMPM trends
  - Programmatic adjustment factors for material changes between FY 2017 and FY 2020
  - Calculation of final trends based on a weighted average of historical annual trends in incurred claims PMPM adjusted for material programmatic changes
- A copy of the Commission's FY 2023 pharmacy trend development working files for all risk group and SDA combinations, including:
  - For each risk group, all risk groups combined program-wide, and all risk groups combined program-wide calibrated to reflect the projected FY 2023 enrollment by risk group:
    - Annual utilization trends PMPM by drug type for the 12-month periods beginning March 2013 through February 2022; utilization trends were provided for both number of scripts and days supply
    - Annual incurred cost trends by drug type for the 12-month periods beginning March 2013 through February 2022; incurred cost trends were provided both PMPM and per days supply
  - Generic dispensing rate in days supply:
    - By risk group
    - For all risk groups combined program-wide
    - For all risk groups combined calibrated to reflect the projected FY 2023 enrollment mix by risk group
  - Calculation of final FY 2023 PMPM trends by risk group based on a weighted average of historical annual trends in incurred claims PMPM adjusted for PDL changes

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PROGRAMMATIC ADJUSTMENTS

We reviewed the programmatic adjustment component of the FY 2024 capitation rates based on the underlying data provided by the Commission and our understanding of the Commission's FY 2024 programmatic adjustment development approach, as described below. The Commission provided all information we requested.

Description of State Fiscal Year (FY) 2024 Programmatic Adjustment Development

The Commission developed and applied programmatic adjustments separately for each itemized change as applicable to the FY 2024 capitation rates, but the Commission's general approach was similar for each change. Our detailed understanding of the programmatic adjustment development is summarized below.

Data Used for Programmatic Adjustment Development

Based on the assessed impact and overall risk to the capitation rate setting process, we did not perform a full replication of the programmatic adjustments. Therefore, we may not have identified every data source used by the Commission to develop these programmatic adjustment factors. The key data sources identified through our review include:

- Encounter data
- MCO supplemental expenditure data submissions and FSRs
- Historical provider and facility reimbursement levels and anticipated future changes to reimbursement levels through FY 2024, including:
  - Medicaid fee schedules
  - DRG groupers
- Historical preferred drug lists (PDLs) and anticipated changes to the PDL through FY 2024

Programmatic Adjustment Factor Development Approach

The Commission applied 23 programmatic adjustments in the FY 2024 STAR program capitation rate development, including:

- 18 adjustments to the medical rate component
- 4 adjustments to the pharmacy rate component
- 1 adjustment to the NEMT rate component

The Commission developed most programmatic adjustment factors at the SDA and risk group level, except where otherwise noted below. The approaches used by the Commission to develop these programmatic adjustment factors varied, but they were generally calculated as the estimated change in claim amounts between the base period and FY 2024 divided by the final base period claims for the following broad categories, as categorized by the Commission:

- *Provider reimbursement adjustments*, such as changes to physician and outpatient fee schedules
- *Other reimbursement changes*, such as removal of non-covered services and significant changes to insulin list prices
- *Inpatient reimbursement changes*, such as hospital fee schedule changes, related party adjustments, and hospital quality initiatives
- *Wrap and carve-out removal*, for costs reported in the base period data that are not covered by the managed care capitation rates in FY 2024
- *PHE adjustment*, to account for the impact of PHE-related disenrollments prior to and during FY 2024

As described in the Base Data Development section of this Appendix, the Commission removed certain costs that are not covered by the program (e.g., not covered by Medicaid, reimbursed directly by the State to the provider) or are covered by non-risk arrangements (i.e., the MCO is fully reimbursed by the State), but are included in the base data, through programmatic adjustments. The adjustments for these costs are often reflected in the wrap and carve-out removals, as well as some of the other reimbursement changes. The adjustments for costs not covered by the STAR program capitation rates include:

- Medical costs for invalid clinician administered drugs (CADs)
- Medical and pharmacy costs for managed care members ages 21 through 64 who have an Institution for Mental Diseases stay in excess of 15 days during any month
- Medical costs for federally qualified health centers ("FQHC") wrap payments

The Commission developed the PHE related cost adjustment by estimating the full impact of the PHE on acuity using two distinct approaches and blending the resulting adjustment factors. The Commission then weighted the blended adjustment factor based on the portion of FY 2024 that the PHE-related members are assumed to be enrolled. The following steps were performed for each risk group and SDA combination:

- Cohort Method:
  - The Commission received IDs from HHS Forecasting of members expected to be disenrolled before the end of FY 2024 due to the expiration of the PHE. The Commission then calculated the base period PMPM costs excluding the members expected to be disenrolled ("cohort PMPM").
  - The Commission set the "cohort method adjustment factor" equal to the cohort PMPM divided by the actual base period PMPM, but not less than 1.0.

$$cohort\ method\ adjustment\ factor = \frac{cohort\ PMPM}{base\ period\ PMPM}$$

- Non-utilizer Method:
  - The Commission calculated the percentage of months where members had $0 claims in both the base period and in the last 12-month period prior to the PHE (March 2019 through February 2020).
  - The Commission calculated the average base period PMPM costs including only months where a member had claims (i.e., excluding months with $0 claims).
  - The Commission calculated an adjusted base period PMPM assuming percentage of months with $0 claims in the base period was the same as the percentage in the last 12-month period prior to the PHE ("non-utilizer PMPM").
  - The Commission set the non-utilizer method adjustment factor equal to the non-utilizer PMPM divided by the actual base period PMPM, but not less than 1.0.

$$non\text{-}utilizer\ method\ adjustment\ factor = \frac{non\text{-}utilizer\ PMPM}{base\ period\ PMPM}$$

- Weighting factor:
  - The Commission estimated the total disenrollment based on the change in forecast enrollment from May 2023 to August 2024. The Commission calculated the monthly net change in enrollment from May 2023 through each month of FY 2024 based on the enrollment forecast.
  - The Commission calculated the "cumulative disenrollment percentage" each month as the cumulative net change in forecast enrollment from May 2023 divided by the total estimated disenrollment.
  - The Commission calculated the weighting factor by multiplying the cumulative disenrollment percentage by the forecast enrollment in each month of FY 2024, adding these factors together, and dividing by the total FY 2024 forecast enrollment. This calculation is intended to represent the estimated percentage of FY 2024 that potentially ineligible members will be enrolled.

$$weighting\ factor = \sum_{month=Sep\ 2023}^{Aug\ 2024} cumulative\ disenrollment\ percentage * forecast\ enrollment$$

  - For risk group and SDA combinations where forecast enrollment as of August 2024 is greater than forecast enrollment as of May 2023, the weighting factor is set equal to 0%.

- The Commission calculated the final PHE adjustment factor as 1 plus the weighting factor multiplied by the average of the cohort method adjustment factor and the non-utilizer method adjustment factor.

$$final\ PHE\ adjustment\ factor = 1 + weighting\ factor\ (\frac{cohort\ factor + non\text{-}utilizer\ factor}{2})$$

Data Provided for Programmatic Adjustment Review

We received the following primary data items from the Commission for the programmatic adjustment review:

- Draft and final versions of the programmatic adjustment development exhibits included in the rate certification
- A copy of the Commission's PHE adjustment development working files
- An adjustment factor summary document prepared by the Commission to describe the programmatic adjustments
- MCO supplemental expenditure data submissions and FSRs used in the base data development
- The Commission's documentation of the programmatic adjustment factor development in the FY 2024 actuarial report
- The Commission's responses to ad hoc questions from Milliman

NON-BENEFIT EXPENSES

We reviewed the non-benefit expense component of the FY 2024 capitation rates based on the underlying data provided by the Commission and our understanding of the Commission's FY 2024 non-benefit expense development approach, as described below. The Commission provided all information we requested.

Description of State Fiscal Year (FY) 2024 Non-Benefit Expense Development

Our detailed understanding of the non-benefit expense development for FY 2024 capitation rates is summarized below.

Data Used for Non-Benefit Expense Development

The Commission's non-benefit expense assumption is the sum of the following components:

- Administrative expense load, including general and quality improvement expenses
- Risk margin
- Taxes, including premium and maintenance taxes

The Commission's final non-benefit expenses were calculated separately for each service grouping (i.e., medical, pharmacy, and NEMT) using the same assumptions as in the prior year's rate development, as shown in Table 4.

Table 4
Texas Medicaid Managed Care Rate Review
STAR Program - Non-Benefit Expense
FY 2024 Non-Benefit Expense Assumption Development

Service Grouping	Medical	Pharmacy	NEMT
Administrative Expenses	$9.00 PMPM + 5.25% of gross premium	$1.60 PMPM	$0.175 PMPM + 22% of gross premium
Risk Margin	1.5% of gross premium	1.5% of gross premium	1.5% of gross premium
Taxes	$0.0725 PMPM + 1.75% of gross premium	1.75% of gross premium	1.75% of gross premium

The Commission allocated the $9.00 PMPM medical administrative expense load as follows:

- $6.00 for general administration expenses
- $3.00 for quality improvement expenses

The Commission only reflected the $0.0725 PMPM maintenance tax in the medical component of the rates because it is assessed based on the number of enrollees.

Data Provided for Non-Benefit Expense Review

We received the following primary data items from the Commission for the non-benefit expense development review:

- A copy of the Commission's historical administrative expense PMPM analysis
- A copy of the Commission's final rate development exhibits
- The Commission's documentation of non-benefit expense development in the FY 2024 actuarial report
- The Commission's responses to ad hoc questions

In addition, we reviewed the publicly available Texas Department of Insurance taxation requirements for premium taxes[9] and maintenance taxes.[10]

[9] "Insurance Premium Tax (Licensed Insurers)," Texas Comptroller of Public Accounts, Retrieved from: https://comptroller.texas.gov/taxes/insurance/licensed.php.
[10] "Insurance Maintenance Tax Rates and Assessments on 2021 Premiums," Texas Comptroller of Public Accounts, Retrieved from: https://comptroller.texas.gov/taxes/publications/94-130.php; "Adopted assessment, exam fee and maintenance tax rates," Texas Department of Insurance, Retrieved from: https://www.tdi.texas.gov/company/taxes3.html.

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CMS COMPLIANCE AND DOCUMENTATION

We reviewed the Commission's FY 2024 rate certification for compliance with the CMS 2023-2024 Medicaid managed care rate setting guidance,[11] as described below.

Description of State Fiscal Year (FY) 2024 CMS Compliance and Documentation

Section I. Medicaid Managed Care Rates

The Commission included information for all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

Data – The Commission included information for all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

Projected Benefit Costs and Trends – The Commission included information for all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

Special Contract Provisions Related to Payment – The Commission included information for all portions of (A) the Incentive Arrangements section, (B) the Withhold Arrangements section, (C) the Risk-Sharing Mechanisms section, (D) the State Directed Payments section, (E) the Pass-Through Payments section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

Projected Non-Benefit Costs – The Commission included information for all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

Risk Adjustment and Acuity Adjustments – The Commission included information for all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

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

This section is not applicable to the STAR program.

Section III. New Adult Group Capitation Rates

This section is not applicable to the STAR program.

Data Provided for CMS Compliance and Documentation Review

The Commission provided us with the final FY 2024 rate certification report for the STAR program. We relied on this document, as well as the publicly available CMS 2023-2024 Medicaid Managed Care Rate Setting Guide to conduct our compliance and documentation review. We also compared the Commission's final report to the technical items we reviewed in other areas of our report to ensure the documentation accurately described the underlying rate methodology.

[11] 2023-2024 Medicaid Managed Care Rate Development Guide, Centers for Medicare & Medicaid Services, May 2023, Retrieved from: 2023-2024 Medicaid Managed Care Rate Development Guide.

APPENDIX B

STAR HEALTH

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PROGRAM OVERVIEW

The STAR Health program, which consists of one MCO contracted on a statewide basis, is managed in partnership with Texas Department of Family and Protective Services ("DFPS") to cover individuals with varying levels of DFPS involvement. Specifically, STAR Health covers following groups of individuals:

- Children in DFPS conservatorship who are under 18 years old
- Children in the Adoption Assistance or Permanency Care Assistance program who are transitioning from STAR Health to STAR or STAR Kids
- Youth aged 21 years and younger with voluntary extended foster care placement agreements ("Extended Foster Care")
- Youth aged twenty and younger who are Former Foster Care Children ("FFCC")[1]

Members in the STAR Health program have access to acute care benefits, such as:

- Regular checkups at the doctor and dentist
- Prescription drugs and vaccines
- Hospital care and services
- X-rays and lab tests
- Vision and hearing care
- Access to medical specialists and mental health care
- Treatment of special health needs and pre-existing conditions
- A 24/7 nurse hotline for caregivers and caseworkers
- Access to the Health Passport, a patient-centered and internet based electronic health record[2]

The STAR Health program is estimated to cover roughly 39,000 beneficiaries in FY 2024 at a program cost of roughly $459 million.

[1] STAR Health, Texas Health and Human Services, Retrieved from: STAR Health | Texas Health and Human Services.
[2] Ibid.

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RATE STRUCTURE

We evaluated the Commission's rate structure for the FY 2024 capitation rate development for the STAR Health program by reviewing the actuarial report and rate development model created by the Commission.

Description of State Fiscal Year (FY) 2024 Rate Structure

In general, the Commission developed capitation rates at the program level for the STAR Health population. The STAR Health program is administered by a single MCO.

Risk Groups

The Commission includes all members of the STAR Health program in one risk group.

Service Delivery Areas (SDAs)

The Commission developed the STAR Health capitation rates at the program level. The rates do not differ by the 13 county and regional-based SDAs, as in other Texas Medicaid managed care programs.

Rate Development Process

The Commission followed the following steps to develop all FY 2024 rates:

- Step One: Develop FY 2024 capitation rates for the STAR Health program by the following service groupings:
  - Medical
  - Pharmacy
  - Non-emergency transportation (NEMT)

  The capitation rate developed by the Commission for each service grouping includes service costs and non-benefit expenses (e.g., administrative costs). This step encompasses the majority of the rate development process and is described throughout the remainder of the report.
- Step Two: Determine the final capitation rate as follows:
  - The final adjusted premium is equal to the sum of the capitation rates for the medical, pharmacy and NEMT service groupings.
- Step Three: Apply experience rebates to the MCO across all managed care programs and SDAs based on the Financial Statistical Reports (FSRs).
  - For FY 2024, the MCO is subject to an experience rebate based on the MCO's Financial Statistical Reports (FSRs) across all managed care programs and SDAs using the following parameters. The experience rebate limits the amount of profit (i.e., pre-tax income) the MCO can retain to no more than 7.2% of revenues.

Table 1
Texas Medicaid Managed Care Rate Review
STAR Health Program – Rate Structure
FY 2024 Experience Rebate Parameters

Pre-Tax Income as a % of Revenues	MCO Share	Commission's 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%

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BASE DATA DEVELOPMENT

We reviewed the base data component of the FY 2024 capitation rates based on the underlying data provided by the Commission and our understanding of the Commission's FY 2024 base data development approach, as described below. The Commission provided all information we requested.

Description of State Fiscal Year (FY) 2024 Base Data Development

For a more detailed description of what base data is and why it matters, please see the Review Process section of the Main Report. Our detailed understanding of the base data development is summarized below for each major component of the FY 2024 capitation rate setting process:

Base Data Selection

- The Commission selected FY 2022 (September 2021 through August 2022) as the base period for both the enrollment data and the service expenditure data for the medical and pharmacy rate components. The Commission selected July 2022 through December 2022 as the base period for both the enrollment and service expenditure data for the NEMT rate component. The populations and services covered by the STAR Health program during FY 2024 are generally the same as those covered by the STAR Health program during the selected base period.

- The Commission provided a monthly enrollment file, which was used as the primary data source for base period enrollment data. This file summarizes monthly enrollment counts but does not provide individual membership records for each beneficiary.

- The managed care organization ("MCO") reported supplemental medical and pharmacy expenditure data in a prescribed reporting template, as designed by the Commission, which the Commission used as the primary data source for base period expenditure data. The data in this submission is not provided at a detailed claim level, but rather includes summarized monthly expenditure amounts for the following categories of service:

  - Professional
  - Outpatient Facility Emergency Room ("ER")
  - Outpatient Facility Non-ER
  - Inpatient Facility
  - Other Acute Care
  - Pharmacy
  - Non-Emergency Medical Transportation ("NEMT")

  For the categories of service above, the MCOs provided the data to the Commission in a "lag" format, which reports claim costs by the combination of the month the service was performed ("incurred month") and the month in which payment was made to the provider ("paid month"). Additional "non-lag" information was provided by the MCO in the supplementary reporting for the following costs:

  - Monthly utilization metrics for the same categories of service in the lag data
  - Monthly capitation payments made from the MCO to a sub-capitated provider at a risk group level
  - Large claim reports for members with costs exceeding $500,000
  - Reinsurance arrangements
  - Monthly third party reimbursement by risk group
  - Monthly other direct service expenses by risk group

Base Data Validation

The Commission performed the following validations of the MCO supplemental data prior to relying on this data for the development of the base data for FY 2024.

- The Commission reconciled the MCO reported supplemental data to the MCO reported Financial Statistical Reports ("FSR") expenditures for overall consistency in aggregate for the base period (FY 2022). The FSRs are self-reported data prepared by the MCOs under the terms and conditions of the Uniformed Managed Care Contract and the Uniform Managed Care Manual. For more information on the FSRs please refer to the Texas Health and Human Services website.[3]

[3] Medicaid & CHIP Financial Statistical Reports: Fiscal Year 2022: Sept. 1, 2021, to Aug. 31, 2022, Texas Health and Human Services, Retrieved from: Medicaid & CHIP Financial Statistical Reports | Texas Health and Human Services.

- The Commission reconciled the MCO reported supplemental lag expenditure data and the FSR data to the Commission's encounter data at the risk group level for FY 2022.

Multiple entities audit the data sources used to validate the MCO supplemental data.

- University of Florida's Institute for Child Health Policy (ICHP), the EQRO vendor for Texas, is contracted to reconcile and validate the encounter data prior to releasing the encounter data to the Commission.
- The Office periodically audits the FSRs for a selected MCO and Program. Historically this audit has only been performed for the STAR+PLUS and STAR Kids programs.
- The Commission additionally contracts with external auditors to perform agreed-upon procedure ("AUP") engagements of the FSRs. These AUP engagements occur more than two years after the end of the state fiscal year.

Base Data Adjustments

- For expenditures paid through the claims system, also referred to as "lag expenditure" in this report, the Commission made the following explicit adjustments:
  - The paid expenditures as of February 2023 for the base period (FY 2022) were adjusted for claims which have been incurred but not reported ("IBNR").
- For expenditures paid outside claims system, also referred to as "non-lag expenditures" in this report, the Commission made the following adjustments:
  - Sub-capitation expenditures are costs for which the MCO subcontracts with a third party to provide specific services in exchange for a fixed monthly premium per member. The contract between the MCO and the subcontractor defines whether the premiums are the same for all members or if they vary based on risk group, SDA, or other characteristics.
    - When applicable, the Commission replaced actual premiums paid to subcontracted third parties during the base period with the most current premium amounts available.
    - The Commission used lag expenditures for vision claims in place of the actual base period premiums paid to the vision subcontractor because the vendor is a related party to the MCO.
  - Net reinsurance cost is the total cost of premiums paid by MCOs to reinsurers less claim payments received from reinsurers. A reinsurer will provide insurance to an MCO to protect the MCO against higher-than-expected claim experience. The MCO in the STAR Health program chose to purchase reinsurance, but reinsurance is not required by the STAR Health program.
    - The Commission excluded reported net reinsurance costs from the rate development.
  - Other itemized expenditures and / or recoveries:
    - Federally qualified health centers ("FQHCs") receive additional "wrap payments" from the MCO in addition to their contracted MCO reimbursement rates to ensure total FQHC funding is consistent with statutorily defined minimum funding levels. The MCO is not at-risk for the wrap payments, so the wrap payment costs are excluded from the capitation rate development. The Commission accounted for the wrap payment exclusion through the programmatic adjustment component of the rates, so the Commission did not include the FQHC wrap payment adjustment in the base data development.
- For third party reimbursements ("TPR"), which are reported in a standalone section of the MCO supplemental data separate from lag expenditures and non-lag expenditures, the Commission removed the TPR from the base data if the reported TPR amounts were confirmed to not be included in other expenses reported in the MCO supplemental data. The Commission validated the MCO reporting of TPR based on reconciliations between the MCO supplemental data and the FSRs.
- The Commission did not adjust the base data to remove costs that are not covered by the program but are included in the data sources. Instead, the Commission removed these costs through programmatic adjustments.

APPENDIX B: STAR HEALTH

Base Data Aggregation

- Because the STAR Health program is operated by a single MCO, the Commission did not perform additional base data aggregation to reflect projected changes in MCO enrollment during FY 2024, as is done for the other Texas Medicaid managed care programs.

Data Provided for Base Data Development Review

We received the following primary data items from the Commission for the base data development review:

- A copy of the source data used by the Commission to develop the final base data for the STAR Health program:
  - MCO FSRs:
    - FY 2022 90 day (September 2021 through August 2022) with runout through November 2022
  - MCO supplemental expenditure data:
    - September 2019 through February 2023
  - The Commission provided summarized monthly enrollment files:
    - Actual enrollment was provided for the period from September 2012 through February 2023
    - Projected enrollment was provided for the period from March 2023 through August 2028
- A copy of the Commission's base data development working files:
  - Lag expenditure completion and adjustment file, which includes the development of final lag base data:
    - Estimates of IBNR claims for expenditures reported through payment lags in the MCO supplemental expenditure data
    - Special adjustments, as needed, to the expenditures reported through payment lags in the MCO supplemental expenditure data
  - Non-lag expenditure calculation and adjustment file, which includes the development of final non-lag base data:
    - The PMPM calculation for each itemized expenditure not reported through payment lags in the MCO supplemental expenditure data
    - Certain reported non-lag expenditures that were excluded from the base data development
- A copy of the Commission's base data expenditure reconciliation files:
  - A comparison of reported total expenditures between the MCO FSR and MCO supplemental expenditure data for FY 2022
  - A comparison of reported lag expenditures across the Commission-provided encounters, MCO FSRs, and MCO supplemental expenditure data for FY 2022
- The Commission's documentation of base data development in the FY 2024 actuarial report
- The Commission's responses to ad hoc questions from Milliman

APPENDIX B: STAR HEALTH

TREND

We reviewed the trend component of the FY 2024 capitation rates based on the underlying data provided by the Commission and our understanding of the Commission's FY 2024 trend development approach, as described below. The Commission provided all information we requested.

Description of State Fiscal Year (FY) 2024 Trend Development

Our detailed understanding of the trend development for FY 2024 capitation rates is summarized below.

Data Used for Trend Development

The Commission used the following data to support the final trends:

Medical Trends

- Monthly historical PMPM medical claim experience from the 3.5 years of STAR Health program experience prior to the beginning of the COVID-19 PHE (September 2016 through February 2020). The Commission used PMPM level data without separate utilization and unit cost detail to develop the selected medical trends.
- Annual adjustment factors for material medical programmatic changes from FY 2017 through FY 2020, including:
  - Provider reimbursement changes
  - Other programmatic changes

Pharmacy Trends

- Historical PMPM pharmacy claim experience for the last five 12-month periods prior to the COVID-19 PHE (March 2015 through February 2020) by month, excluding the following costs:
  - Drugs carved out of managed care for FY 2024 (i.e., costs are reimbursed directly to providers by the State through FFS Medicaid coverage and are not included in the managed care program)
  - Drugs covered under managed care, but reimbursed to MCOs separate from the capitation rates on a non-risk basis (i.e., non-risk arrangements)
  - The drug Orkambi
  - Anti-viral and progestational agent drug classes

  Historical data was summarized separately for utilization and unit cost.
- Adjustment factors for material preferred drug list (PDL) changes from FY 2018 through FY 2020

NEMT Trends

- Historical PMPM NEMT managed transportation organization (MTO)[4] claims for demand response services[5] (i.e., non-fixed route transportation systems that require advanced scheduling by the individual customer) for the last four 12-month periods prior to the COVID-19 PHE (March 2016 through February 2020), adjusted as follows:
  - The Commission excluded MTO Regions 1 and 10 due to changes in MTOs in September 2017.
  - The Commission excluded MTO Region 4 because the NEMT services were provided FFS.

[4] NEMT services were provided by MTOs prior to June 1, 2021; services areas under the MTO program were defined differently than under the MCO contracts.
[5] "Demand response" is any non-fixed route system of transporting individuals that requires advanced scheduling by the customer, including services provided by public entities, nonprofits, and private providers. (49 C.F.R Section 604.3(g)). Examples can be found at https://www.transit.dot.gov/sites/fta.dot.gov/files/docs/Demand_Response_Fact_Sheet_Final_with_NEZ_edits_02-13-13.pptx

  - The Commission applied adjustments to Regions 6 through 9, 11, and 13 to account for provider reimbursement changes (Regions 6 through 8 and 11), the impact of Hurricane Harvey in 2017 (Regions 9 and 13), and a stretcher service policy change in November 2016 (Region 13).

- Consumer Price Index – All Urban Consumers (CPI) for transportation services from March 2009 through February 2020 published by the Bureau of Labor Statistics (BLS)

Normalization Process

Medical Trends

The Commission performed the following steps to normalize medical trends to adjust for historical programmatic changes:

- The Commission calculated the statewide incurred medical claims PMPM for each 12-month period from March 2015 through February 2020.

- The Commission multiplied the program-wide medical claims PMPM by programmatic change adjustment factors, so the year-to-year values could be evaluated on a consistent basis for measuring trend without the influence of other change drivers.

- The Commission calculated the statewide PMPM trends as the percentage change in PMPM values (adjusted for programmatic changes).

Pharmacy Trends

The Commission excluded certain costs covered under the capitation rates from the pharmacy trend analysis because they drove material one-time impacts on costs (e.g., progestational agents) or they are historically volatile and expected to remain volatile on an ongoing basis (e.g., anti-viral treatments that fluctuate based on the intensity of the flu season). In addition, the Commission performed the following steps to normalize pharmacy trends to adjust for historical PDL changes:

- The Commission calculated the statewide incurred pharmacy claims PMPM (inclusive of all drug types, but net of excluded costs mentioned above), allocated to utilization (defined as “days supply”) PMPM and unit cost (defined as "incurred claims per days supply"), for each 12-month period from March 2016 through February 2020.

- The Commission multiplied the statewide incurred pharmacy claims per days supply by the annual PDL adjustment factors. The adjusted incurred claims per days supply estimate the unit costs that would have been incurred based on the PDL in effect prior to March 2017.

  - The Commission assumed costs for drugs that were not assumed to be explicit replacements for other drugs (e.g., emerging therapies that have been added to the PDL) are the same as the actual incurred costs.

- The Commission calculated the annual statewide utilization and unit cost trends as the year-over-year percentage change in days supply PMPM and adjusted incurred claims per days supply, respectively.

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NEMT Trends

The Commission did not apply any normalization adjustments for the NEMT trend analysis.

Final Selection of Trend Assumptions

Medical Trends

The Commission calculates the statewide medical annual trend by weighting the historical annual statewide trends as follows:

Table 2
Texas Medicaid Managed Care Rate Review
STAR Health Program - Trend Development
Weighting of Historical Trends for Final Medical Trend Calculation

Trend Denominator	Trend Numerator	Weight in Overall Trend Calculation
FY 2016	FY 2017	28.57% = 12 / 42 months
FY 2017	FY 2018	28.57% = 12 / 42 months
FY 2018	FY 2019	28.57% = 12 / 42 months
FY 2019 H1	FY 2020 H1	14.29% = 6 / 42 months

Pharmacy Trends

The Commission calculates the statewide pharmacy annual utilization and unit cost trends by weighting the historical annual statewide trends as follows:

Table 3
Texas Medicaid Managed Care Rate Review
STAR Health Program - Trend Development
Weighting of Historical Trends for Final Pharmacy Trend Calculation

Trend Denominator	Trend Numerator	Weight in Overall Trend Calculation
March 2016 through February 2017	March 2017 through February 2018	16.67% = 1 / 6
March 2017 through February 2018	March 2018 through February 2019	33.33% = 2 / 6
March 2018 through February 2019	March 2019 through February 2020	50.00% = 3 / 6

The Commission then calculates the statewide pharmacy PMPM trend as the cumulative impact of the selected utilization and unit cost trends. The Commission uses the following standard algebraic formula to calculate the PMPM trend:

PMPM trend = (1 + utilization trend) * (1 + unit cost trend) - 1

NEMT Trends

The Commission selected the NEMT annual trend assumption for all risk groups using an equal 50% weight for the experience-based trend assumption developed from MTO historical data and a 50% weight for an industry trend assumption.

- The Commission's experience-based trend assumption is equal to the average of the historical annual statewide trends for the 12-month periods beginning March 2016 through February 2020 using managed care experience.
- The Commission's industry trend assumption is equal to the sum of an inflation trend and a utilization trend:
  - The inflation trend is equal to the average year-over-year trend in CPI for each month over ten years ending February 2020.
  - The utilization trend is selected by the Commission.

APPENDIX B: STAR HEALTH

Data Provided for Trend Review

We received the following primary data items from the Commission for the trend development review:

- Historical medical claim experience for September 2019 through February 2023 by service category and month:
  - Incurred claims in total and PMPM
- A copy of the Commission's medical trend development working files, including:
  - Summarized FY 2020 – FY 2023 (through February 2023) managed care PMPM trends
  - Programmatic adjustment factors for material changes between FY 2021 and FY 2023
  - Calculation of final trends based on a weighted average of historical annual trends in incurred claims PMPM adjusted for material programmatic changes
- The Commission's documentation of trend development in the FY 2024 actuarial report
- The Commission's responses to ad hoc questions

We also relied on the following additional information provided by the Commission for our FY 2023 rate review:

- Historical medical claim experience for September 2018 through August 2019 by service category and month:
  - Incurred claims in total and PMPM
- Historical pharmacy claim experience for March 2012 through February 2022 by drug type (brand, generic, or specialty) and month including:
  - Total utilization and utilization PMPM classified by days supply and scripts
  - Total incurred claims and incurred claims PMPM
  - Incurred claims per days supply
- A copy of the Commission's pharmacy trend development working files, including:
  - Annual utilization trends PMPM by drug type for the 12-month periods beginning March 2015 through February 2020; utilization trends were provided for both number of scripts and days supply
  - Annual incurred cost trends by drug type for the 12-month periods beginning March 2015 through February 2020; incurred cost trends were provided both PMPM and per days supply
  - Calculation of final trends based on a weighted average of historical annual trends in incurred claims PMPM adjusted for PDL changes

APPENDIX B: STAR HEALTH

PROGRAMMATIC ADJUSTMENTS

We reviewed the programmatic adjustment component of the FY 2024 capitation rates based on the underlying data provided by the Commission and our understanding of the Commission's FY 2024 programmatic adjustment development approach, as described below. The Commission provided all information we requested.

Description of State Fiscal Year (FY) 2024 Programmatic Adjustment Development

The Commission developed and applied programmatic adjustments separately for each itemized change as applicable to the FY 2024 capitation rates, but the Commission's general approach was similar for each change. Our detailed understanding of the programmatic adjustment development is summarized below.

Data Used for Programmatic Adjustment Development

Based on the assessed impact and overall risk to the capitation rate setting process, we did not perform a full replication of the programmatic adjustments. Therefore, we may not have identified every data source used by the Commission to develop these programmatic adjustment factors. The key data sources identified through our review include:

- Encounter data
- MCO supplemental expenditure data submissions and FSRs
- Historical provider and facility reimbursement levels and anticipated future changes to reimbursement levels through FY 2023, including:
  - Medicaid fee schedules
  - DRG groupers
- Historical preferred drug lists (PDLs) and anticipated changes to the PDL through FY 2024

Programmatic Adjustment Factor Development Approach

The Commission applied 7 programmatic adjustments in the FY 2024 STAR Health program capitation rate development, including:

- 3 adjustments to the medical rate component
  - The Commission pooled the impact of 17 separate adjustments into 3 distinct adjustment factors.
- 3 adjustments to the pharmacy rate component
- 1 adjustment to the NEMT rate component

The approaches used by the Commission to develop these programmatic adjustment factors varied, but they were generally calculated as the estimated change in claim amounts between the base period and FY 2024 divided by the final base period claims for the following broad categories, as categorized by the Commission:

- *Provider reimbursement adjustments*, such as changes to physician and outpatient fee schedules, as well as removing costs reported in the base period data that are not covered by the managed care capitation rates in FY 2024
- *Hospital reimbursement changes*, such as hospital fee schedule changes and hospital quality initiatives
- *Pharmacy reimbursement changes*, such as significant changes to insulin list prices
- *NEMT reimbursement changes*, such as changes to mileage reimbursement
- *PHE adjustment*, to account for the impact of PHE-related disenrollments prior to and during FY 2024

APPENDIX B: STAR HEALTH

As described in the Base Data Development section of this Appendix, the Commission removed certain costs that are not covered by the program (e.g., not covered by Medicaid, reimbursed directly by the State to the provider) or are covered by non-risk arrangements (i.e., the MCO is fully reimbursed by the State), but are included in the base data, through programmatic adjustments. The adjustments for costs not covered by the STAR Health program capitation rates include:

- Medical costs for invalid clinician administered drugs (CADs)
- Medical costs for federally qualified health centers ("FQHC") wrap payments

The Commission developed the PHE related cost adjustment by estimating the full impact of the PHE on acuity using two distinct approaches and blending the resulting adjustment factors. The Commission then weighted the blended adjustment factor based on the portion of FY 2024 that the PHE-related members are assumed to be enrolled. The following steps were performed:

- Cohort Method:
  - The Commission received IDs from HHS Forecasting for members expected to be disenrolled before the end of FY 2024 due to the expiration of the PHE. The Commission then calculated the base period PMPM costs excluding the members expected to be disenrolled ("cohort PMPM").
  - The Commission set the "cohort method adjustment factor" equal to the cohort PMPM divided by the actual base period PMPM, but not less than 1.0.

$$cohort\ method\ adjustment\ factor = \frac{cohort\ PMPM}{base\ period\ PMPM}$$

- Non-utilizer Method:
  - The Commission calculated the percentage of months where members had $0 claims in both the base period and in the last 12-month period prior to the PHE (March 2019 through February 2020).
  - The Commission calculated the average base period PMPM costs including only months where a member had claims (i.e., excluding months with $0 claims).
  - The Commission calculated an adjusted base period PMPM assuming percentage of months with $0 claims in the base period was the same as the percentage in the last 12-month period prior to the PHE ("non-utilizer PMPM").
  - The Commission set the non-utilizer method adjustment factor equal to the non-utilizer PMPM divided by the actual base period PMPM, but not less than 1.0.

$$non\text{-}utilizer\ method\ adjustment\ factor = \frac{non\text{-}utilizer\ PMPM}{base\ period\ PMPM}$$

- Weighting factor:
  - The Commission estimated the total disenrollment based on the change in forecast enrollment from May 2023 to August 2024. The Commission calculated the monthly net change in enrollment from May 2023 through each month of FY 2024 based on the enrollment forecast.
  - The Commission calculated the "cumulative disenrollment percentage" each month as the cumulative net change in forecast enrollment from May 2023 divided by the total estimated disenrollment.
  - The Commission calculated the weighting factor by multiplying the cumulative disenrollment percentage by the forecast enrollment in each month of FY 2024, adding these factors together, and dividing by the total FY 2024 forecast enrollment. This calculation is intended to represent the estimated percentage of FY 2024 that potentially ineligible members will be enrolled.

$$weighting\ factor = \sum_{month=Sep\ 2023}^{Aug\ 2024} cumulative\ disenrollment\ percentage * forecast\ enrollment$$

  - For populations where forecast enrollment as of August 2024 is greater than forecast enrollment as of May 2023, the weighting factor is set equal to 0%.

- The Commission calculated the final PHE adjustment factor as 1 plus the weighting factor multiplied by the average of the cohort method adjustment factor and the non-utilizer method adjustment factor.

$$final\ PHE\ adjustment\ factor = 1 + weighting\ factor\ (\frac{cohort\ factor + non\text{-}utilizer\ factor}{2})$$

Data Provided for Programmatic Adjustment Review

We received the following primary data items from the Commission for the programmatic adjustment review:

- Draft and final versions of the programmatic adjustment development exhibits included in the rate certification
- A copy of the Commission's PHE adjustment development working files
- An adjustment factor summary document prepared by the Commission to describe the programmatic adjustments
- MCO supplemental expenditure data submissions and FSRs used in the base data development
- The Commission's documentation of the programmatic adjustment factor development in the FY 2024 actuarial report
- The Commission's responses to ad hoc questions from Milliman

APPENDIX B: STAR HEALTH

NON-BENEFIT EXPENSES

We reviewed the non-benefit expense component of the FY 2024 capitation rates based on the underlying data provided by the Commission and our understanding of the Commission's FY 2024 non-benefit expense development approach, as described below. The Commission provided all information we requested.

Description of State Fiscal Year (FY) 2024 Non-Benefit Expense Development

Our detailed understanding of the non-benefit expense development for FY 2024 capitation rates is summarized below.

Data Used for Non-Benefit Expense Development

The Commission's non-benefit expense assumption is the sum of the following components:

- Administrative expense load, including general and quality improvement expenses
- Risk margin
- Taxes, including premium and maintenance taxes

The Commission's final non-benefit expenses were calculated separately for each service grouping (i.e., medical, pharmacy, and NEMT) using the same assumptions as in the prior year's rate development, as shown in Table 10. These assumptions are the same as in the prior year's rate development, except the Commission changed the medical administrative expense PMPM from $30.00 to $9.00 due to their reallocation of some quality improvement expenses from the administrative expense PMPM to the service coordination PMPM.

Table 10
Texas Medicaid Managed Care Rate Review
STAR Health Program - Non-Benefit Expense
FY 2023 Non-Benefit Expense Assumption Development

Service Grouping	Medical	Pharmacy	NEMT
Administrative Expenses	$9.00 PMPM + 5.25% of gross premium	$1.60 PMPM	$0.175 PMPM + 22% of gross premium
Risk Margin	1.5% of gross premium	1.5% of gross premium	1.5% of gross premium
Taxes	$0.0725 PMPM + 1.75% of gross premium	1.75% of gross premium	1.75% of gross premium

The Commission allocated the $9.00 PMPM medical administrative expense load as follows:

- $7.00 for general administration expenses
- $2.00 for quality improvement expenses

The Commission only reflected the $0.0725 PMPM maintenance tax in the medical component of the rates because it is assessed based on the number of enrollees.

Data Provided for Non-Benefit Expense Review

We received the following primary data items from the Commission for the non-benefit expense development review:

- A copy of the Commission's historical administrative expense PMPM analysis
- A copy of the Commission's final rate development exhibits
- The Commission's documentation of non-benefit expense development in the FY 2023 actuarial report
- The Commission's responses to ad hoc questions

In addition, we reviewed the publicly available Texas Department of Insurance taxation requirements for premium taxes[6] and maintenance taxes.[7]

[6] "Insurance Premium Tax (Licensed Insurers)," Texas Comptroller of Public Accounts, Retrieved from: https://comptroller.texas.gov/taxes/insurance/licensed.php.
[7] "Insurance Maintenance Tax Rates and Assessments on 2022 Premiums," Texas Comptroller of Public Accounts, Retrieved from: https://comptroller.texas.gov/taxes/publications/94-130.php; "Adopted assessment, exam fee and maintenance tax rates," Texas Department of Insurance, Retrieved from: https://www.tdi.texas.gov/company/taxes3.html.

APPENDIX B: STAR HEALTH

CMS COMPLIANCE AND DOCUMENTATION

We reviewed the Commission's FY 2024 rate certification for compliance with the CMS 2023-2024 Medicaid managed care rate setting guidance,[8] as described below. For a full description of the approach used to review CMS compliance and documentation, please see the Review Process section in the Main Report.

Description of State Fiscal Year (FY) 2024 CMS Compliance and Documentation

Section I. Medicaid Managed Care Rates

The Commission included information for all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

Data - The Commission included information for all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

Projected Benefit Costs and Trends - The Commission included information for all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

Special Contract Provisions Related to Payment - The Commission included information for all portions of (A) the Incentive Arrangements section, (B) the Withhold Arrangements section, (C) the Risk-Sharing Mechanisms section, (D) the State Directed Payments section, (E) the Pass-Through Payments section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

Projected Non-Benefit Costs - The Commission included information for all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

Risk Adjustment and Acuity Adjustments - The Commission included information for all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

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

This section is not applicable to the STAR Health program.

Section III. New Adult Group Capitation Rates

This section is not applicable to the STAR Health program.

Data Provided for CMS Compliance and Documentation Review

The Commission provided us with the final FY 2024 rate certification report for the STAR Health program. We relied on this document, as well as the publicly available CMS 2023-2024 Medicaid Managed Care Rate Setting Guide to conduct our compliance and documentation review. We also compared the Commission's final report to the technical items we reviewed in other areas of our report to ensure the documentation accurately described the underlying rate methodology.

[8] 2023-2024 Medicaid Managed Care Rate Development Guide, Centers for Medicare & Medicaid Services, May 2023, Retrieved from: 2023-2024 Medicaid Managed Care Rate Development Guide.

APPENDIX C

DENTAL

APPENDIX C: DENTAL

PROGRAM OVERVIEW

Children and young adults have access to dental health services through the Medicaid Dental program. The Commission contracts with three Dental Health Maintenance Organizations (DHMOs), which operate similarly to the MCOs in other programs, on a statewide basis for these services. The dental policies outline the types of procedures and treatments for which the Commission will pay for specific conditions.[1] Below are several types of dental health services offered for children and young adults (through age 20) in Medicaid.[2]

Preventive Services include:

- Dental examinations, which include initial or periodic
- Cleaning, specifically prophylaxis
- Oral health education
- Application of topical fluoride
- Application of sealants to certain teeth
- Maintenance of space[3]

Treatment Services include:

- Restorations, especially fillings and crowns
- Endodontic treatment, especially pulp therapy and root canals
- Periodontic treatment, especially gum disease
- Prosthodontics, especially full or partial dentures
- Oral surgery, especially extractions
- Maxillofacial prosthetics[4]

Emergency Dental Services include:

- Procedures necessary to control bleeding, relieve pain, and eliminate acute infection
- Procedures that are required to prevent imminent loss of teeth
- Treatment of injuries to the teeth or supporting structures[5]

Orthodontic Services include (a prior authorization is needed before receiving the services):

- Correction of cleft palate
- Crossbite therapy
- Treatment for severe, handicapping malocclusion
- Treatment for facial accidents involving severe traumatic deviation[6]

The Dental program is estimated to cover roughly 3.3 million beneficiaries in FY 2024 at a program cost of roughly $1.2 billion.

[1] Medicaid Medical & Dental Policies, Texas Health and Human Services, Retrieved from: Medicaid Medical & Dental Policies | Texas Health and Human Services.
[2] Dental Providers, Texas Health and Human Services, Retrieved from: Dental Providers | Texas Health and Human Services.
[3] Ibid.
[4] Ibid
[5] Ibid.
[6] Ibid.

APPENDIX C: DENTAL

RATE STRUCTURE

We evaluated the Commission's rate structure for the FY 2024 capitation rate development for the Dental program by reviewing the actuarial report and rate development model created by the Commission.

Description of State Fiscal Year (FY) 2024 Rate Structure

In general, the Commission developed statewide Dental Health Maintenance Organization (DHMO) specific capitation rates at a risk group level for the Dental population. The Dental program covers both Medicaid and CHIP members through three DHMOs; however, the CHIP program is not within the scope of our review because it is not part of Medicaid.

Risk Groups

The Commission segmented Medicaid Dental members into one of five risk groups as part of the rate structure based on their anticipated risk acuity and cost differences based on the member's following characteristics:

- Children Under Age 1
- Children Ages 1 to 5
- Children Ages 6 to 14
- Children Ages 15 to 18
- Children Ages 19 to 20

Service Delivery Areas (SDAs)

The Commission developed Dental capitation rates at a statewide level. The rates do not differ by the 13 county and regional-based SDAs, as in other programs.

Rate Development Process

The Commission followed the following steps to develop all FY 2024 rates:

- Step One: Develop FY 2024 capitation rates for each DHMO by risk group. The capitation rates developed by the Commission include service costs and non-benefit expenses (e.g., administrative costs). This step encompasses the majority of the rate development process and is described throughout the remainder of the report.

- Step Two: Aggregate the DHMO specific capitation rates into community rates (the average capitation rate across all DHMOs) for each risk group based upon the projected DHMO enrollment mix. The Commission used their judgement to determine if the underlying data at a risk group level was fully credible to calculate capitation rates. For the Dental program, all risk groups were determined to be credible at the statewide level.

- Step Three: Adjust the community rates to reflect the expected acuity differences between the new DHMO added September 2020 and the two continuing DHMOs. The Commission developed risk scores and applied the risk scores to the community rate.

  - The Commission evaluated the average PMPM in each risk group during the base period (FY 2022) for (1) the new DHMO added to the Dental program as of September 2020, (2) for the two continuing DHMOs combined, and (3) across all three DHMOs.

  - The Commission calculated the full acuity adjustment for each risk group and DHMO as the ratio of the FY 2022 PMPM for the new DHMO or the continuing DHMOs combined, respectively, divided by the statewide FY 2022 PMPM.

  - The Commission applied a 50% credibility factor to the full acuity adjustments with the other 50% weight applied to 1.000 (i.e., no acuity adjustment).

  - The adjusted acuity factors were recalibrated to be budget neutral (i.e., the total projected cost of the program is unaffected) for each risk group in the Medicaid Dental program.

  - The risk score calculation is illustrated for the sample risk group Ages 6 to 14 in Table 1.

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Table 1 Texas Medicaid Managed Care Rate Review Dental Program - Rate Structure FY 2024 Risk Score Development					
			(1) New DHMO	(2) Existing DHMOs	(3) All DHMOs Combined
Average PMPM - FY 2022	i		$25.74	$26.05	$26.03
Acuity Factor	ii	= i (1) *or* i (2) / i (3)	0.98875	1.00072	
Credibility Blended Acuity Factor	iii	= ii * 50% + 1 * 50%	.99437	1.00036	
Budget Neutral Factor	iv		1.00013	1.00013	
Budget Neutral Acuity Adjustment	**v**	**= iii * iv**	**0.99451**	**1.00049**	

The Commission applied risk scores on a budget neutral basis at the risk group level across the DHMOs, ensuring that additional funding is not introduced or removed from the program due to the application the risk scores.

A review of the risk adjustment methodologies is not included in the scope of our review of the FY 2024 Texas Medicaid managed care capitation rates, since risk adjustment is applied on a budget neutral basis, meaning it does not increase or decrease the total program funding, just the allocation of payments across DHMOs within a risk group***.***

- Step Four: Apply experience rebates based on the Financial Statistical Reports (FSRs).
  - For FY 2024, the Commission incorporated experience rebates based on the Financial Statistical Reports (FSRs). The experience rebates vary by DHMO and limit the amount of profit (i.e., pre-tax income) a DHMO can retain. According to the Commission's rate certification, the revised structure for FY 2023 will limit the maximum DHMO profit to between 3.6% and 4.5% of premiums.

APPENDIX C: DENTAL

BASE DATA DEVELOPMENT

We reviewed the base data component of the FY 2024 capitation rates based on the underlying data provided by the Commission and our understanding of the Commission's FY 2024 base data development approach, as described below. The Commission provided all information we requested.

Description of State Fiscal Year (FY) 2024 Base Data Development

For a more detailed description of what base data is and why it matters, please see the Review Process section of the Main Report. Our detailed understanding of the base data development is summarized below for each major component of the FY 2024 capitation rate setting process:

Base Data Selection

- The Commission selected FY 2022 (September 2021 through August 2022) as the base period for both the enrollment data and the service expenditure data.
- The Commission provided a monthly enrollment file, which was used as the primary data source for base period enrollment data. This file summarizes monthly enrollment counts at a risk group and DHMO level, but does not provide individual membership records for each beneficiary.
- The dental health maintenance organizations ("DHMOs") reported supplemental medical expenditure data in a prescribed reporting template, as designed by the Commission, which the Commission used as the primary data source for base period expenditure data. The data in this submission is not provided at a detailed claim level, but rather includes summarized monthly expenditure amounts by risk group for the following categories of service:
  - Diagnostic
  - Preventive
  - Restorative
  - Orthodontic
  - All Other

  For the categories of service above, the DHMOs provided the data to the Commission in a "lag" format, which reports claim costs by the combination of the month the service was performed ("incurred month") and the month in which payment was made to the provider ("paid month"). Additional "non-lag" information was provided by the DHMOs in the supplementary reporting for the following costs:
  - Monthly utilization metrics for the same categories of service in the lag data
  - Monthly other direct service expenses by risk group

Base Data Validation

The Commission performed the following validations of the DHMO supplemental data prior to relying on this data for the development of the base data for FY 2024.

- The Commission reconciled DHMO reported supplemental data to the DHMO reported Financial Statistical Reports ("FSR") expenditures for overall consistency in aggregate across all risk groups at the DHMO level for the base period (FY 2022). The FSRs are self-reported data prepared by the DHMOs under the terms and conditions of the Uniformed Managed Care Contract and the Uniform Managed Care Manual. For more information on the FSRs, please refer to the Texas Health and Human Services website.[7]
- The Commission reconciled the DHMO reported supplemental lag expenditure data and the FSR data to the Commission's encounter data at the risk group level for FY 2022 separately for all DHMOs.

[7] Medicaid & CHIP Financial Statistical Reports: Fiscal Year 2022: Sept. 1, 2021, to Aug. 31, 2022, Texas Health and Human Services, Retrieved from: Medicaid & CHIP Financial Statistical Reports | Texas Health and Human Services.

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Multiple entities audit the data sources used to validate the DHMO supplemental data.

- University of Florida's Institute for Child Health Policy ("ICHP"), the EQRO vendor for Texas, is contracted to reconcile and validate the encounter data prior to releasing the encounter data to the Commission.
- The Office periodically audits the FSRs for a selected MCO (or DHMO) and Program. Historically this audit has only been performed for the STAR+PLUS and STAR Kids programs.
- The Commission additionally contracts with external auditors to perform agreed-upon procedure ("AUP") engagements of the FSRs. These AUP engagements occur more than two years after the end of the state fiscal year.

Base Data Adjustments

- Since the Commission develops DHMO-specific rates based on each DHMO's individual base period experience, the Commission applied all base data adjustments at the DHMO level.
- For expenditures paid through the claims system, also referred to as "lag expenditure" in this report, the Commission made the following explicit adjustments:
  - The paid expenditures as of February 2022 for the base period (FY 2022) were adjusted for claims which have been incurred but not reported ("IBNR").
- For expenditures paid outside claims system, also referred to as "non-lag expenditures" in this report, the Commission made the following adjustments:
  - Sub-capitation expenditures are costs for which the DHMO subcontracts with a third party to provide specific services in exchange for a fixed monthly premium per member. The contract between the DHMO and the subcontractor defines whether the premiums are the same for all members or if they vary based on risk group or other characteristics.
    - When explicitly reported by DHMOs, the Commission removed the administrative portion of the sub-capitated expenditures from the base data.
    - When applicable, the actual premiums paid to subcontracted third parties during the base period were replaced with the most current premium amounts available.
  - Other itemized expenditures and / or recoveries:
    - Federally qualified health centers ("FQHCs") receive additional "wrap payments" from the DHMOs in addition to their contracted DHMO reimbursement rates to ensure total FQHC funding is consistent with statutorily defined minimum funding levels. The DHMOs are not at-risk for the wrap payments, so the wrap payment costs are excluded from the capitation rate development. The Commission accounted for the wrap payment exclusion through the programmatic adjustment component of the rates, so the Commission did not include the FQHC wrap payment adjustment in the base data development.
    - Base period sub-capitation costs, provider incentive payments, and other settlement and recoupment costs were accounted for outside the base data development. These non-claim expenses were combined in the rate development exhibits as "Other Dental Expense / Capitation."
- Adjustments are not applied to remove services included in the data sources that are not covered by the program, if applicable, from the base data, but rather removed and programmatic adjustments.

Base Data Aggregation

- Aggregation of DHMO-specific base data for community base data development:
  - The base data used to develop community rates for each risk group was calculated by aggregating DHMO-specific base period PMPMs as incurred in the base period using each DHMO's projected enrollment for FY 2024.

APPENDIX C: DENTAL

Data Provided for Base Data Development Review

We received the following primary data items from the Commission for the base data development review:

- A copy of the source data used by the Commission to develop the final base data for in-depth base data review and replication for the Dental program:
  - DHMO FSRs:
    - FY 2022 90 day (September 2021 through August 2022) with runout through November 2022
  - DHMO supplemental expenditure data:
    - September 2019 through February 2023
  - The Commission provided summarized monthly enrollment files by each DHMO and risk group:
    - Actual enrollment was provided for the period from September 2018 through February 2023
    - Projected enrollment was provided for the period from March 2023 through August 2024
- A copy of the Commission's base data development working files for all DHMOs:
  - Lag expenditure completion and adjustment file, which includes the development of final lag base data at the DHMO and risk group level for lag expenditures:
    - Estimates of IBNR claims for expenditures reported through payment lags in the DHMO supplemental expenditure data
    - Special adjustments, as limited to a few plans on a case-by-case basis, to the expenditures reported through payment lags in the DHMO supplemental expenditure data
  - Non-lag expenditure calculation and adjustment file, which includes the development of final non-lag base data at the DHMO and risk group level for expenditures paid outside lags:
    - The PMPM calculation for each itemized expenditure not reported through payment lags in the DHMO supplemental expenditure data
    - Certain reported non-lag expenditures that were excluded from the base data development
- A copy of the Commission's base data expenditure reconciliation files for all DHMOs:
  - A comparison of reported total expenditures at the DHMO level across all risk groups between the DHMO FSR and DHMO supplemental expenditure data from September 2019 through February 2023
- The Commission's documentation of base data development in the FY 2024 actuarial report
- The Commission's responses to ad hoc questions from Milliman

APPENDIX C: DENTAL

TREND

We reviewed the trend component of the FY 2024 capitation rates based on the underlying data provided by the Commission and our understanding of the Commission's FY 2024 trend development approach, as described below. The Commission provided all information we requested.

Description of State Fiscal Year (FY) 2024 Trend Development

Our detailed understanding of the trend development for FY 2024 capitation rates is summarized below.

Data Used for Trend Development

The Commission used the following data to support the final trends:

- Historical dental incurred claims and utilization experience for the last four 12-month periods prior to the COVID-19 PHE (March 2016 through February 2020) by dental service category, excluding orthodontic costs
- Utilization adjustment factors for restorative utilization for changes to prior authorizations effective during FY 2019
- Unit cost adjustment factors for restorative and all other dental service categories for fee schedule changes effective September 2018

Historical Trend Development

The Commission performed the following steps to calculate historical dental trends:

- The Commission calculated the total incurred claim PMPM for each 12-month period as the product of the following:
  - Total utilization PMPM during the 12-month period
  - Composite unit cost during the 12-month period based on actual unit costs for each dental service category weighted using base period service mix
- The Commission calculated an adjusted PMPM for each 12-month period by applying the following adjustments to the utilization and unit costs in the total incurred claim PMPM
  - Utilization adjustment factors for restorative utilization for changes to prior authorizations effective during February and March 2019
  - Unit cost adjustment factors for restorative and all other dental service categories for fee schedule changes effective September 2018
- The Commission calculated the historical trend for each 12-month period as the change between the adjusted PMPM and the prior 12-month period's total incurred claim PMPM (unadjusted)
  - The Commission explained that the current period was adjusted so the impact of the restorative prior authorization and fee schedule changes would be on the same basis as the unadjusted prior period

Final Selection of Trend Assumptions

The Commission calculated the statewide dental annual trend at the program level by weighting the historical annual trends as follows:

Table 3
Texas Medicaid Managed Care Rate Review
Dental Program - Trend Development
Weighting of Historical Trends for Final Trend Calculation

Trend Denominator	Trend Numerator	Weight in Overall Trend Calculation
March 2016 through February 2017	March 2017 through February 2018	20%
March 2017 through February 2018	March 2018 through February 2019	30%
March 2018 through February 2019	March 2019 through February 2020	50%

Data Provided for Trend Review

The Commission did not make any changes to the statewide annual trend for FY 2024. We received the Commission's documentation of trend development in the FY 2024 actuarial report. In addition, we received the following primary data items from the Commission for the FY 2023 trend development review:

- Historical dental claim experience for March 2016 through February 2020 by dental service category (excluding orthodontic) and 12-month period:
  - Total utilization and utilization PMPM
  - Incurred claims in total and PMPM
  - Incurred claims per unit
- A copy of the Commission's trend development working files, including:
  - Annual utilization trends PMPM by dental service category for the 12-month periods beginning March 2016 through February 2020
  - Annual incurred cost trends by dental service category for the 12-month periods beginning March 2016 through February 2020; incurred cost trends were provided both PMPM and per unit of utilization
  - Calculation of final trends by dental service category based on a weighted average of historical annual trends in incurred claims PMPM adjusted for changes in restorative prior authorizations and fee schedules
- The Commission's responses to ad hoc questions

APPENDIX C: DENTAL

PROGRAMMATIC ADJUSTMENTS

We reviewed the programmatic adjustment component of the FY 2024 capitation rates based on the underlying data provided by the Commission and our understanding of the Commission's FY 2024 programmatic adjustment development approach, as described below. The Commission provided all information we requested.

Description of State Fiscal Year (FY) 2024 Programmatic Adjustment Development

The Commission developed and applied programmatic adjustments separately for each itemized change as applicable to the FY 2024 capitation rates, but the Commission's general approach was similar for each change. Our detailed understanding of the programmatic adjustment development is summarized below.

Data Used for Programmatic Adjustment Development

Based on the assessed impact and overall risk to the capitation rate setting process, we did not perform a full replication of the programmatic adjustments. Therefore, we may not have identified every data source used by the Commission to develop these programmatic adjustment factors. The key data sources identified through our review include:

- DHMO supplemental expenditure data submissions and FSRs

Programmatic Adjustment Factor Development Approach

The Commission applied two programmatic adjustments in the FY 2024 Dental program capitation rate development. The Commission developed both programmatic adjustment factors at the risk group level.

As described in the Base Data Development section of this appendix, the Commission removed certain costs that are not covered by the program (e.g., not covered by Medicaid, reimbursed directly by the State to the provider) or are covered by non-risk arrangements (i.e., the DHMO is fully reimbursed by the State), but are included in the base data, through programmatic adjustments. The adjustments for costs not covered by the Dental program capitation rates include medical costs for federally qualified health centers ("FQHC") wrap payments. This adjustment factor was calculated as the amount of the wrap payments during the base period (adjusted for projected FY 2024 enrollment) divided by the final base period claims.

The Commission developed the PHE related cost adjustment by estimating the full impact of the PHE on acuity using two distinct approaches and blending the resulting adjustment factors. The Commission then weighted the blended adjustment factor based on the portion of FY 2024 that the PHE-related members are assumed to be enrolled. The following steps were performed for each risk group and SDA combination:

- Cohort Method:
  - The Commission received IDs from HHS Forecasting for members expected to be disenrolled before the end of FY 2024 due to the expiration of the PHE. The Commission then calculated the base period PMPM costs excluding the members expected to be disenrolled ("cohort PMPM").
  - The Commission set the "cohort method adjustment factor" equal to the cohort PMPM divided by the actual base period PMPM, but not less than 1.0.

$$cohort\ method\ adjustment\ factor = \frac{cohort\ PMPM}{base\ period\ PMPM}$$

- Non-utilizer Method:
  - The Commission calculated the percentage of months where members had $0 claims in both the base period and in the last 12-month period prior to the PHE (March 2019 through February 2020).
  - The Commission calculated the average base period PMPM costs including only months where a member had claims (i.e., excluding months with $0 claims).
  - The Commission calculated an adjusted base period PMPM assuming percentage of months with $0 claims in the base period was the same as the percentage in the last 12-month period prior to the PHE ("non-utilizer PMPM").

- The Commission set the non-utilizer method adjustment factor equal to the non-utilizer PMPM divided by the actual base period PMPM, but not less than 1.0.

$$non\text{-}utilizer\ method\ adjustment\ factor = \frac{non\text{-}utilizer\ PMPM}{base\ period\ PMPM}$$

- Weighting factor:
  - The Commission estimated the total disenrollment based on the change in forecast enrollment from May 2023 to August 2024. The Commission calculated the monthly net change in enrollment from May 2023 through each month of FY 2024 based on the enrollment forecast.
  - The Commission calculated the "cumulative disenrollment percentage" each month as the cumulative net change in forecast enrollment from May 2023 divided by the total estimated disenrollment.
  - The Commission calculated the weighting factor by multiplying the cumulative disenrollment percentage by the forecast enrollment in each month of FY 2024, adding these factors together, and dividing by the total FY 2024 forecast enrollment. This calculation is intended to represent the estimated percentage of FY 2024 that potentially ineligible members will be enrolled.

$$weighting\ factor = \sum_{month=Sep\ 2023}^{Aug\ 2024} cumulative\ disenrollment\ percentage * forecast\ enrollment$$

  - For risk group and SDA combinations where forecast enrollment as of August 2024 is greater than forecast enrollment as of May 2023, the weighting factor is set equal to 0%.
- The Commission calculated the final PHE adjustment factor as 1 plus the weighting factor multiplied by the average of the cohort method adjustment factor and the non-utilizer method adjustment factor.

$$final\ PHE\ adjustment\ factor = 1 + weighting\ factor\ (\frac{cohort\ factor + non\text{-}utilizer\ factor}{2})$$

Data Provided for Programmatic Adjustment Review

We received the following primary data items from the Commission for the programmatic adjustment review:

- Draft and final versions of the programmatic adjustment development exhibits included in the rate certification
- A copy of the Commission's PHE adjustment development working files for all rate components (included with the trend development working files)
- An adjustment factor summary document prepared by the Commission to describe the programmatic adjustments
- DHMO supplemental expenditure data submissions and FSRs used in the base data development
- The Commission's documentation of the programmatic adjustment factor development in the FY 2024 actuarial report
- The Commission's responses to ad hoc questions from Milliman

APPENDIX C: DENTAL

NON-BENEFIT EXPENSES

We reviewed the non-benefit expense component of the FY 2024 capitation rates based on the underlying data provided by the Commission and our understanding of the Commission's FY 2024 non-benefit expense development approach, as described below. The Commission provided all information we requested.

Description of State Fiscal Year (FY) 2024 Non-Benefit Expense Development

Our detailed understanding of the non-benefit expense development for FY 2024 capitation rates is summarized below.

Data Used for Non-Benefit Expense Development

The Commission's non-benefit expense assumption is the sum of the following components:

- Administrative expense load
- Risk margin
- Taxes, including premium and maintenance taxes

The Commission's final non-benefit expenses were calculated using the same assumptions as in the prior year's rate development, as shown in Table 7.

Table 7
Texas Medicaid Managed Care Rate Review
Dental Program - Non-Benefit Expense
FY 2024 Non-Benefit Expense Assumption Development

Administrative Expenses	$1.75 PMPM
Risk Margin	1.5% of gross premium
Taxes	$0.024 PMPM + 1.75% of gross premium

Data Provided for Non-Benefit Expense Review

We received the following primary data items from the Commission for the non-benefit expense development review:

- A copy of the Commission's final rate development exhibits
- The Commission's documentation of non-benefit expense development in the FY 2024 actuarial report
- The Commission's responses to ad hoc questions

In addition, we reviewed the publicly available Texas Department of Insurance taxation requirements for premium taxes[8] and maintenance taxes.[9]

[8] "Insurance Premium Tax (Licensed Insurers)," Texas Comptroller of Public Accounts, Retrieved from: https://comptroller.texas.gov/taxes/insurance/licensed.php.
[9] "Insurance Maintenance Tax Rates and Assessments on 2022Premiums," Texas Comptroller of Public Accounts, Retrieved from: https://comptroller.texas.gov/taxes/publications/94-130.php; "Adopted assessment, exam fee and maintenance tax rates," Texas Department of Insurance, Retrieved from: https://www.tdi.texas.gov/company/taxes3.html.

APPENDIX C: DENTAL

CMS COMPLIANCE AND DOCUMENTATION

We reviewed the Commission's FY 2024 rate certification for compliance with the CMS 2023-2024 Medicaid managed care rate setting guidance,[10] as described below.

Description of State Fiscal Year (FY) 2024 CMS Compliance and Documentation

Section I. Medicaid Managed Care Rates

The Commission included information for all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

Data - The Commission included information for all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

Projected Benefit Costs and Trends - The Commission included information for all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

Special Contract Provisions Related to Payment - The Commission included information for all portions of (A) the Incentive Arrangements section, (B) the Withhold Arrangements section, (C) the Risk-Sharing Mechanisms section, (D) the State Directed Payments section, (E) the Pass-Through Payments section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

Projected Non-Benefit Costs - The Commission included information for all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

Risk Adjustment and Acuity Adjustments - The Commission included information for all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

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

This section is not applicable to the Dental program.

Section III. New Adult Group Capitation Rates

This section is not applicable to the Dental program.

Data Provided for CMS Compliance and Documentation Review

The Commission provided us with the final FY 2024 rate certification report for the Dental program. We relied on this document, as well as the publicly available CMS 2023-2024 Medicaid Managed Care Rate Setting Guide to conduct our compliance and documentation review. We also compared the Commission's final report to the technical items we reviewed in other areas of our report to ensure the documentation accurately described the underlying rate methodology.

[10] 2023-2024 Medicaid Managed Care Rate Development Guide, Centers for Medicare & Medicaid Services, May 2023, Retrieved from: 2023-2024 Medicaid Managed Care Rate Development Guide.

APPENDIX D

STAR+PLUS

APPENDIX D: STAR+PLUS

PROGRAM OVERVIEW

STAR+PLUS, which consists of four MCOs across 13 SDAs, is a Texas Medicaid managed care program for adults with disabilities or age 65 or older.[1] Adults in STAR+PLUS select their health plan from the MCOs approved to provide Medicaid healthcare and long-term services and supports.[2] Adults with complex medical needs can choose to live and receive care in a home setting instead of a nursing facility.[3]

Within STAR+PLUS, MCOs must have a service coordinator visit with the member within 30 days of enrolling in the program[4] to gain an understanding of the member's needs and develop a plan of care. In addition to acute care services (i.e., those covered by STAR) and nursing facility services, covered individuals in STAR+PLUS have access to long-term services and supports that can include:

- Day Activity and Health Services ("DAHS")
- Primary Home Care ("PHC")[5]

Other services under the STAR+PLUS Home and Community-Based Services ("HCBS") Waiver include:

- Personal assistance services
- Adaptive aids
- Adult foster care home services
- Assisted living
- Emergency response services
- Home delivered meals
- Medical supplies
- Minor home modifications – for instance, making changes to your home so you can safely move around
- Nursing services
- Respite care, more specifically short-term care to provide a break for caregivers
- Therapies, which include occupational, physical, and speech-language therapy
- Transitional assistance services[6]

The STAR+PLUS managed care program is estimated to cover roughly 570,000 beneficiaries in FY 2024 at a program cost of roughly $11.3 billion (excluding directed payments).

[1] STAR+PLUS, Texas Health and Human Services, Retrieved from: STAR+PLUS | Texas Health and Human Services.
[2] Ibid.
[3] Ibid.
[4] Ibid.
[5] Ibid.
[6] Ibid.

APPENDIX D: STAR+PLUS

RATE STRUCTURE

We evaluated the Commission's rate structure for the FY 2024 capitation rate development for the STAR+PLUS program by reviewing the actuarial report and rate development model created by the Commission.

Description of State Fiscal Year (FY) 2024 Rate Structure

In general, the Commission developed MCO specific capitation rates at a risk group and service delivery area (SDA) level for the STAR+PLUS population.

Risk Groups

The Commission segmented members into the following risk groups as part of the rate structure based on their anticipated risk acuity and cost differences based on the member's following characteristics:

- Medicare eligibility status:
  - Dual eligible: Eligible for both Medicaid and Medicare
  - Medicaid only: Eligible for Medicaid but not Medicare
- Service setting:
  - Other Community Care ("OCC")
  - Home and community-based services ("HCBS")
  - Nursing facility ("NF")
- Other Medicaid populations:
  - Intellectual or developmental disabilities ("IDD") over age 21
  - Medicaid for Breast and Cervical Cancer program ("MBCCP")

The Commission combined these three characteristics to form the following eight mutually exclusive risk groups used to develop the FY 2024 capitation rates:

- Medicaid Only – OCC
- Medicaid Only – HCBS
- Medicaid Only – NF
- Dual Eligible – OCC
- Dual Eligible - HCBS
- Dual Eligible - NF
- IDD
- MBCCP

Service Delivery Areas (SDAs)

The Commission segmented the state into the following 13 county and regional-based SDAs as part of the rate structure to account for regional cost variations:

- Bexar County Service Area - San Antonio
- Dallas County Service Area - Dallas
- El Paso County Service Area - El Paso
- Harris County Service Area - Houston
- Hidalgo County Service Area - Brownsville
- Jefferson County Service Area - Beaumont
- Lubbock County Service Area - Lubbock
- Nueces County Service Area - Corpus Christi
- Tarrant County Service Area - Fort Worth
- Travis County Service Area - Austin
- Medicaid Rural Service Area - Central (MRSA Central)
- Medicaid Rural Service Area - Northeast (MRSA Northeast)
- Medicaid Rural Service Area - West (MRSA West)

APPENDIX D: STAR+PLUS

Rate Development Process

The Commission followed the following steps to develop all FY 2024 rates:

- Step One: Develop MCO-specific FY 2024 capitation rates using each MCO's projected experience by SDA, risk group, and the following service groupings:

  - Acute care
  - Long-term care (LTC)
  - Pharmacy
  - Non-emergency transportation (NEMT)

  The capitation rate developed by the Commission for each service grouping includes service costs and non-benefit expenses (e.g., administrative costs). All costs included in the capitation rates are developed net of patient liability. This step encompasses the majority of the rate development process and is described throughout the remainder of the report.

- Step Two: Aggregate the MCO specific capitation rates for each service grouping into community rates (the average capitation rate across all MCOs) for each SDA and risk group based upon the projected MCO enrollment mix. The Commission used their judgement to determine if the underlying data at a risk group and SDA level was fully credible to calculate capitation rates.

  - For the STAR+PLUS program the following three risk groups were defined as not credible at the SDA level for NEMT services due to their relatively small enrollment sizes. Therefore, the NEMT rates are developed at the statewide level without SDA level variations for these risk groups:

    - Medicaid Only - NF
    - IDD
    - MBCCP

- Step Three: Adjust the community rates for each MCO using risk adjustment to reflect the expected acuity differences by MCO due to the underlying health conditions of the members in each plan. Risk scores were applied to the community rate for each service grouping as follows:

  - Acute care: The Commission engages the University of Florida's Institute for Child Health Policy (ICHP) to develop MCO risk scores using the Chronic Illness and Disability Payment System (CDPS).

  - LTC: The Commission developed MCO specific risk scores based on the relative percentage of unique members that utilize personal attendant services.

  - Pharmacy: The same risk scores applied to the acute care community rate are applied to the pharmacy community rate.

  - NEMT: No risk adjustment is applied to the NEMT community rate.

  The Commission applied risk scores on a budget neutral basis to the State (i.e., the total projected cost of the program is unaffected) at the risk group level across the MCOs in a given SDA, ensuring that additional funding is not introduced or removed from the program due to the application of the risk scores.

  A review of the risk adjustment methodologies is not included in the scope of our review of the FY 2024 Texas Medicaid managed care capitation rates, since risk adjustment is applied on a budget neutral basis, meaning it does not increase or decrease the total program funding, just the allocation of payments across MCOs within a risk group***.***

- Step Four: Add MCO specific amounts to the capitation rates by risk group and SDA for the following directed payment programs in the STAR+PLUS program.

  - Network Access Improvement Program (NAIP)
  - Quality Incentive Payment Program for Nursing Facilities (QIPP)
  - Comprehensive Hospital Increase Reimbursement Program (CHIRP)
  - Texas Incentives for Physicians and Professional Services (TIPPS)
  - Directed Payment Program for Behavioral Health Services (DPP BHS)
  - Rural Access to Primary and Preventative Services (RAPPS)

A review of the development of directed payment programs is not included in the scope of our review of the FY 2024 Texas Medicaid managed care capitation rates since directed payment programs are separately developed, reviewed, and funded outside the standard capitation rate development process.

- Step Five: Apply experience rebates to each MCO across all managed care programs and SDAs based on the Financial Statistical Reports (FSRs).
  - For FY 2024, each MCO is subject to an experience rebate based on the MCO's Financial Statistical Reports (FSRs) across all managed care programs and SDAs using the following parameters. The experience rebate limits the amount of profit (i.e., pre-tax income) an MCO can retain to no more than 7.2% of revenues.

Table 1
Texas Medicaid Managed Care Rate Review
STAR+PLUS Program – Rate Structure
FY 2024 Experience Rebate Parameters

Pre-Tax Income as a % of Revenues	MCO Share	Commission's 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%

APPENDIX D: STAR+PLUS

BASE DATA DEVELOPMENT

We reviewed the base data component of the FY 2024 capitation rates based on the underlying data provided by the Commission and our understanding of the Commission's FY 2024 base data development approach, as described below. The Commission provided all information we requested.

Description of State Fiscal Year (FY) 2024 Base Data Development

For a more detailed description of what base data is and why it matters, please see the Review Process section of the Main Report. Our detailed understanding of the base data development is summarized below for each major component of the FY 2024 capitation rate setting process:

Base Data Selection

- The Commission selected FY 2022 (September 2021 through August 2022) as the base period for both the enrollment data and the service expenditure data for the medical and pharmacy rate components. The Commission selected July 2022 through December 2022 as the base period for both the enrollment and service expenditure data for the NEMT rate component. The populations and services covered by the STAR+PLUS program during FY 2024 are generally the same as those covered by the STAR+PLUS program during the selected base period.

- The Commission provided a monthly enrollment file, which was used as the primary data source for base period enrollment data. This file summarizes monthly enrollment counts at an SDA, risk group, and MCO level, but does not provide individual membership records for each beneficiary.

- The managed care organizations ("MCOs") reported supplemental medical and pharmacy expenditure data in a prescribed reporting template, as designed by the Commission, which the Commission used as the primary data source for base period expenditure data. The data in this submission is not provided at a detailed claim level, but rather includes summarized monthly expenditure amounts by SDA and risk group for the following categories of service:

  - Professional
  - Outpatient Facility Emergency Room ("ER")
  - Outpatient Facility Non-ER
  - Inpatient Facility
  - Other Acute Care
  - Attendant Care
  - Nursing Facility
  - Other Long-Term Care ("LTC")
  - Pharmacy
  - Non-Emergency Medical Transportation ("NEMT")

  For the categories of service above, the MCOs provided the data to the Commission in a "lag" format, which reports claim costs by the combination of the month the service was performed ("incurred month") and the month in which payment was made to the provider ("paid month"). Additional "non-lag" information was provided by the MCOs in the supplementary reporting for the following costs:

  - Monthly utilization metrics for the same categories of service in the lag data
  - Monthly capitation payments made from the MCO to a sub-capitated provider at a risk group level
  - Large claim reports for members with costs exceeding $500,000
  - Reinsurance arrangements
  - Monthly third-party reimbursement by risk group
  - Monthly other direct service expenses by risk group
  - Monthly patient liability by risk group

Base Data Validation

The Commission performed the following validations of the MCO supplemental data prior to relying on this data for the development of the base data for FY 2024.

- The Commission reconciled MCO reported supplemental data to the MCO reported Financial Statistical Reports ("FSR") expenditures for consistency in aggregate and by risk group at the MCO and SDA level for the base period (FY 2022). The FSRs are self-reported data prepared by the MCOs under the terms and conditions of the Uniformed Managed Care Contract and the Uniform Managed Care Manual. For more information on the FSRs please refer to the Texas Health and Human Services website.[7]

- The Commission reconciled MCO reported supplemental lag expenditure data and the FSR data to the Commission's encounter data at the risk group level for FY 2022 for all MCO and SDA combinations.

Multiple entities audit the data sources used to validate the MCO supplemental data.

- University of Florida's Institute for Child Health Policy ("ICHP"), the External Quality Review Organization ("EQRO") vendor for Texas, is contracted to reconcile and validate the encounter data prior to releasing the encounter data to the Commission.

- The Office periodically audits the FSRs for a selected MCO and Program. Historically this audit has only been performed for the STAR+PLUS and STAR Kids programs.

- The Commission additionally contracts with external auditors to perform agreed-upon procedure ("AUP") engagements of the FSRs. These AUP engagements occur more than two years after the end of the state fiscal year.

Base Data Adjustments

- For expenditures paid through the claims system, also referred to as "lag expenditure" in this report, the Commission made the following explicit adjustments:

  - The paid expenditures as of February 2023 for the base period (FY 2022) were adjusted for claims which have been incurred but not reported ("IBNR").

  - The paid pharmacy expenditures reported by the MCOs for Medicaid and Medicare dually eligible risk groups were excluded, as such expenditures are paid by MCOs on a non-risk basis outside the capitation rates.

  - Adjustments were applied to the service categorization from acute care to long-term care ("LTC") for MCO reported acute care costs for Medicaid and Medicare dually eligible risk groups.

  - Adjustments were applied to the service categorization from LTC to acute care for MCO reported LTC costs for the intellectual developmental disabilities ("IDD") risk group.

  - Special adjustments were applied, as applicable, on an MCO specific basis for lag expenditures.

- For expenditures paid outside claims system, also referred to as "non-lag expenditures" in this report, the Commission made the following adjustments:

  - Sub-capitation expenditures are costs for which the MCO subcontracts with a third party to provide specific services in exchange for a fixed monthly premium per member. The contract between the MCO and the subcontractor defines whether the premiums are the same for all members or if they vary based on risk group, SDA, or other characteristics.

    - When explicitly reported by MCOs, the Commission removed the administrative portion of the sub-capitated expenditures from the base data.

    - When applicable, the Commission replaced actual premiums paid to subcontracted third parties during the base period with the most current premium amounts available.

    - The Commission excluded the fixed monthly premium payments to a third-party subcontractor from the rate development costs for an MCO that subcontracts with a related party. Instead, the Commission included the actual payments to providers from the MCO lag data in the projected claim costs for this MCO.

[7] Medicaid & CHIP Financial Statistical Reports: Fiscal Year 2022: Sept. 1, 2021, to Aug. 31, 2022, Texas Health and Human Services, Retrieved from: Medicaid & CHIP Financial Statistical Reports | Texas Health and Human Services.

  - Net reinsurance cost is the total cost of premiums paid by MCOs to reinsurers less claim payments received from reinsurers. A reinsurer will provide insurance to an MCO to protect the MCO against higher-than-expected claim experience. Some MCOs in the STAR+PLUS program choose to purchase reinsurance, but reinsurance is not required by the STAR+PLUS program.
    - The Commission capped reported net reinsurance costs to be no greater than $0.50 per member per month ("PMPM"), as applicable.
  - Other itemized expenditures and / or recoveries:
    - Federally qualified health centers ("FQHCs") receive additional "wrap payments" from the MCOs in addition to their contracted MCO reimbursement rates to ensure total FQHC funding is consistent with statutorily defined minimum funding levels. The MCOs are not at-risk for the wrap payments, so the wrap payment costs are excluded from the capitation rate development. The Commission accounted for the wrap payment exclusion through the programmatic adjustment component of the rates, so the Commission did not include the FQHC wrap payment adjustment in the base data development.
    - The Commission primarily accounted for quality improvement expenditures, if reported, through the service coordination component of the rates; therefore, the Commission did not include these expenditures in the base data development.
    - The Commission excluded reported state directed payments, which are listed in the Rate Structure section of this appendix.

- For third party reimbursements ("TPR"), which are reported in a standalone section of the MCO supplemental data separate from lag expenditures and non-lag expenditures, the Commission removed the TPR from the base data if the reported TPR amounts were confirmed to not be included in other expenses reported in the MCO supplemental data. The Commission validated the MCO reporting of TPR based on reconciliations between the MCO supplemental data and the FSRs.
- The Commission did not adjust the base data to remove services that are not covered by the program but are included in the base data sources. Instead, the Commission removed these costs through programmatic adjustments.

Base Data Aggregation

- Aggregation of MCO-specific base data for community base data development:
  - The Commission's base data used to develop community rates for each risk group within each SDA was calculated by aggregating MCO-specific base period PMPMs as incurred in the base period using each MCO's projected enrollment for FY 2024.

Data Provided for Base Data Development Review

We received the following primary data items from the Commission for the base data development review:

- A copy of the source data used by the Commission to develop the final base data for Bexar SDA as Milliman's selected sample SDA for in-depth base data review and replication for the STAR+PLUS program:
  - MCO FSRs:
    - FY 2022 Year-End 90-Day (September 2021 through August 2022) with runout through November 2022
  - MCO supplemental expenditure data:
    - September 2019 through February 2023

  - The Commission provided summarized monthly enrollment files by each MCO and risk group:
    - Actual enrollment was provided for the period from September 2012 through February 2023.
    - Projected enrollment was provided for the period from March 2023 through August 2028.

- A copy of the Commission's base data development working files for all MCO and SDA combinations:
  - Lag expenditure completion and adjustment file which includes the development of final lag base data at the SDA, MCO, and risk group level for lag expenditures:
    - Estimates of IBNR claims for expenditures reported through payment lags in the MCO supplemental expenditure data
    - Special adjustments, as limited to a few plans on a case-by-case basis, to the expenditures reported through payment lags in the MCO supplemental expenditure data
  - Non-lag expenditure calculation and adjustment file, which includes the development of final non-lag base data at the SDA, MCO, and risk group level for expenditures paid outside lags:
    - The PMPM calculation for each itemized expenditure not reported through payment lags in the MCO supplemental expenditure data
    - Certain reported non-lag expenditures that were excluded from the base data development
- A copy of the Commission's base data expenditure reconciliation files for all MCOs and all SDAs:
  - A comparison of reported total expenditures at the MCO level across all risk groups in each SDA between the MCO FSR and MCO supplemental expenditure data for the base period for FY 2022
  - A comparison of reported lag expenditures at the MCO and risk group level in each SDA across the commission provided encounters, MCO FSRs, and MCO supplemental expenditure data for FY 2021 and FY 2022
- The Commission's documentation of base data development in the FY 2024 actuarial report
- The Commission's responses to ad hoc questions from Milliman

APPENDIX D: STAR+PLUS

TREND

We reviewed the trend component of the FY 2024 capitation rates based on the underlying data provided by the Commission and our understanding of the Commission's FY 2024 trend development approach, as described below. The Commission provided all information we requested.

Description of State Fiscal Year (FY) 2024 Trend Development

Our detailed understanding of the trend development for FY 2024 capitation rates is summarized below.

Data Used for Trend Development

The Commission used the following data to support the final trends:

Medical Trends (further separated between Acute care trends and LTC care trends)

For all risk groups other than MBCCP:

- Monthly historical PMPM medical claim experience from the 3.5 years of STAR+PLUS program experience prior to the beginning of the COVID-19 PHE (September 2016 through February 2020) and the most recent two years and four months of available STAR+PLUS program experience (September 2020 through December 2022) summarized by risk group and SDA. The Commission used PMPM level data without separate utilization and unit cost trends to develop the selected medical trends.
- Annual adjustment factors for material medical programmatic changes from FY 2015 through FY 2023, including:
  - Provider reimbursement changes
  - Other programmatic changes
  - NF COLA adjustments
  - ARPA Trend Adjustment

For MBCCP, the Commission used the data above beginning September 2017 or FY 2018, when the MBCCP risk group coverage became effective under the STAR+PLUS program.

Pharmacy Trends

For all risk groups other than MBCCP:

- Historical PMPM pharmacy claim experience for the last seven 12-month periods (March 2015 through February 2023) by risk group and month, excluding the following costs:
  - Drugs carved out of managed care for FY 2024 (i.e., costs are reimbursed directly to providers by the State through FFS Medicaid coverage and are not included in the managed care program)
  - Drugs covered under managed care but reimbursed to MCOs separate from the capitation rates on a non-risk basis (i.e., non-risk arrangements)
  - The drug Orkambi
  - Anti-viral and progestational agent drug classes
- Historical claim payment amounts were adjusted to reflect managed care pharmacy reimbursement provisions. Historical data was summarized separately for utilization and unit cost
- Adjustment factors for material preferred drug list (PDL) changes from FY 2018 through FY 2024

For MBCCP, the Commission used the data above beginning September 2017 or FY 2018, when the MBCCP risk group coverage became effective under the STAR+PLUS program.

NEMT Trends

- Historical PMPM NEMT managed transportation organization (MTO)[8] claims for demand response services[9] (i.e., non-fixed route transportation systems that require advanced scheduling by the individual customer) for the last four 12-month periods prior to the COVID-19 PHE (March 2016 through February 2020), adjusted as follows:
  - The Commission excluded MTO Regions 1 and 10 due to changes in MTOs in September 2017
  - The Commission excluded MTO Region 4 because the NEMT services were provided FFS
  - The Commission applied adjustments to Regions 6 through 9, 11, and 13 to account for provider reimbursement changes (Regions 6 through 8 and 11), the impact of Hurricane Harvey in 2017 (Regions 9 and 13), and a stretcher service policy change in November 2016 (Region 13)
- Consumer Price Index – All Urban Consumers (CPI) for transportation services from March 2009 through February 2020 published by the Bureau of Labor Statistics (BLS)

Normalization Process

Medical Trends (further separated between Acute care trends and LTC care trends)

The Commission performed the following steps to normalize medical trends to adjust for historical programmatic changes:

- The Commission calculated the incurred medical claims PMPM by risk group and SDA for FY 2017 through FY 2019, September 2019 through February 2020 ("FY 2020 H1"), FY 2022, and September 2022 through December 2022.
- The Commission multiplied the SDA level incurred medical claims PMPM by programmatic change adjustment factors so the year-to-year values could be evaluated on a consistent basis for measuring trend without the influence of other change drivers.
- The Commission calculated SDA-specific PMPM trends as the percentage change in PMPM values (adjusted for programmatic changes) from year 1 to year 2.

Pharmacy Trends

The Commission excluded certain costs covered under the capitation rates from the pharmacy trend analysis because they drove material one-time impacts on costs (e.g., progestational agents) or they are historically volatile and expected to remain volatile on an ongoing basis (e.g., anti-viral treatments that fluctuate based on the intensity of the flu season). In addition, the Commission performed the following steps to normalize pharmacy trends to adjust for historical PDL changes:

- The Commission calculated the statewide incurred pharmacy claims PMPM (inclusive of all drug types, but net of excluded costs mentioned above), allocated to utilization (defined as "days supply") PMPM and unit cost (defined as "incurred claims per days supply"), by risk group for each 12-month period from March 2016 through February 2020.
- The Commission multiplied the statewide incurred pharmacy claims per days supply by the annual PDL adjustment factors. The adjusted incurred claims per days supply estimate the unit costs that would have been incurred based on the PDL in effect prior to March 2017.
  - The Commission assumed costs for drugs that were not assumed to be explicit replacements for other drugs (e.g., emerging therapies that have been added to the PDL) are the same as the actual incurred costs.

[8] NEMT services were provided by MTOs prior to June 1, 2021; services areas under the MTO program were defined differently than under the MCO contracts.
[9] "Demand response" is any non-fixed route system of transporting individuals that requires advanced scheduling by the customer, including services provided by public entities, nonprofits, and private providers. (49 C.F.R Section 604.3(g)). Examples can be found at https://www.transit.dot.gov/sites/fta.dot.gov/files/docs/Demand_Response_Fact_Sheet_Final_with_NEZ_edits_02-13-13.pptx

- The Commission calculated the annual statewide utilization and unit cost trends as the year-over-year percentage change in days supply PMPM and adjusted incurred claims per days supply, respectively.

NEMT Trends

The Commission did not apply any normalization adjustments for the NEMT trend analysis.

Aggregation

Medical Trends (further separated between Acute care trends and LTC care trends)

The Commission aggregated all historical SDA specific PMPM trends into one single historical statewide PMPM trend. The Commission calculated the single historical statewide PMPM trend as the dollar weighted average of the thirteen historical SDA specific PMPM trends using adjusted year 1 expenditures as weights. For example, if one trend data point is measured from FY 2018 to FY 2019, the medical costs by SDA in FY 2018 are used to weight the SDA specific trends into the statewide trend.

Pharmacy and NEMT Trends

The Commission does not use SDA-level trends to develop pharmacy or NEMT trends. Therefore, the Commission's trend development for these components does not require additional aggregation steps.

Final Selection of Trend Assumptions

Medical Trends (further separated between Acute care trends and LTC care trends)

The Commission calculates the statewide medical annual trend at the risk group level by weighting the historical annual statewide trends for each risk group as follows:

Table 4
Texas Medicaid Managed Care Rate Review
STAR+PLUS Program - Trend Development
Weighting of Historical Trends for Final Medical Trend Calculation

Trend Denominator (Year 1)	Trend Numerator (Year 2)	Weight in Overall Trend Calculation
All Risk Groups Other than MBCCP		
FY 2016	FY 2017	22.86% = 12 / 42 months * 80%
FY 2017	FY 2018	22.86% = 12 / 42 months * 80%
FY 2018	FY 2019	22.86% = 12 / 42 months * 80%
FY 2019 H1	FY 2020 H1	11.43% = 6 / 42 months * 80%
FY 2021	FY 2022	15% = 12 / 16 months * 20%
9/2021 through 12/2021	9/2022 through 12/2022	5% = 4 / 16 months * 20%
MBCCP		
FY 2018	FY 2019	53.33% = 12 / 18 months * 80%
FY 2019 H1	FY 2020 H1	26.67% = 6 / 18 months * 80%
FY 2021	FY 2022	15% = 12 / 16 months * 20%
9/2021 through 12/2021	9/2022 through 12/2022	5% = 4 / 16 months * 20%

Pharmacy Trends

The Commission calculates the statewide pharmacy annual utilization and unit cost trends at the risk group level by weighting the historical annual statewide utilization and unit cost trends for each risk group as follows:

Table 5 Texas Medicaid Managed Care Rate Review STAR+PLUS Program - Trend Development Weighting of Historical Trends for Final Pharmacy Trend Calculation		
Trend Denominator	**Trend Numerator**	**Weight in Overall Trend Calculation**
All Risk Groups Other than MBCCP		
March 2016 through February 2017	March 2017 through February 2018	13.33% = 1 / 6 Months * 80%
March 2017 through February 2018	March 2018 through February 2019	26.67% = 2 / 6 Months * 80%
March 2018 through February 2019	March 2019 through February 2020	40.00% = 3 / 6 Months * 80%
March 2021 through February 2022	March 2022 through February 2023	20%
MBCCP		
September 2017 through February 2018	September 2018 through February 2019	26.67% = 1 / 3 Months * 80%
September 2018 through February 2019	September 2019 through February 2020	53.33% = 2 / 3 Months * 80%
September 2021 through February 2022	September 2022 through February 2023	20%

The Commission then calculates the statewide pharmacy PMPM trend as the cumulative impact of the selected utilization and unit cost trends. The Commission uses the following standard algebraic formula to calculate the PMPM trend:

PMPM trend = (1 + utilization trend) * (1 + unit cost trend) - 1

NEMT Trends

The Commission selected the NEMT annual trend assumption for all risk groups using an equal 50% weight for the experience-based trend assumption developed from MTO historical data and a 50% weight for an industry trend assumption.

- The Commission's experience-based trend assumption is equal to the average of the historical annual statewide trends for the 12-month periods beginning March 2016 through February 2020 using managed care experience.
- The Commission's industry trend assumption is equal to the sum of an inflation trend and a utilization trend:
  - The inflation trend is equal to the average year-over-year trend in CPI for each month over 10 years ending February 2020.
  - The utilization trend is selected by the Commission.

Data Provided for Trend Review

We received the following primary data items from the Commission for the trend development review:

- Historical medical claim experience (acute care and long-term care (LTC)) for September 2019 through February 2023 by risk group, SDA and month:
  - Incurred claims in total and PMPM

  Note, pharmacy claim experience begins September 2014 for the IDD population and March 2015 for the NF population, consistent with their addition to the STAR+PLUS program.
- A copy of the Commission's medical trend development working files for all risk group and SDA combinations, including:
  - Summarized FY 2020 – FY 2023 (through February 2023) managed care PMPM trends
  - Programmatic adjustment factors for material changes between FY 2021 and FY 2023
  - Calculation of final trends based on a weighted average of historical annual trends in incurred claims PMPM adjusted for material programmatic changes

- Trend adjustment factors for the following adjustments:
  - Reimbursement related adjustments
  - Programmatic / benefit related adjustments
- The Commission's documentation of trend development in the FY 2024 actuarial report
- The Commission's responses to ad hoc questions

We also relied on the following additional information provided by the Commission for our FY 2023 rate review:

- Historical medical claim experience for September 2017 through August 2019 by risk group, SDA, and month:
  - Incurred claims in total and PMPM
- Historical pharmacy claim experience for March 2012 through February 2022 by drug type (brand, generic, or specialty), risk group, and month including:
  - Total utilization and utilization PMPM classified by days supply and scripts
  - Total incurred claims and incurred claims PMPM
  - Incurred claims per days supply
- A copy of the Commission's FY 2023 medical trend development working files for all risk group and SDA combinations, including:
  - Summarized FY 2017 – FY 2019 managed care PMPM trends
  - Programmatic adjustment factors for material changes between FY 2017 and FY 2020
  - Calculation of final trends based on a weighted average of historical annual trends in incurred claims PMPM adjusted for material programmatic changes
- A copy of the Commission's FY 2023 pharmacy trend development working files for all risk group and SDA combinations, including:
  - For each risk group, all risk groups combined program-wide, and all risk groups combined program-wide calibrated to reflect the projected FY 2023 enrollment by risk group:
    - Annual utilization trends PMPM by drug type for the 12-month periods beginning March 2013 through February 2022; utilization trends were provided for both number of scripts and days supply
    - Annual incurred cost trends by drug type for the 12-month periods beginning March 2013 through February 2022; incurred cost trends were provided both PMPM and per days supply
  - Generic dispensing rate in days supply:
    - By risk group
    - For all risk groups combined program-wide
    - For all risk groups combined calibrated to reflect the projected FY 2023 enrollment mix by risk group
  - Calculation of final FY 2023 PMPM trends by risk group based on a weighted average of historical annual trends in incurred claims PMPM adjusted for PDL changes

APPENDIX D: STAR+PLUS

PROGRAMMATIC ADJUSTMENTS

We reviewed the programmatic adjustment component of the FY 2024 capitation rates based on the underlying data provided by the Commission and our understanding of the Commission's FY 2024 programmatic adjustment development approach, as described below. The Commission provided all information we requested.

Description of State Fiscal Year (FY) 2024 Programmatic Adjustment Development

The Commission developed and applied programmatic adjustments separately for each itemized change as applicable to the FY 2024 capitation rates, but the Commission's general approach was similar for each change. Our detailed understanding of the programmatic adjustment development is summarized below.

Data Used for Programmatic Adjustment Development

Based on the assessed impact and overall risk to the capitation rate setting process, we did not perform a full replication of the programmatic adjustments. Therefore, we may not have identified every data source used by the Commission to develop these programmatic adjustment factors. The key data sources identified through our review include:

- Encounter data
- MCO supplemental expenditure data submissions and FSRs
- Historical provider and facility reimbursement levels and anticipated future changes to reimbursement levels through FY 2024, including:
  - Medicaid fee schedules
  - DRG groupers
- Historical preferred drug lists (PDLs) and anticipated changes to the PDL through FY 2024

Programmatic Adjustment Factor Development Approach

The Commission applied 24 programmatic adjustments specific to this program in the FY 2024 capitation rate development, including:

- 19 adjustments to the medical rate component
- 4 adjustments to the pharmacy rate component
- 1 adjustment to the NEMT rate component

The Commission developed most programmatic adjustment factors at the SDA and risk group level primarily using base period encounters. The approaches used by the Commission to develop these programmatic adjustment factors varied, but they were generally calculated as the estimated change to base period claim amounts for any applicable changes between the base period and FY 2024 divided by the base period claim amounts prior to the changes for the following broad programmatic change categories:

- Changes to provider reimbursement
- Changes to the covered services, such as changes to the formulary
- Other changes, such as PHE related changes, regulatory required changes (IMD long-stay removal), and targeted managed care efficiency adjustments
- *PHE adjustment*, to account for the impact of PHE-related disenrollments prior to and during FY 2024

As described in the Base Data Development section in this Appendix, the Commission removed certain costs that are not covered by the program (e.g., not covered by Medicaid, reimbursed directly by the State to the provider) or are covered by non-risk arrangements (i.e., the MCO is fully reimbursed by the State), but are included in the base data, through programmatic adjustments. The adjustments for these costs are often reflected in the wrap and carve-out removals, as well as some of the other reimbursement changes. The adjustments for costs not covered by the STAR+PLUS program capitation rates include:

- Medical costs for invalid clinician administered drugs (CADs)
- Medical and pharmacy costs for managed care members ages 21 through 64 who have an IMD stay in excess of 15 days during any month
- Medical costs for federally qualified health centers ("FQHC") wrap payments

The Commission developed the PHE related cost adjustment by estimating the full impact of the PHE on acuity using two distinct approaches and blending the resulting adjustment factors. The Commission then weighted the blended adjustment factor based on the portion of FY 2024 that the PHE-related members are assumed to be enrolled. The following steps were performed for each risk group and SDA combination:

- Cohort Method:
  - The Commission received IDs from HHS Forecasting for members expected to be disenrolled before the end of FY 2024 due to the expiration of the PHE. The Commission then calculated the base period PMPM costs excluding the members expected to be disenrolled ("cohort PMPM").
  - The Commission set the "cohort method adjustment factor" equal to the cohort PMPM divided by the actual base period PMPM, but not less than 1.0.

$$cohort\ method\ adjustment\ factor = \frac{cohort\ PMPM}{base\ period\ PMPM}$$

- Non-utilizer Method:
  - The Commission calculated the percentage of months where members had $0 claims in both the base period and in the last 12-month period prior to the PHE (March 2019 through February 2020).
  - The Commission calculated the average base period PMPM costs including only months where a member had claims (i.e., excluding months with $0 claims).
  - The Commission calculated an adjusted base period PMPM assuming percentage of months with $0 claims in the base period was the same as the percentage in the last 12-month period prior to the PHE ("non-utilizer PMPM").
  - The Commission set the non-utilizer method adjustment factor equal to the non-utilizer PMPM divided by the actual base period PMPM, but not less than 1.0.

$$non\text{-}utilizer\ method\ adjustment\ factor = \frac{non\text{-}utilizer\ PMPM}{base\ period\ PMPM}$$

- Weighting factor:
  - The Commission estimated the total disenrollment based on the change in forecast enrollment from May 2023 to August 2024. The Commission calculated the monthly net change in enrollment from May 2023 through each month of FY 2024 based on the enrollment forecast.
  - The Commission calculated the "cumulative disenrollment percentage" each month as the cumulative net change in forecast enrollment from May 2023 divided by the total estimated disenrollment.
  - The Commission calculated the weighting factor by multiplying the cumulative disenrollment percentage by the forecast enrollment in each month of FY 2024, adding these factors together, and dividing by the total FY 2024 forecast enrollment. This calculation is intended to represent the estimated percentage of FY 2024 that potentially ineligible members will be enrolled.

$$weighting\ factor = \sum_{month=Sep\ 2023}^{Aug\ 2024} cumulative\ disenrollment\ percentage * forecast\ enrollment$$

  - For risk group and SDA combinations where forecast enrollment as of August 2024 is greater than forecast enrollment as of May 2023, the weighting factor is set equal to 0%.

- The Commission calculated the final PHE adjustment factor as 1 plus the weighting factor multiplied by the average of the cohort method adjustment factor and the non-utilizer method adjustment factor.

$$final\ PHE\ adjustment\ factor = 1 + weighting\ factor\ (\frac{cohort\ factor + non\text{-}utilizer\ factor}{2})$$

Data Provided for Programmatic Adjustment Review

We received the following primary data items from the Commission for the programmatic adjustment review:

- Draft and final versions of the programmatic adjustment development exhibits included in the rate certification
- A copy of the Commission's PHE adjustment development working files
- An adjustment factor summary document prepared by the Commission to describe the programmatic adjustments
- MCO supplemental expenditure data submissions and FSRs used in the base data development
- The Commission's documentation of the programmatic adjustment factor development in the FY 2024 actuarial report
- The Commission's responses to ad hoc questions from Milliman

APPENDIX D: STAR+PLUS

NON-BENEFIT EXPENSES

We reviewed the non-benefit expense component of the FY 2024 capitation rates based on the underlying data provided by the Commission and our understanding of the Commission's FY 2024 non-benefit expense development approach, as described below. The Commission provided all information we requested.

Description of State Fiscal Year (FY) 2024 Non-Benefit Expense Development

Our detailed understanding of the non-benefit expense development for FY 2024 capitation rates is summarized below.

Data Used for Non-Benefit Expense Development

The Commission's non-benefit expense assumption is the sum of the following components:

- Administrative expense load, including general and quality improvement expenses
- Risk margin
- Taxes, including premium and maintenance taxes

The Commission's final non-benefit expenses were calculated separately for each service grouping (i.e., medical, pharmacy, and NEMT) using the same assumptions as in the prior year's rate development, as shown in Table 14.

Table 6
Texas Medicaid Managed Care Rate Review
STAR+PLUS Program - Non-Benefit Expense
FY 2024 Non-Benefit Expense Assumption Development

Service Grouping	Medical	Pharmacy	NEMT
Administrative Expenses	$7.00 PMPM + 5.25% (Non-NF) or 2.63% (NF) of gross premium	$1.60 PMPM	$0.175 PMPM + 22% of gross premium
Risk Margin	1.75% of gross premium	1.75% of gross premium	1.75% of gross premium
Taxes	$0.0725 PMPM + 1.75% of gross premium	1.75% of gross premium	1.75% of gross premium

The Commission allocated the $7.00 PMPM medical administrative expense load as follows:

- $5.00 for general administration expenses
- $2.00 for quality improvement expenses

The Commission only reflected the $0.0725 PMPM maintenance tax in the medical component of the rates because it is assessed based on the number of enrollees.

Data Provided for Non-Benefit Expense Review

We received the following primary data items from the Commission for the non-benefit expense development review:

- A copy of the Commission's historical administrative expense PMPM analysis
- A copy of the Commission's final rate development exhibits for all SDAs and MCOs (for risk groups that had MCO rating)
- The Commission's documentation of non-benefit expense development in the FY 2024 actuarial report
- The Commission's responses to ad hoc questions

In addition, we reviewed the publicly available Texas Department of Insurance taxation requirements for premium taxes[10] and maintenance taxes.[11]

[10] "Insurance Premium Tax (Licensed Insurers)," Texas Comptroller of Public Accounts, Retrieved from: https://comptroller.texas.gov/taxes/insurance/licensed.php.
[11] "Insurance Maintenance Tax Rates and Assessments on 2022 Premiums," Texas Comptroller of Public Accounts, Retrieved from: https://comptroller.texas.gov/taxes/publications/94-130.php; "Adopted assessment, exam fee and maintenance tax rates," Texas Department of Insurance, Retrieved from: https://www.tdi.texas.gov/company/taxes3.html.

APPENDIX D: STAR+PLUS

CMS COMPLIANCE AND DOCUMENTATION

We reviewed the Commission's FY 2024 rate certification for compliance with the CMS 2023-2024 Medicaid managed care rate setting guidance,[12] as described below.

Description of State Fiscal Year (FY) 2024 CMS Compliance and Documentation

Section I. Medicaid Managed Care Rates

The Commission included information for all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

Data - The Commission included information for all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

Projected Benefit Costs and Trends - The Commission included information for all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

Special Contract Provisions Related to Payment - The Commission included information for all portions of (A) the Incentive Arrangements section, (B) the Withhold Arrangements section, (C) the Risk-Sharing Mechanisms section, (D) the State Directed Payments section, (E) the Pass-Through Payments section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

Projected Non-Benefit Costs - The Commission included information for all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

Risk Adjustment and Acuity Adjustments - The Commission included information for all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

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

The Commission included information for all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

Section III. New Adult Group Capitation Rates

This section is not applicable to the STAR+PLUS program.

Data Provided for CMS Compliance and Documentation Review

The Commission provided us with the final FY 2024 rate certification report for the STAR+PLUS program. We relied on this document, as well as the publicly available CMS 2023-2024 Medicaid Managed Care Rate Setting Guide to conduct our compliance and documentation review. We also compared the Commission's final report to the technical items we reviewed in other areas of our report to ensure the documentation accurately described the underlying rate methodology.

[12] 2023-2024 Medicaid Managed Care Rate Development Guide, Centers for Medicare & Medicaid Services, May 2023, Retrieved from: 2023-2024 Medicaid Managed Care Rate Development Guide.

APPENDIX E

STAR KIDS

APPENDIX E: STAR KIDS

PROGRAM OVERVIEW

Effective November 1, 2016, the Commission implemented a new managed care program for disabled children named STAR Kids.[1] The STAR Kids program, which consists of nine MCOs across 13 SDAs, is available statewide and is mandatory for those Medicaid clients under age 21 who meet at least one of the following:

- Receive Social Security Income ("SSI") and SSI-related Medicaid
- Receive SSI and Medicare
- Receive Medically Dependent Children Program ("MDCP") waiver services
- Receive Youth Empowerment Services ("YES") waiver services
- Receive Intellectual and Developmental Disabilities ("IDD") waiver services (e.g., Community Living Assistance and Support Services ("CLASS"), Deaf Blind with Multiple Disabilities ("DBMD"), Home and Community-based Services ("HCS"), and Texas Home Living ("TXHmL")
- Reside in a community-based intermediate care facility for individuals with intellectual disabilities ("ICF-IID")[2]

Members in the STAR Kids program, who select their health plan from one of the approved MCOs have access to acute care Medicaid benefits, such as:

- Regular checkups with the doctor and dentist
- Prescription drugs and vaccines
- Hospital care and services
- X-rays and lab tests
- Vision and hearing care
- Access to medical specialists and mental health care
- Treatment of special health needs and pre-existing conditions

These individuals also have access to a number of additional specialized services, including:

- Personal care services
- Private duty nursing services
- Day Activity and Health Services ("DAHS")
- MDCP waiver services

The STAR Kids managed care program is estimated to cover roughly 165,000 beneficiaries in FY 2024 at a program cost of roughly $3.8 billion (excluding directed payments).

[1] STAR Kids, Rate Setting Actuarial Analysis, Texas Health and Human Services, Retrieved from: https://pfd.hhs.texas.gov/managed-care-services/star-kids.
[2] Ibid.

APPENDIX E: STAR KIDS

RATE STRUCTURE

We evaluated the Commission's rate structure for the FY 2024 capitation rate development for the STAR Kids program by reviewing the actuarial report and rate development model created by the Commission.

Description of State Fiscal Year (FY) 2024 Rate Structure

In general, the Commission developed MCO specific capitation rates at a risk group and service delivery area (SDA) level for the STAR Kids population.

Risk Groups

The Commission segmented members into one of seven risk groups as part of the rate structure based on their anticipated risk acuity differences, which are measured by the status of their waiver category and their age. Specifically, members eligible for this program are first assigned into one of the three mutually exclusive waiver category-based risk groups if they are eligible for any of the three waivers. The rest of the members are then assigned into one of the remaining four mutually exclusive age band based risk groups:

- Medically Dependent Children Program ("MDCP") waiver
- Intellectual and Developmental Disability ("IDD") waiver
- Youth Empowerment Services ("YES") waiver
- Under Age 1
- Age 1-5
- Age 6-14
- Age 15-20

Service Delivery Areas (SDAs)

The Commission segmented the state into the following 13 county and regional-based SDAs as part of the rate structure to account for regional cost variations:

- Bexar County Service Area - San Antonio
- Dallas County Service Area - Dallas
- El Paso County Service Area - El Paso
- Harris County Service Area - Houston
- Hidalgo County Service Area - Brownsville
- Jefferson County Service Area - Beaumont
- Lubbock County Service Area - Lubbock
- Nueces County Service Area - Corpus Christi
- Tarrant County Service Area - Fort Worth
- Travis County Service Area - Austin
- Medicaid Rural Service Area - Central (MRSA Central)
- Medicaid Rural Service Area - Northeast (MRSA Northeast)
- Medicaid Rural Service Area - West (MRSA West)

Rate Development Process

The Commission followed the following steps to develop all FY 2024 rates:

- Step One: Develop MCO-specific FY 2024 capitation rates using each MCO's projected experience by SDA, risk group, and the following service groupings:
  - Medical (Acute care and Long-term care (LTC))
  - Pharmacy
  - Non-emergency transportation (NEMT)

  The capitation rate developed by the Commission for each service grouping includes service costs and non-benefit expenses (e.g., administrative costs). This step encompasses the majority of the rate development process and is described throughout the remainder of the report.

- Step Two: Aggregate the MCO specific capitation rates for each service grouping into community rates (the average capitation rate across all MCOs) for each SDA and risk group based upon the projected MCO enrollment mix to determine a community rate. The Commission used their judgement to determine if the underlying data at a risk group and SDA level was fully credible to calculate capitation rates.

  - For the STAR Kids program the following two risk groups were defined as not credible at the SDA level due to their relatively small enrollment sizes. Therefore, the capitation rates for the acute care, LTC, and pharmacy components are developed at the statewide level without SDA level variations for these risk groups.

    - YES
    - Under Age 1

  - The capitation rates for the NEMT component are developed at the statewide level without SDA level variations for the following three risk groups.

    - IDD
    - YES
    - Under Age 1

- Step Three: Adjust the community rates for each MCO using risk adjustment to reflect the expected acuity differences by MCO due to the underlying health conditions of the members in each plan. Risk scores were applied to the community rate for each service grouping as follows:

  - Medical: The Commission engages the University of Florida's Institute for Child Health Policy (ICHP) to develop MCO risk scores using the Chronic Illness and Disability Payment System (CDPS).

  - Pharmacy: The same risk scores applied to the medical community rate are applied to the pharmacy community rate.

  - NEMT: No risk adjustment is applied to the NEMT community rate.

  The Commission applied risk scores on a budget neutral basis at the risk group level across the MCOs in a given SDA, ensuring that additional funding is not introduced or removed from the program due to the application the risk scores. Due to credibility concerns, the following risk groups are not risk adjusted:

  - YES
  - Under Age 1

  A review of the risk adjustment methodologies is not included in the scope of our review of the FY 2024 Texas Medicaid managed care capitation rates since risk adjustment is applied on a budget neutral basis, meaning it does not increase or decrease the total program funding, just the allocation of payments across MCOs within a risk group***.***

- Step Four: Calculate MCO specific medical and pharmacy capitation rates as the minimum of (a) 108% of the MCO-specific capitation rate developed using the individual experience of the MCO from Step One and (b) the risk adjusted community rate from Step Three. Similar to Step Two, due to credibility concerns one overall statewide rate that does not vary by MCO is used for the following risk groups:

  - YES
  - Under Age 1

  The NEMT component of each MCO's capitation rate is equal to the community rate.

- Step Five: Add MCO specific amounts to the capitation rates by risk group and SDA for the following directed payment programs in the STAR Kids program.

  - Texas Incentives for Physicians and Professional Services (TIPPS)
  - Directed Payment Program for Behavioral Health Services (DPP BHS)
  - Rural Access to Primary and Preventative Services (RAPPS)

A review of the development of directed payment programs is not included in the scope of our review of the FY 2024 Texas Medicaid managed care capitation rates since directed payment programs are separately developed, reviewed, and funded outside the standard capitation rate development process.

- Step Six: Apply experience rebates to each MCO across all managed care programs and SDAs based on the Financial Statistical Reports (FSRs).

  - For FY 2024, each MCO is subject to an experience rebate based on the MCO's Financial Statistical Reports (FSRs) across all managed care programs and SDAs using the following parameters. The experience rebate limits the amount of profit (i.e., pre-tax income) an MCO can retain to no more than 7.2% of revenues.

Table 1
Texas Medicaid Managed
STAR Kids Program – Rate Structure
FY 2024 Experience Rebate Parameters

Pre-Tax Income as a % of Revenues	MCO Share	Commission's 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%

APPENDIX E: STAR KIDS

BASE DATA DEVELOPMENT

We reviewed the base data component of the FY 2024 capitation rates based on the underlying data provided by the Commission and our understanding of the Commission's FY 2024 base data development approach, as described below. The Commission provided all information we requested.

Description of State Fiscal Year (FY) 2024 Base Data Development

For a more detailed description of what base data is and why it matters, please see the Review Process section of the Main Report. Our detailed understanding of the base data development is summarized below for each major component of the FY 2024 capitation rate setting process:

Base Data Selection

- The Commission selected FY 2022 (September 2021 through August 2022) as the base period for both the enrollment data and the service expenditure data for the medical and pharmacy rate components. The Commission selected July 2022 through December 2022 as the base period for both the enrollment data and the service expenditure for the Non-Emergency Medical Transportation ("NEMT") component. The populations and services covered by the STAR Kids program during FY 2024 are generally the same as those covered by the STAR Kids program during the selected base period.

- The Commission provided a monthly enrollment file, which was used as the primary data source for base period enrollment data. This file summarizes monthly enrollment counts at an SDA, risk group, and MCO level, but does not provide individual membership records for each beneficiary.

- The managed care organizations ("MCOs") reported supplemental medical and pharmacy expenditure data in a prescribed reporting template, as designed by the Commission, which the Commission used as the primary data source for base period expenditure data. The data in this submission is not provided at a detailed claim level, but rather includes summarized monthly expenditure amounts by SDA and risk group for the following categories of service:

  - Professional
  - Outpatient Facility Emergency Room (ER)
  - Outpatient Facility Non-ER
  - Inpatient Facility
  - Other Acute Care
  - Attendant Care
  - Nursing Facility
  - Other Long-Term Care ('LTC")
  - Pharmacy
  - NEMT

  For the categories of service above, the MCOs provided the data to the Commission in a "lag" format, which reports claim costs by the combination of the month the service was performed ("incurred month") and the month in which the payment was made to the provider ("paid month"). Additional "non-lag" information was provided by the MCOs in the supplementary reporting for the following costs:

  - Monthly utilization metrics for the same categories of service in the lag data
  - Monthly capitation payments made from the MCO to a subcapitated provider at a risk group level
  - Large claim reports for members with costs exceeding $500,000
  - Reinsurance arrangements
  - Monthly third-party reimbursement by risk group
  - Monthly other direct service expenses by risk group

Base Data Validation

The Commission performed the following validations of the MCO supplemental data prior to relying on this data for the development of the base data for FY 2024.

- The Commission reconciled MCO reported supplemental data to the MCO reported Financial Statistical Reports ("FSR") expenditures for consistency in aggregate and by risk group at the MCO and SDA level for the base period (FY 2022). The FSRs are self-reported data prepared by the MCOs under the terms and conditions of the Uniformed Managed Care Contract and the Uniform Managed Care Manual. For more information on the FSRs please refer to the Texas Health and Human Services website.[3]

- The Commission reconciled the MCO reported supplemental lag expenditure data and the FSR data to the Commission's encounter data provided at the risk group level for FY 2022 for all MCO and SDA combinations.

Multiple entities audit the data sources used to validate the MCO supplemental data.

- University of Florida's Institute for Child Health Policy ("ICHP"), the External Quality Review Organization ("EQRO") vendor for Texas, is contracted to reconcile and validate the encounter data prior to releasing the encounter data to the Commission.

- The Office periodically audits the FSRs for a selected MCO and Program. Historically this audit has only been performed for the STAR+PLUS and STAR Kids programs.

- The Commission additionally contracts with external auditors to perform agreed-upon procedure ("AUP") engagements of the FSRs. These AUP engagements occur more than two years after the end of the state fiscal year.

Base Data Adjustments

- For expenditures paid through the claims system, also referred to as "lag expenditure" in this report, the Commission made the following explicit adjustments:

  - The paid expenditures as of February 2023 for the base period (FY 2022) were adjusted for claims which have been incurred but not reported ("IBNR").

  - Special adjustments were applied, as applicable, on an MCO specific basis for lag expenditures.

- For expenditures paid outside claims system, also referred to as "non-lag expenditures" in this report, the Commission made the following adjustments:

  - Sub-capitation expenditures are costs for which the MCO subcontracts with a third party to provide specific services in exchange for a fixed monthly premium per member. The contract between the MCO and the subcontractor defines whether the premiums are the same for all members or if they vary based on risk group, SDA, or other characteristics.

    - When explicitly reported by MCOs, the Commission removed the administrative portion of the sub-capitated expenditures from the base data.

    - When applicable, the Commission replaced actual premiums paid to subcontracted third parties during the base period with the most current premium amounts available.

    - The Commission excluded the fixed monthly premium payments to a third-party subcontractor from the rate development costs for an MCO that subcontracts with a related party. Instead, the Commission included the actual payments to providers from the MCO lag data in the projected claim costs for this MCO.

  - Net reinsurance cost is the total cost of premiums paid by MCOs to reinsurers less claim recovery payments received from reinsurers. A reinsurer will provide insurance to an MCO to protect the MCO against certain catastrophic claims risks. Some MCOs in the STAR Kids program choose to purchase reinsurance, but reinsurance is not required by the STAR Kids program.

    - The Commission capped reported net reinsurance costs to be no greater than $2.00 per member per month ("PMPM"), as applicable.

[3] Medicaid & CHIP Financial Statistical Reports: Fiscal Year 2022: Sept. 1, 2021, to Aug. 31, 2022, Texas Health and Human Services, Retrieved from: Medicaid & CHIP Financial Statistical Reports | Texas Health and Human Services.

  - Other itemized expenditures and / or recoveries:
    - Federally qualified health centers ("FQHCs") receive additional "wrap payments" from the MCOs in addition to their contracted MCO reimbursement rates to ensure total FQHC funding is consistent with statutorily defined minimum funding levels. The MCOs are not at-risk for the wrap payments, so the wrap payment costs are excluded from the capitation rate development. The Commission accounted for the wrap payment exclusion through the programmatic adjustment component of the rates, so the Commission did not include the FQHC wrap payment adjustment in the base data development.
    - The Commission primarily accounted for quality improvement expenditures, if reported, through the service coordination component of the rates, and are therefore, not included in the base data development.

- For third party reimbursements ("TPR"), which are reported in a standalone section of the MCO supplemental data separate from lag expenditures and non-lag expenditures, the Commission removed the TPR from the base data if the reported TPR amounts were confirmed to not be included in other expenses reported in the MCO supplemental data. The Commission validated the MCO reporting of TPR based on reconciliations between the MCO supplemental data and the FSRs.
- The Commission did not adjust the base data to remove services that are not covered by the program but are included in the base data sources. Instead, the Commission removed these costs through programmatic adjustments.

Base Data Aggregation

- Aggregation of MCO-specific base data for community base data development:
  - The Commission's base data used to develop community rates for each risk group within each SDA was calculated by aggregating MCO-specific base period PMPMs as incurred in the base period using each MCO's projected enrollment for FY 2024.

Data Provided for Base Data Development Review

We received the following primary data items from the Commission for the base data development review:

- A copy of the source data used by the Commission to develop the final base data for Harris SDA as Milliman's selected sample SDA for in-depth base data review and replication for the STAR Kids program:
  - MCO FSRs:
    - FY 2022 Year-End 90-Day (September 2021 through August 2022) with runout through November 2022
  - MCO supplemental expenditure data:
    - September 2019 through February 2023
  - The Commission provided summarized monthly enrollment files by each MCO and risk group:
    - Actual enrollment was provided for the period from September 2012 through February 2023.
    - Projected enrollment was provided for the period from March 2023 through August 2028.
- A copy of the Commission's base data development working files for all MCO and SDA combinations:
  - Lag expenditure completion and adjustment file, which includes the development of final lag base data at the SDA, MCO, and risk group level for lag expenditures:
    - Estimates of IBNR claims for expenditures reported through payment lags in the MCO supplemental expenditure data

        - Special adjustments, as limited to a few plans on a case-by-case basis, to the expenditures reported through payment lags in the MCO supplemental expenditure data

    - Non-lag expenditure calculation and adjustment file, which includes the development of final non-lag base data at the SDA, MCO, and risk group level for expenditures paid outside lags:

        - The PMPM calculation for each itemized expenditure not reported through payment lags in the MCO supplemental expenditure data

        - Certain reported non-lag expenditures that were excluded from the base data development

- A copy of the Commission's base data expenditure reconciliation files for all MCOs and all SDAs:

    - A comparison of reported total expenditures at the MCO level across all risk groups in each SDA between the MCO FSR and MCO supplemental expenditure data for FY 2022

    - A comparison of reported lag expenditures at the MCO and risk group level in each SDA across the commission provided encounters, MCO FSRs, and MCO supplemental expenditure data for FY 2021 and FY 2022

- The Commission's documentation of base data development in the FY 2024 actuarial report

- The Commission's responses to the ad hoc base data review questions from Milliman

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TREND

We reviewed the trend component of the FY 2024 capitation rates based on the underlying data provided by the Commission and our understanding of the Commission's FY 2024 trend development approach, as described below. The Commission provided all information we requested.

Description of State Fiscal Year (FY) 2024 Trend Development

Our detailed understanding of the trend development for FY 2024 capitation rates is summarized below.

Data Used for Trend Development

The Commission used the following data to support the final trends:

Medical Trends

- Monthly historical PMPM medical claim experience from the 2 years of FFS data prior to the beginning of the STAR Kids program in November 2016 (September 2014 through August 2016), the 2.5 years of STAR Kids program experience prior to the beginning of the COVID-19 PHE (September 2018 through February 2020), and the most recent 2 years and 4 months of STAR Kids program experience (September 2020 through December 2022), summarized by risk group and SDA
- The Commission used PMPM level data without separate utilization and unit cost detail to develop the selected medical trends.
- Annual adjustment factors for material medical programmatic changes from FY 2015 through FY 2023, including:
  - Provider reimbursement changes
  - Other programmatic changes

Pharmacy Trends

- Historical PMPM pharmacy claim experience for the last seven 12-month periods (March 2015 through February 2023) by risk group and month, excluding the following costs:
  - Drugs carved out of managed care for FY 2024 (i.e., costs are reimbursed directly to providers by the State through FFS Medicaid coverage and are not included in the managed care program)
  - Drugs covered under managed care but reimbursed to MCOs separate from the capitation rates on a non-risk basis (i.e., non-risk arrangements)
  - The drug Orkambi
  - Anti-viral and progestational agent drug classes

  Historical claim payment amounts were adjusted to reflect managed care pharmacy reimbursement provisions. Historical data was summarized separately for utilization and unit cost.
- Adjustment factors for material preferred drug list (PDL) changes from FY 2018 through FY 2024

NEMT Trends

- Historical PMPM NEMT managed transportation organization (MTO)[4] claims for demand response services[5] (i.e., non-fixed route transportation systems that require advanced scheduling by the individual customer) for the last four 12-month periods prior to the COVID-19 PHE (March 2016 through February 2020), adjusted as follows:

[4] NEMT services were provided by MTOs prior to June 1, 2021; services areas under the MTO program were defined differently than under the MCO contracts.
[5] "Demand response" is any non-fixed route system of transporting individuals that requires advanced scheduling by the customer, including services provided by public entities, nonprofits, and private providers. (49 C.F.R Section 604.3(g)). Examples can be found at https://www.transit.dot.gov/sites/fta.dot.gov/files/docs/Demand_Response_Fact_Sheet_Final_with_NEZ_edits_02-13-13.pptx

  - The Commission excluded MTO Regions 1 and 10 due to changes in MTOs in September 2017.
  - The Commission excluded MTO Region 4 because the NEMT services were provided FFS.
  - The Commission applied adjustments to Regions 6 through 9, 11, and 13 to account for provider reimbursement changes (Regions 6 through 8 and 11), the impact of Hurricane Harvey in 2017 (Regions 9 and 13), and a stretcher service policy change in November 2016 (Region 13).

- Consumer Price Index – All Urban Consumers (CPI) for transportation services from March 2009 through February 2020 published by the Bureau of Labor Statistics (BLS)

Normalization Process

Medical Trends

The Commission performed the following steps to normalize medical trends to adjust for historical programmatic changes:

- The Commission calculated the incurred medical claims PMPM by risk group and SDA for FY 2014 through FY 2016 (prior to transitioning to managed care), FY 2018, FY 2019, the six-month periods from September 2018 through February 2019 (i.e., the first half of FY 2019, or "FY 2019 H1") and September 2019 through February 2020 ("FY 2020 H1"), FY 2022, and September 2022 through December 2022.
- The Commission multiplied the SDA level incurred medical claims PMPM by programmatic change adjustment factors so the year-to-year values could be evaluated on a consistent basis for measuring trend without the influence of other change drivers.
- The Commission calculated SDA-specific PMPM trends as the percentage change in PMPM values (adjusted for programmatic changes) from year 1 to year 2.

Pharmacy Trends

The Commission excluded certain costs covered under the capitation rates from the pharmacy trend analysis because they drove material one-time impacts on costs (e.g., progestational agents) or they are historically volatile and expected to remain volatile on an ongoing basis (e.g., anti-viral treatments that fluctuate based on the intensity of the flu season). In addition, the Commission performed the following steps to normalize pharmacy trends to adjust for historical PDL changes:

- The Commission calculated the statewide incurred pharmacy claims PMPM (inclusive of all drug types, but net of excluded costs mentioned above) by risk group for each 12-month period from March 2016 through February 2020.
- The Commission multiplied the statewide incurred pharmacy claims per days supply by the annual PDL adjustment factors. The adjusted incurred claims per days supply estimate the unit costs that would have been incurred based on the PDL in effect prior to March 2017.
  - The Commission assumed costs for drugs that were not assumed to be explicit replacements for other drugs (e.g., emerging therapies that have been added to the PDL) are the same as the actual incurred costs.
- The Commission calculated the annual statewide utilization and unit cost trends as the year-over-year percentage change in days supply PMPM and adjusted incurred claims per days supply, respectively.

NEMT Trends

The Commission did not apply any normalization adjustments for the NEMT trend analysis.

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Aggregation

Medical Trends

The Commission aggregated all historical SDA specific PMPM trends into one single historical statewide PMPM trend. The Commission calculated the single historical statewide PMPM trend as the dollar weighted average of the thirteen historical SDA specific PMPM trends using adjusted year 1 expenditures as weights. For example, if one trend data point is measured from FY 2018 to FY 2019, the medical costs by SDA in FY 2018 are used to weight the SDA specific trends into the statewide trend.

Pharmacy and NEMT Trends

The Commission does not use SDA-level trends to develop pharmacy or NEMT trends. Therefore, the Commission's trend development for these components does not require additional aggregation steps.

Final Selection of Trend Assumptions

Medical Trends

The Commission calculates the statewide medical annual trend at the risk group level by weighting the historical annual statewide trends for each risk group as follows:

Table 2
Texas Medicaid Managed Care Rate Review
STAR Kids Program - Trend Development
Weighting of Historical Trends for Final Medical Trend Calculation

Trend Denominator (Year 1)	Trend Numerator (Year 2)	Weight in Overall Trend Calculation
FY 2014	FY 2015	22.86% = 12 / 42 months * 80%
FY 2015	FY 2016	22.86% = 12 / 42 months * 80%
FY 2018	FY 2019	22.86% = 12 / 42 months * 80%
FY 2019 1H	FY 2022 1H	11.43% = 6 / 42 months * 80%
FY 2021	FY 2022	15.00% = 12 / 16 months * 20%
9/2021 through 12/2021	9/2022 through 12/2022	5.00% = 4 / 16 months * 20%

Pharmacy Trends

The Commission calculates the statewide pharmacy annual utilization and unit cost trends at the risk group level by weighting the historical annual statewide utilization and unit cost trends for each risk group as follows:

Table 3
Texas Medicaid Managed Care Rate Review
STAR Kids Program - Trend Development
Weighting of Historical Trends for Final Pharmacy Trend Calculation

Trend Denominator[1]	Trend Numerator[1]	Weight in Overall Trend Calculation
March 2016 through February 2017	March 2017 through February 2018	13.33% = 1 / 6 * 80%
March 2017 through February 2018	March 2018 through February 2019	26.67% = 2 / 6 * 80%
March 2018 through February 2019	March 2019 through February 2020	40.00% = 3 / 6 * 80%
March 2021 through February 2022	March 2022 through February 2023	20.00%

[1] FFS experience prior to November 2016 was adjusted to reflect managed care pharmacy reimbursement provisions.

The Commission then calculates the statewide pharmacy PMPM trend as the cumulative impact of the selected utilization and unit cost trends. The Commission uses the following standard algebraic formula to calculate the PMPM trend:

PMPM trend = (1 + utilization trend) * (1 + unit cost trend) - 1

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NEMT Trends

The Commission selected the NEMT annual trend assumption for all risk groups using an equal 50% weight for the experience-based trend assumption developed from MTO historical data and a 50% weight for an industry trend assumption.

- The Commission's experience-based trend assumption is equal to the average of the historical annual statewide trends for the 12-month periods beginning March 2016 through February 2020 using managed care experience.
- The Commission's industry trend assumption is equal to the sum of an inflation trend and a utilization trend:
  - The inflation trend is equal to the average year-over-year trend in CPI for each month over ten years ending February 2020.
  - The utilization trend is selected by the Commission.

Data Provided for Trend Review

We received the following primary data items from the Commission for the trend development review:

- Historical medical and pharmacy claim experience for September 2019 through February 2023 by risk group, SDA and month:
  - Incurred claims in total and PMPM
- A copy of the Commission's medical trend development working files for all risk group and SDA combinations:
  - Summarized FY 2015 – FY 2016 FFS PMPM trends (prior to transitioning to managed care)
  - Summarized FY 2019 – 1H FY 2020 managed care PMPM trends
  - Summarized FY 2022 – Dec 2022 managed care PMPM trends
- Trend adjustment factors for the following adjustments:
  - Reimbursement related adjustments
  - Programmatic/benefit related adjustments

We also relied on the following additional information provided by the Commission for our FY 2023 rate review:

- Historical medical claim experience for September 2017 through August 2019 by risk group, SDA, and month:
  - Incurred claims in total and PMPM
- Historical pharmacy claim experience for March 2012 through February 2022 by drug type (brand, generic, or specialty), risk group, and month including:
  - Total utilization and utilization PMPM classified by days supply and scripts
  - Total incurred claims and incurred claims PMPM
  - Incurred claims per days supply
- A copy of the Commission's FY 2023 medical trend development working files for all risk group and SDA combinations, including:
  - Summarized FY 2017 – FY 2019 managed care PMPM trends
  - Programmatic adjustment factors for material changes between FY 2017 and FY 2020
  - Calculation of final trends based on a weighted average of historical annual trends in incurred claims PMPM adjusted for material programmatic changes

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- A copy of the Commission's FY 2023 pharmacy trend development working files for all risk group and SDA combinations, including:
  - For each risk group, all risk groups combined program-wide, and all risk groups combined program-wide calibrated to reflect the projected FY 2023 enrollment by risk group:
    - Annual utilization trends PMPM by drug type for the 12-month periods beginning March 2013 through February 2022; utilization trends were provided for both number of scripts and days supply
    - Annual incurred cost trends by drug type for the 12-month periods beginning March 2013 through February 2022; incurred cost trends were provided both PMPM and per days supply
  - Generic dispensing rate in days supply:
    - By risk group
    - For all risk groups combined program-wide
    - For all risk groups combined calibrated to reflect the projected FY 2023 enrollment mix by risk group
  - Calculation of final FY 2023 PMPM trends by risk group based on a weighted average of historical annual trends in incurred claims PMPM adjusted for PDL changes

APPENDIX E: STAR KIDS

PROGRAMMATIC ADJUSTMENTS

We reviewed the programmatic adjustment component of the FY 2024 capitation rates based on the underlying data provided by the Commission and our understanding of the Commission's FY 2024 programmatic adjustment development approach, as described below. The Commission provided all information we requested.

Description of State Fiscal Year (FY) 2024 Programmatic Adjustment Development

The Commission developed and applied programmatic adjustments separately for each itemized change as applicable to the FY 2024 capitation rates, but the Commission's general approach was similar for each change. Our detailed understanding of the programmatic adjustment development is summarized below.

Data Used for Programmatic Adjustment Development

Based on the assessed impact and overall risk to the capitation rate setting process, we did not perform a full replication of the programmatic adjustments. Therefore, we may not have identified every data source used by the Commission to develop these programmatic adjustment factors. The key data sources identified through our review include:

- Encounter data
- MCO supplemental expenditure data submissions and FSRs
- Historical provider and facility reimbursement levels and anticipated future changes to reimbursement levels through FY 2024, including:
  - Medicaid fee schedules
  - DRG groupers
- Historical preferred drug lists (PDLs) and anticipated changes to the PDL through FY 2024

Programmatic Adjustment Factor Development Approach

The Commission applied 21 programmatic adjustments specific to this program in the FY 2024 capitation rate development, including:

- 17 adjustments to the medical rate component
- 3 adjustments to the pharmacy rate component
- 1 adjustment to the NEMT rate component

The Commission developed most programmatic adjustment factors at the SDA and risk group level primarily using base period encounters. The approaches used by the Commission to develop these programmatic adjustment factors varied, but they were generally calculated as the estimated change to base period claim amounts for any applicable changes between the base period and the rating period FY 2024 divided by the base period claim amounts prior to the changes for the following broad programmatic change categories:

- Changes to provider reimbursement
- Changes to the covered services, such as changes to the formulary
- Other changes, such as PHE related changes and targeted managed care efficiency adjustments
- PHE adjustment, to account for the impact of PHE-related disenrollments prior to and during FY 2024
  -

As described in the Base Data Development section in this Appendix, the Commission removed certain costs that are not covered by the program (e.g., not covered by Medicaid, reimbursed directly by the State to the provider) or are covered by non-risk arrangements (i.e., the MCO is fully reimbursed by the State), but are included in the base data, through programmatic adjustments. The adjustments for these costs are often reflected in the wrap and carve-out removals, as well as some of the other reimbursement changes. The adjustments for costs not covered by the STAR Kids program capitation rates include:

- Medical costs for invalid clinician administered drugs (CADs).
- Medical costs for federally qualified health centers ("FQHC") wrap payments.

The Commission developed the PHE related cost adjustment by estimating the full impact of the PHE on acuity using two distinct approaches and blending the resulting adjustment factors. The Commission then weighted the blended adjustment factor based on the portion of FY 2024 that the PHE-related members are assumed to be enrolled. The following steps were performed for each risk group and SDA combination:

- Cohort Method:
  - The Commission received IDs from HHS Forecasting for members expected to be disenrolled before the end of FY 2024 due to the expiration of the PHE. The Commission then calculated the base period PMPM costs excluding the members expected to be disenrolled ("cohort PMPM").
  - The Commission set the "cohort method adjustment factor" equal to the cohort PMPM divided by the actual base period PMPM, but not less than 1.0.

$$cohort\ method\ adjustment\ factor = \frac{cohort\ PMPM}{base\ period\ PMPM}$$

- Non-utilizer Method:
  - The Commission calculated the percentage of months where members had $0 claims in both the base period and in the last 12-month period prior to the PHE (March 2019 through February 2020).
  - The Commission calculated the average base period PMPM costs including only months where a member had claims (i.e., excluding months with $0 claims).
  - The Commission calculated an adjusted base period PMPM assuming percentage of months with $0 claims in the base period was the same as the percentage in the last 12-month period prior to the PHE ("non-utilizer PMPM").
  - The Commission set the non-utilizer method adjustment factor equal to the non-utilizer PMPM divided by the actual base period PMPM, but not less than 1.0.

$$non\text{-}utilizer\ method\ adjustment\ factor = \frac{non\text{-}utilizer\ PMPM}{base\ period\ PMPM}$$

- Weighting factor:
  - The Commission estimated the total disenrollment based on the change in forecast enrollment from May 2023 to August 2024. The Commission calculated the monthly net change in enrollment from May 2023 through each month of FY 2024 based on the enrollment forecast.
  - The Commission calculated the "cumulative disenrollment percentage" each month as the cumulative net change in forecast enrollment from May 2023 divided by the total estimated disenrollment.
  - The Commission calculated the weighting factor by multiplying the cumulative disenrollment percentage by the forecast enrollment in each month of FY 2024, adding these factors together, and dividing by the total FY 2024 forecast enrollment. This calculation is intended to represent the estimated percentage of FY 2024 that potentially ineligible members will be enrolled.

$$weighting\ factor = \sum_{month=Sep\ 2023}^{Aug\ 2024} cumulative\ disenrollment\ percentage * forecast\ enrollment$$

  - For risk group and SDA combinations where forecast enrollment as of August 2024 is greater than forecast enrollment as of May 2023, the weighting factor is set equal to 0%.

- The Commission calculated the final PHE adjustment factor as 1 plus the weighting factor multiplied by the average of the cohort method adjustment factor and the non-utilizer method adjustment factor.

$$final\ PHE\ adjustment\ factor = 1 + weighting\ factor\ (\frac{cohort\ factor + non\text{-}utilizer\ factor}{2})$$

Data Provided for Programmatic Adjustment Review

The following items were requested by Milliman and received from the Commission for the programmatic adjustment review:

- Draft and final versions of the programmatic adjustment development exhibits included in the rate certification
- A copy of the Commission's PHE adjustment development working files for all rate components
- An adjustment factor summary document prepared by the Commission to describe the programmatic adjustments
- MCO supplemental expenditure data submissions and FSRs used in the base data development
- The Commission's documentation of the programmatic adjustment factor development in the FY 2024 actuarial report
- The Commission's responses to ad hoc questions from Milliman

APPENDIX E: STAR KIDS

NON-BENEFIT EXPENSES

We reviewed the non-benefit expense component of the FY 2024 capitation rates based on the underlying data provided by the Commission and our understanding of the Commission's FY 2024 non-benefit expense development approach, as described below. The Commission provided all information we requested.

Description of State Fiscal Year (FY) 2024 Non-Benefit Expense Development

Our detailed understanding of the non-benefit expense development for FY 2024 capitation rates is summarized below.

Data Used for Non-Benefit Expense Development

The Commission's non-benefit expense assumption is the sum of the following components:

- Administrative expense load, including general and quality improvement expenses
- Risk margin
- Taxes, including premium and maintenance taxes

The Commission's final non-benefit expenses were calculated separately for each service grouping (i.e., medical, pharmacy, and NEMT) as shown in Table 4.

Table 4
Texas Medicaid Managed Care Rate Review
STAR Kids Program - Non-Benefit Expense
FY 2024 Non-Benefit Expense Assumption Development

Service Grouping	Medical	Pharmacy	NEMT
Administrative Expenses	$25.00 PMPM + 5.25% of gross premium	$1.60 PMPM	$0.175 PMPM + 22% of gross premium
Risk Margin	1.75% of gross premium	1.75% of gross premium	1.75% of gross premium
Taxes	$0.0725 PMPM + 1.75% of gross premium	1.75% of gross premium	1.75% of gross premium

The Commission allocated the $25.00 PMPM medical administrative expense load as follows:

- $22.00 for general administration expenses
- $3.00 for quality improvement expenses

The Commission only reflected the $0.0725 PMPM maintenance tax in the medical component of the rates because it is assessed based on the number of enrollees.

Data Provided for Non-Benefit Expense Review

We received the following primary data items from the Commission for the non-benefit expense development review:

- A copy of the Commission's historical administrative expense PMPM analysis
- A copy of the Commission's final rate development exhibits for all SDAs and MCOs (for risk groups that had MCO rating)
- The Commission's documentation of non-benefit expense development in the FY 2024 actuarial report
- The Commission's responses to ad hoc questions

In addition, we reviewed the publicly available Texas Department of Insurance taxation requirements for premium taxes[6] and maintenance taxes.[7]

[6] "Insurance Premium Tax (Licensed Insurers)," Texas Comptroller of Public Accounts, Retrieved from: https://comptroller.texas.gov/taxes/insurance/licensed.php.
[7] "Insurance Maintenance Tax Rates and Assessments on 2022 Premiums," Texas Comptroller of Public Accounts, Retrieved from: https://comptroller.texas.gov/taxes/publications/94-130.php; "Adopted assessment, exam fee and maintenance tax rates," Texas Department of Insurance, Retrieved from: https://www.tdi.texas.gov/company/taxes3.html.

APPENDIX E: STAR KIDS

CMS COMPLIANCE AND DOCUMENTATION

We reviewed the Commission's FY 2024 rate certification for compliance with the CMS 2023-2024 Medicaid managed care rate setting guidance,[8] as described below.

Description of State Fiscal Year (FY) 2024 CMS Compliance and Documentation

Section I. Medicaid Managed Care Rates

The Commission included information for all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

Data - The Commission included information for all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

Projected Benefit Costs and Trends - The Commission included information for all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

Special Contract Provisions Related to Payment - The Commission included information for all portions of (A) the Incentive Arrangements section, (B) the Withhold Arrangements section, (C) the Risk-Sharing Mechanisms section, (D) the State Directed Payments section, (E) the Pass-Through Payments section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

Projected Non-Benefit Costs - The Commission included information for all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

Risk Adjustment and Acuity Adjustments - The Commission included information for all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

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

The Commission included information for all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

Section III. New Adult Group Capitation Rates

This section is not applicable to the STAR Kids program.

Data Provided for CMS Compliance and Documentation Review

The Commission provided us with the final FY 2024 rate certification report for the STAR Kids program. We relied on this document, as well as the publicly available CMS 2023-2024 Medicaid Managed Care Rate Setting Guide, to conduct our compliance and documentation review. We also compared the Commission's final report to the technical items we reviewed in other areas of our report to ensure the documentation accurately described the underlying rate methodology.

[8] 2023-2024 Medicaid Managed Care Rate Development Guide, Centers for Medicare & Medicaid Services, May 2023, Retrieved from: 2023-2024 Medicaid Managed Care Rate Development Guide.

APPENDIX F

DUAL DEMONSTRATION

APPENDIX F: DUAL DEMONSTRATION

PROGRAM OVERVIEW

Effective March 1, 2015, the Commission implemented a new managed care program for certain beneficiaries dually enrolled in Medicare and Medicaid (also known as dual-eligible) – the Texas Eligible Integrated Care Demonstration Project (Dual Demonstration).[1] The program is a joint venture between the federal authority CMS and the Commission as part of the Financial Alignment Demonstration capitated model established by the Medicare-Medicaid Coordination Office and is designed to better align the financial incentives of Medicare and Medicaid and to improve coordination of care for dual-eligibles.[2] The Dual Demonstration program is an innovative payment and service delivery model to improve coordination of services for dual-eligible members, enhance quality of care, and reduce costs for both the state and the federal government.[3] Through an individual being enrolled in a single Medicare-Medicaid health plan, Medicare and Medicaid benefits work together to better meet the member's health-care needs.[4] The program is voluntary and open to eligible beneficiaries in the following counties: Bexar, Dallas, El Paso, Harris, Hidalgo and Tarrant.[5] The Dual Demonstration program is currently offered through the same four Medicare-Medicaid Plans (MMPs) that participate in the STAR+PLUS program.

The objectives of the Dual Demonstration program include:

- Making it easier for clients to get care
- Promoting independence in the community
- Eliminating cost shifting between Medicare and Medicaid
- Achieving cost savings for the state and federal government through improvements in care and coordination[6]

A person must meet the following eligibility criteria to enroll in the Dual Demonstration program:

- Be 21 or older
- Have Medicare Part A, B and D, and be receiving full Medicaid benefits
- Be enrolled in the Medicaid STAR+PLUS program for at least 30 days[7]

The program does not include clients who reside in intermediate care facilities for individuals with intellectual disabilities and related conditions, or individuals with developmental disabilities who get services through one of the following waivers:

- Community Living Assistance and Support Services
- Deaf Blind with Multiple Disabilities Program
- Home and Community-Based Services
- Texas Home Living[8]

Other dual-eligible members may opt to enroll in the program including:

- Individuals in a Medicare Advantage plan not operated by the same parent organization that operates a STAR+PLUS dual eligible project ("MMP") and who meet the eligibility criteria for the demonstration may enroll if they disenroll from their Medicare Advantage plan

- Individuals in the Program of All-Inclusive Care for the Elderly ("PACE") who meet the eligibility criteria may enroll if they disenroll from PACE and enroll in the Medicaid STAR+PLUS program for at least 30 days

- Eligible individuals participating in the CMS Independence at Home demonstration may switch to this demonstration project[9]

Individuals in the Dual Demonstration program receive access to their full STAR+PLUS benefits, as well as Medicare benefits.

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[1] Dual-eligible Integrated Care Demonstration Project, Rate Setting Actuarial Analysis, Texas Health and Human Services, Retrieved from: Dual-eligible Integrated Care Demonstration Project (Dual Demo) | Provider Finance Department (texas.gov).
[2] Ibid.
[3] Dual Eligible Project (MMP), Texas Health and Human Services, Retrieved from: Dual Eligible Project (MMP) | Texas Health and Human Services.
[4] Ibid.
[5] Duel-eligible Integrated Care Demonstration Project, Rate Setting Actuarial Analysis, Texas Health and Human Services, Retrieved from: Dual-eligible Integrated Care Demonstration Project (Dual Demo) | Provider Finance Department (texas.gov).
[6] Dual Eligible Project (MMP), Texas Health and Human Services, Retrieved from: Dual Eligible Project (MMP) | Texas Health and Human Services.
[7] Ibid.
[8] Ibid.
[9] Ibid.

APPENDIX F: DUAL DEMONSTRATION

The Dual Demonstration program is estimated to cover roughly 33,000 beneficiaries in FY 2024 at a program cost of roughly $502 million (excluding directed payments). Under this demonstration, Medicare and Medicaid each contribute to the total capitation payment to the participating MMPs. CMS develops the portion of the capitation payment for Medicare covered services, while the Commission develops the portion of the capitation rate for Medicaid services. Our review focuses only on the Medicaid portion of the total capitation payment.

APPENDIX F: DUAL DEMONSTRATION

RATE STRUCTURE

We reviewed the actuarial report and rate development model created by the Commission to review the rate structure used for the FY 2024 capitation rate development for the Dual Demonstration program.

Description of State Fiscal Year (FY) 2024 Rate Structure

The Dual Demonstration program is a joint venture between the Commission and CMS. The Commission develops the Medicaid portion of the capitation rate paid to the four Medicare-Medicaid Plans (MMPs) participating in the program.

Risk Groups

Members are segmented into one of three risk groups as part of the rate structure based on their anticipated risk acuity differences based upon their service setting, consistent with the STAR+PLUS program risk groups for dual eligible members:

- Dual Eligible – Other Community Care (OCC)
- Dual Eligible – Home and Community Based Service (HCBS)
- Dual Eligible – Nursing Facility clients

Service Delivery Areas

Unlike the other programs in this report, the Dual Demonstration programs only covers members in the following six counties. The Commission develops capitation rates separately for each county to account for regional cost variations:

- Bexar County
- Dallas County
- El Paso County
- Harris County
- Hidalgo County
- Tarrant County

Rate Development Process

The FY 2024 community Dual Demonstration Medicaid capitation rates (i.e., all participating MMPs combined) were developed by the Commission using the following steps:

- Step One: The Commission developed FY 2024 Dual Demonstration capitation rates at the county and risk group level for each of the service groupings listed below. The development of the capitation rate for each service grouping includes service costs and non-benefit expenses (e.g., administrative costs). The capitation rates in Step One are required to estimate the cost of providing services absent the Dual Demonstration program.

  - Acute care
  - Long-term care (LTC)
  - Pharmacy
  - Non-emergency Transportation (NEMT)

  The Commission relies upon STAR+PLUS experience in the development of the Dual Demonstration rates as follows:

  - Acute care: Fee-for-service data from members enrolled in STAR+PLUS dual eligible risk groups is used as the base data for the Dual Demonstration dual eligible risk groups (i.e., the OCC risk group from STAR+PLUS is used for the OCC risk group in Dual Demonstration program).

  - Long-term care: The capitation rates from STAR+PLUS dual eligible risk groups are the starting point for the Dual Demonstration capitation rates, with further adjustment as described in the following steps.

  - Pharmacy: Fee-for-service data from members enrolled in STAR+PLUS dual eligible risk groups is used as the base data for the Dual Demonstration dual eligible risk groups.

  - Non-emergency Transportation: The Dual Demonstration capitation rates relies upon the methodology and assumptions used to develop the STAR+PLUS NEMT costs from the historical experience submitted by participating MCOs, with further adjustment as described in the following steps.

- Step Two: The Commission adjusted the community rates using risk adjustment to reflect the expected acuity differences by MMP due to the underlying health conditions of the members in each plan. Risk scores were applied to the community rate for each service grouping as follows:

  - Acute care: No risk adjustment is applied to the community rate.

  - LTC: The Commission developed MMP specific risk scores based on the relative percentage of unique members that utilize personal attendant services.

  - Pharmacy: No risk adjustment is applied to the community rate.

  - NEMT: No risk adjustment is applied to the community rate.

  Risk scores are applied on a budget neutral basis at the risk group level across the MMPs in each county, ensuring that additional funding is not introduced or removed from the program due to the application of the risk scores.

  A review of the risk adjustment methodologies is not included in the scope of our review of the FY 2024 Texas Medicaid managed care capitation rates, since risk adjustment is applied on a budget neutral basis, meaning it does not increase or decrease the total program funding, just the allocation of payments across MMPs within a risk group***.***

- Step Three: The Commission added MMP specific amounts to the capitation rates by risk group and county for the following directed payment programs in the Dual Demonstration program.

  - Network Access Improvement Program (NAIP)
  - Quality Incentive Payment Program for Nursing Facilities (QIPP)
  - Comprehensive Hospital Increase Reimbursement Program (CHIRP)
  - Texas Incentives for Physicians and Professional Services (TIPPS)
  - Directed Payment Program for Behavioral Health Services (DPP BHS)
  - Rural Access to Primary and Preventative Services (RAPPS)

  A review of the development of directed payment programs is not included in the scope of our review of the FY 2024 Texas Medicaid managed care capitation rates, since directed payment programs are separately developed, reviewed, and funded outside the standard capitation rate development process.

- Step Four: The Commission applied the contracted 5.5% savings assumption to convert the capitation rates from being an estimate of costs absent the Dual Demonstration to the costs anticipated under the Dual Demonstration program. This savings assumption, which is contractually set at 5.5%, reflects the estimated efficiencies to be achieved by coordinating care between the Medicare and Medicaid programs.

APPENDIX F: DUAL DEMONSTRATION

BASE DATA DEVELOPMENT

The base data used by the Commission to develop the Dual Demonstration FY 2024 capitation rates is the dual-eligible risk groups' base data from the STAR+PLUS program or fee-for-service data for these STAR+PLUS members. The Commission provided all information we requested. Please see Appendix D for an overview of the STAR+PLUS base data development, as well as any observations or recommendations related to the STAR+PLUS base data in the Main Report.

For a full description of the approach used to review the base data, as well as a high-level description of the regulatory and policy authority to be followed in the development of the base data, please see the Review Process section in the Main Report.

Description of State Fiscal Year (FY) 2024 Base Data Development

For a more detailed description of what base data is and why it matters, please see the Review Process section of the Main Report. Our detailed understanding of the base data development is summarized below for each major component of the FY 2024 capitation rate setting process:

Base Data Selection

- The Commission selected FY 2022 (September 2021 through August 2022) from the STAR+PLUS dual-eligible risk groups as the base period data for all categories of service in the Dual Demonstration program.
- The Commission reviewed Dual Demonstration historical experience for acute care and pharmacy services but determined the data reported by the participating MMPs was too volatile to use for the base data, likely due to difficulty in the MMPs reporting Medicaid and Medicare covered services separately. Therefore, fee-for-service data for STAR+PLUS dual eligible members was used for the base data for acute care and pharmacy services.

Base Data Adjustments

- The Commission applies a member selection adjustment to the STAR+PLUS base data to reflect acuity differences between the STAR+PLUS and Dual Demonstration enrollees. The member selection adjustment was developed by reviewing historical experience for eight experience periods from March 2014 through December 2021. Within each of these experience periods the relative cost difference was calculated for members that stayed in the STAR+PLUS program relative to those that moved to the Dual Demonstration. The member selection adjustments for each category of service and county were calculated as the average across the eight experience periods weighted on the distribution of Dual Demonstration membership included in the analysis. Based on the results of this analysis, the Commission declined to apply member selection adjustments in some cases due to limited differences or data credibility concerns. The Commission applied member selection adjustments for the following:
  - Long Term Care: County specific member selection adjustment factors were applied for the OCC risk group.
  - Acute Care: County specific member selection adjustment factors were applied for the OCC and HCBS risk groups.
  - Pharmacy: Statewide member selection adjustment factors were applied for the OCC risk group.
  - NEMT: County specific acute care member selection adjustments factors were applied to NEMT services.

Data Provided for Base Data Development

We received the following primary data items from the Commission for the base data development review:

- Detailed STAR+PLUS trend analyses performed by the Commission for LTC services, as described in Appendix D
- Dual Demonstration specific acute care and pharmacy monthly PMPM trend analysis from September 2016 to August 2022 by risk group

APPENDIX F: DUAL DEMONSTRATION

TREND

We gained a detailed understanding of the Commission's FY 2024 trend development approach used for the Dual Demonstration program. We relied on underlying data provided by the Commission, as well as responses to our specific trend review questions. The Commission provided all information we requested.

As noted in the Risk Level Classification section of the Main Report, the NEMT service grouping component comprises a small and lower-risk portion of the overall capitation rates. As such, we performed a review of the Commission's FY 2024 NEMT trend development methodology to become comfortable in the context of overall rate soundness.

For a full description of the approach used to review the trend, as well as a high-level description of the regulatory and policy authority to be followed in the development of the trend, please see the Review Process section in the Main Report.

Description of State Fiscal Year (FY) 2024 Trend Development

The Commission did not specifically develop trend assumptions using Dual Demonstration data, due to credibility concerns with the Medicaid data specific to these members. Rather, the following data sources and methodologies were used for each type of service.

LTC

The Dual Demonstration LTC historical costs were not developed by the Commission using the detailed steps to calculate capitation rates, such as starting with base data and then applying trend assumptions. Rather the Commission relies upon the ending capitation rates from the STAR+PLUS program. Therefore, no separate trend analysis was performed for the LTC portion of the Dual Demonstration capitation rates.

Acute Care

The Dual Demonstration specific acute care costs were not credible to rely upon to develop Dual Demonstration specific acute care trends. Therefore, the Commission reviewed fee-for-service historical experience for STAR+PLUS members in the three dual eligible risk groups in service areas that are not covered by the Dual Demonstration program. The Commission calculates the statewide medical annual trend at the risk group level by weighting the historical annual trends for each risk group as follows:

Table 1
Texas Medicaid Managed Care Rate Review
Dual Demonstration Program - Trend Development
Weighting of Historical Trends for Final Medical Trend Calculation

Trend Denominator (Year 1)	Trend Numerator (Year 2)	Weight in Overall Trend Calculation
March 2016 through February 2017	March 2017 through February 2018	25% = 1 / 4
March 2017 through February 2018	March 2018 through February 2019	25% = 1 / 4
March 2018 through February 2019	March 2019 through February 2020	25% = 1 / 4
September 2020 through August 2021	September 2021 through August 2022	25% = 1 / 4

Pharmacy

The Commission noted that changes in the Medicaid pharmacy historical experience for the Dual Demonstration program is more a result of changes in the wrap services, rather than driven by utilization and or unit cost changes for pharmacy services. Therefore, the Commission did not rely upon historical experience and set an annual trend assumption of 3% based on the historical average pharmacy trends across other Medicaid programs.

NEMT

The Dual Demonstration NEMT trend assumptions rely upon the analysis performed by the Commission for the STAR+PLUS program described in Appendix D.

APPENDIX F: DUAL DEMONSTRATION

PROGRAMMATIC ADJUSTMENTS

Description of State Fiscal Year (FY) 2024 Programmatic Adjustment Development

The Commission did not develop programmatic adjustments specifically for the Dual Demonstration program. Instead, applicable programmatic adjustments for the long-term care and NEMT services rely on programmatic adjustment from the STAR+PLUS capitation rate development, outlined in Appendix D. The Commission did not apply any programmatic adjustments to the acute care or pharmacy services since these costs are largely the cost sharing components not covered by Medicare and not subject to programmatic changes in the Medicaid program.

APPENDIX F: DUAL DEMONSTRATION

NON-BENEFIT EXPENSES

We examined the Commission's FY 2024 non-benefit expense development approach used for the Dual Demonstration program. We relied on data and analysis provided by the Commission, as well as responses to our specific non-benefit expense review questions. The Commission provided all information we requested.

As noted in the Risk Level Classification section of the Main Report, the NEMT service grouping component comprises a small and lower-risk portion of the overall capitation rates. As such, we performed a review of the Commission's FY 2024 NEMT non-benefit expense development methodology to become comfortable in the context of overall rate soundness.

For a full description of the approach used to review the non-benefit expense, as well as a high-level description of the regulatory and policy authority to be followed in the development of the non-benefit expense, please see the Review Process section in the Main Report.

Description of State Fiscal Year (FY) 2024 Non-Benefit Expense Development

The Commission did not develop non-benefit expenses specifically for the Dual Demonstration program for the long-term care or NEMT services, and instead they rely on non-benefit expenses included in the STAR+PLUS capitation rate development, outlined in Appendix D.

The expense assumptions developed by the Commission for the acute care and pharmacy non-benefit expense assumptions are summarized in Table 2.

Table 2
Texas Medicaid Managed Care Rate Review
Dual Demonstration Program
FY 2023 Non-Benefit Expense Assumption Development

Service Grouping	Acute Care	Pharmacy
Administrative Expenses	$2.92 PMPM	$0.29 PMPM
Risk Margin	0%	0%
Taxes	$0	$0

The $2.92 PMPM for acute care services is based on the current amount to administer services for dual eligible members in the State's Texas Medicaid & Health Partnership (TMHP) contract. The $0.29 PMPM for pharmacy services is based on the cost to administer pharmacy services for dual eligible members prior to the Dual Demonstration program under the State's TMHP contract.

The Commission noted that risk margin and taxes are not included in the projection of acute care and pharmacy services since the projection is intended to represent costs absent the Dual Demonstration program, and those would not have been historical costs incurred for these services since they are not covered by the STAR+PLUS program.

APPENDIX F: DUAL DEMONSTRATION

CMS COMPLIANCE AND DOCUMENTATION

We reviewed the Commission's FY 2024 rate certification for compliance with the CMS 2023-2024 Medicaid managed care rate setting guidance,[10] as described below. While we are not conducting a compliance review on CMS' behalf, we reviewed the rate certification to ensure that the Commission has answered all portions of the CMS 2023-2024 Medicaid managed care rate setting guidance and provided sufficient documentation to comply with actuarial standards of practice. We reviewed the following sections of the CMS 2023-2024 Medicaid managed care rate setting guidance and compared them against what the Commission submitted in their Medicaid managed care capitation rate certification for the Dual Demonstration program: (1) Section I. Medicaid Managed Care Rates, Data, Projected Benefit Costs and Trends, Special Contract Provisions Related to Payment, Projected Non-Benefit Costs, and Risk Adjustment and Acuity Adjustments; (2) Section II. Medicaid Managed Care Rates with Long-Term Services and Supports; and (3) Section III. New Adult Group Capitation Rates.

Description of State Fiscal Year (FY) 2024 CMS Compliance and Documentation

Section I. Medicaid Managed Care Rates

The Commission included information for all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

Data - The Commission included information for all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

Projected Benefit Costs and Trends - The Commission included information for all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

Special Contract Provisions Related to Payment - The Commission included information for all portions of (A) the Incentive Arrangements section, (B) the Withhold Arrangements section, (C) the Risk-Sharing Mechanisms section, (D) the State Directed Payments section, (E) the Pass-Through Payments section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

Projected Non-Benefit Costs - The Commission included information for all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

Risk Adjustment and Acuity Adjustments - The Commission included information for all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

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

The Commission included information for all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2023-2024 Medicaid managed care rate setting guidance.

Section III. New Adult Group Capitation Rates

This section is not applicable to the Dual Demonstration program.

Data Provided for CMS Compliance and Documentation Review

The Commission provided us with the final FY 2024 rate certification report for the Dual Demonstration program. We relied on this document, as well as the publicly available CMS 2023-2024 Medicaid Managed Care Rate Setting Guide to conduct our compliance and documentation review. We also compared the Commission's final report to the technical items we reviewed in other areas of our report to ensure the documentation accurately described the underlying rate methodology.

[10] 2022-2023 Medicaid Managed Care Rate Development Guide, Centers for Medicare & Medicaid Services, April 2022, Retrieved from: 2022-2023 Medicaid Managed Care Rate Development Guide.

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milliman.com

CONTACT

Jill Bruckert
jill.bruckert@milliman.com

Greg Herrle
greg.herrle@milliman.com

Nicholas Gersch
nicholas.gersch@milliman.com

Alisa Gordon
alisa.gordon@milliman.com

Response from the Health and Human Services Commission to the Milliman Report

Management Responses – Milliman Report – Texas State Auditor's Office –
Review of FY 2024 Texas Medicaid Managed Care
Capitation Rate Development Process

General Concerns/Comments

This document presents the responses of HHSC Actuarial Analysis and Rudd and Wisdom, Inc. to the Recommendations included in Exhibit 1 and Observations included in Exhibit 2 of the Texas State Auditor's Office (SAO) audit of the FY2024 capitation rating process, titled "Review of FY 2024 Texas Medicaid Managed Care Capitation Rate Development Process."

Prior to commenting on the initial findings themselves, which are classified as either recommendations or observations, we note **the overall conclusion that the review did not find any material issues to indicate that the capitated rates are not actuarially sound. Further, HHSC generally followed appropriate rate setting methods.**

The report includes in its definition of observations, "technical deviations from Medicaid capitation rate setting best practices…." (Report, page 3). We note that the term "best practices" does not have a common definition, legal, technical or otherwise, but instead represents a wide range of actions and assumptions used by reasonable actuaries. Like most issues in actuarial science, there is little in rate setting that is prescribed by rule or statute. Instead, actuaries rely on the Actuarial Standards of Practice (ASOP) and Medicaid Managed Care Rate Development Guides published by CMS for guidance and use their experience and professional judgement to develop actuarially sound capitation rates.

Similarly, the report defines recommendations as used "where the capitation rate development process varies from commonly accepted rate setting practices." (Report, page 3) As with the previous term, there is no standard definition of "commonly accepted rate setting practices." This term again represents a wide range of reasonable approaches to rate setting used by different actuaries. It may be difficult for an audience that is unfamiliar with rate setting and the actuary's responsibilities in rate setting to realize that these terms are subjective and the opinion of the author. It is also likely that any distinction between the terms "best practices" and "commonly accepted" practices, to the extent that one exists, will be lost on most readers.

The report definitions also present a hierarchy of severity between observations and recommendations, the latter of which is "more serious in nature". This may be problematic as an audience unfamiliar with rate setting may conclude recommendations are serious findings with material financial impact when in fact many of the recommendations would have no financial impact or represent differences of opinion between actuaries as opposed to material risks to the MCOs, state or HHSC.

Rate Structure Recommendations and Observations

Recommendation A:

Consider consolidating SDAs for the purpose of rate development.
Applicable program(s): STAR, STAR+PLUS, STAR Kids
This recommendation is unchanged from the FY 2023 review.

Management Response

Consideration will be given to adjusting the rate structure in future rating periods, but changes may be deemed unnecessary given SDA, MCO and provider network configurations.

No changes to the rate development process should be made in the short term as SDAs are defined in advance when managed care plans are selected. While the state could combine SDAs for the purpose of rate development, doing so does not necessarily improve the ratemaking process or produce savings for the state given that consolidating SDAs would be budget neutral. It also presents challenges related to significant differences among geographic regions of Texas in provider network-related costs and practice patterns. In addition, different MCOs currently participate in each SDA and any changes to the SDAs will need to align with future RFPs to coordinate MCO participation within an SDA. Consolidating SDAs would be budget neutral as the rates are a function of the cost of the managed care program and combining SDAs does not impact the cost but merely aggregates the cost across a larger population.

Adjustments may be considered in the long term but must coincide with future RFPs.

Action Plan

HHSC Actuarial Analysis and Rudd and Wisdom will continue to monitor this situation on an ongoing basis to determine if any changes are needed. Future actions will be dependent upon RFPs and the composition of managed care plans across the various SDAs.

Responsible Manager

Michael Joyner, Chief Actuary, HHSC Actuarial Analysis

Recommendation B:

Consider combining risk groups to enhance credibility and reduce annual volatility. Applicable program(s): STAR Kids
This recommendation is unchanged from the FY 2023 review

Management Response

Rates continue to be calculated on a statewide basis for the YES and Under Age 1 risk groups for all rate components due to their size and claims volatility. Furthermore, the NEMT rate component was set on a statewide basis for the IDD risk group due to the same concerns. Consideration was given to using statewide rates for other risk groups, but no further changes were made.

While a statewide rate could be considered in order to increase credibility of certain risk groups, this must be done without compromising the ability to differentiate between the historically demonstrated cost patterns that exist within Texas for the various SDAs. Given the size of the state and the composition of provider networks (i.e., children's hospitals, public hospitals, specialty providers, etc…) statewide

rating should be limited to circumstances which do not create inequities among the SDAs and the participating MCOs.

Rates are set by risk group in order to differentiate populations with varying cost profiles due primarily to acuity and utilization differences and serve as an underlying risk adjustment process. Combining risk groups with varying cost profiles could result in MCOs targeting or avoiding certain subpopulations in order to earn additional profits. As a result, the rate structure, including the risk group and SDA definitions, must be carefully considered to avoid unintended consequences and create incentives for MCO to behave in a manner that is counter to the program goals of providing cost effective care to the entire population.

HHSC Actuarial Analysis and Rudd and Wisdom disagree with the elimination of MCO experience rating as an interim step for the community rate development. Although this step further reduces the size of certain risk groups and MCO combinations it is an important means of (a) ensuring low-cost plans are not excessively profitable and (b) incentivizing the efficient delivery of health care. Eliminating this component of the rate development would increase overall program cost and result in larger profits for the lowest cost health plans in each SDA.

Action Plan

HHSC Actuarial Analysis and Rudd and Wisdom will continue to monitor this situation on an ongoing basis to determine if any changes are needed. The rate structure is continually evaluated and updated if deemed appropriate.

Responsible Manager

Michael Joyner, Chief Actuary, HHSC Actuarial Analysis

Observations A - C:

- Rates are developed individually by MCO rather than across all MCOs. Applicable program(s): STAR, STAR Kids
- Allocation of benefit and non-benefit expenses in final rates to MCOs are not clearly identified. Applicable program(s): STAR, STAR Kids

- LTC rates developed separately for nursing facility and community residents. Applicable program(s): STAR+PLUS

Management Response:

Observation A

The use of MCO individual experience rates in the development of capitation rates for Texas Medicaid is preferred for several reasons. The unique combination of for-profit and non-profit MCOs within the various Service Delivery Areas (SDAs) throughout Texas present different cost profiles that represent different philosophies of care and management. This combination has the potential to result in situations where excessive profits could theoretically be possible for lower-cost, for-profit plans that operate within the same SDAs as higher-cost, provider-owned plans in a pure community rating environment. The current rate development approach is a balance between seeking to eliminate circumstances such as this while still incentivizing low-cost plans to remain as productive participants in the Medicaid program. A 108% cap on the individual experience rate has been applied in both STAR and STAR Kids and is based on more than a decade's worth of comparing risk-adjusted community rates for the various health plans. This provision reduces the overall premium for FY2024 by $42.9 million all funds and results in savings to HHSC. Revising the rating methodology to remove this provision would result in excessive profits being earned by a small number of MCOs in the STAR and STAR Kids programs and be a net cost to the state.

Observation B

The administrative formula for each program is clearly identified in the applicable section of the actuarial reports and is applied uniformly to all MCOs within each program. The 108% cap is applied to the total rate, inclusive of non-benefit expenses when compared to the community rate with risk adjustment. The 108% calculation is not intended to apply separately to the various components of the total rate but rather to set a maximum threshold at which the lowest cost MCOs will

be compensated. As noted, the fixed and variable components of the administrative fee formula are then applied to the capped premium.

Observation C

HHSC Actuarial Analysis and Rudd and Wisdom continue to assist Medicaid and CHIP services in studying the impact of a blended versus non-blended rate development for nursing facility and community residents. As noted, HHSC produced a paper regarding a blended rate approach and is awaiting further feedback from stakeholders.

Base Data Development Recommendations and Observations

Recommendation C

Use state encounter data as the primary base data source for expenditure data. Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids.
This recommendation is unchanged from the FY 2023 review

Management Response

The report notes "In general, encounter data is the preferred data source for base expenditure date development, to the extent complete and accurate encounter data is available…." (Report, page 30, emphasis added) HHSC Actuarial Analysis and Rudd and Wisdom understand the benefit of encounter data but continue to have concerns regarding the completeness and accuracy of the data. While the encounter data is certified by an EQRO, the certification standards which typically include a 2-4% variance tolerance are higher than the variance of other data sources. Current concerns with the encounter data include but are not limited to:

1. The timing of when the data is received. Encounter data is typically available in late March which is 2-3 months later than the current rate development process begins.
2. While the aggregate data may have a relatively low variance in aggregate, we have observed individual MCOs with much larger variation requiring resubmissions and further delays.
3. Encounter data typically only includes 2-3 months of runout requiring additional estimation while other data sources include 6 months of runout.

Currently, the rate development process includes three sources of data i) the Financial Statistical Report (FSR), ii) MCO Supplemental Data and iii) Encounter Data. HHSC Actuarial Analysis and Rudd and Wisdom complete extensive analysis to reconciles the data sources and ensure that all are as complete and accurate as possible. The three data sources are compared to ensure consistent results such that the three are considered interchangeable in aggregate. Although interchangeable in total, each data source has a unique role in the rating analysis.

The FSR provides high level summary information of claims data, subcapitated expenses, reinsurance expenses and administrative costs. The FSRs are used to determine the experience rebate amount for each MCO. The allowability of expenses 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 Cost Principles for Expenses from chapter 6.1 of the HHSC Uniform Managed Care Manual provides a detailed description of what is considered an allowable and unallowable expense for FSR reporting. The FSRs are audited to ensure accurate reporting by the MCOs.

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. The 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 it back to the MCOs to confirm

the accuracy. The Data Book is used to determine base year data used in the rating analysis. We concluded that the MCO supplemental data should be used as the primary source for base year data because:

1) The MCO supplemental data reconciles to the FSR to ensure accuracy and completeness given that i) the FSR only includes allowable expenses and ii) the FSRs are eventually audited.
2) There is little variance between MCO supplemental data and the FSR. Using the MCO supplemental data ensures all allowable expense are captured in the rate development.
3) The MCO supplemental data includes more recent claims than the encounter data. The encounter data is a point-in-time estimate that is not updated for retroactive eligibility changes or claims adjustments to the extent that they impact the data. The encounter data typically only includes 2-3 months of claims runout while the supplemental data includes a minimum of 6 months.
4) Transparency: the supplemental data is derived directly from the most recent MCO information and is confirmed by the MCO.

All three data sources have been reconciled to ensure consistency among the three. We have no concerns with any of the data sources and note that each plays a critical role in the rate development. These roles are evaluated on an ongoing basis and updated annually as needed based on the quality and availability of each data source. Utilizing the three data sources increases the flexibility of the rating model and prevents the analysis from being impacted by the limitations of a single dataset.

Action Plan

Rudd and Wisdom and HHSC Actuarial Analysis will continue to evaluate the data sources used in the rate development during future rating cycles and will ensure that the most complete, accurate available information will be utilized. As the quality and accuracy of the encounter data improves, further consideration will be given to using this information as the primary data source. In the short term, given the extensive reconciliation between the three data sources noted above we have no concerns with the credibility, quality or accuracy of the data being used for rate development purposes.

Responsible Manager

Michael Joyner, Chief Actuary, HHSC Actuarial Analysis

Recommendation D

Use the state capitation payment file as the primary base data source for enrollment data. Applicable program(s): STAR, Dental, STAR+PLUS, STAR Kids
This recommendation is unchanged from the FY 2023 review

Management Response

The rating analysis primarily relies on three data sources for enrollment: i) the Financial Statistical Report (FSR), ii) summary-level enrollment provided by HHS Forecasting and iii) detailed eligibility files. The three data sources are compared to ensure consistent results such that the three are considered interchangeable in aggregate. The difference between the three data sources for the base period is less than 0.03% for all Medicaid programs. In addition to being immaterial in aggregate, the differences have been studied by risk group within each program and the risk group variation is insignificant as well. Any changes in source data for enrollment information would have an immaterial net impact on the actuarially sound rates.

Action Plan

Rudd and Wisdom and HHSC Actuarial Analysis will continue to evaluate the data sources used in the rate development during future rating cycles and will ensure that the most complete, accurate available information will be utilized.

Responsible Manager

Michael Joyner, Chief Actuary, HHSC Actuarial Analysis

Recommendation E

Develop base period for each SDA by weighting each MCO's experience with actual enrollment instead of projected enrollment.
Applicable program(s): STAR, STAR+PLUS, STAR Kids
This recommendation is unchanged from the FY 2023 review

Management Response

The current approach ensures the community rates are budget neutral in comparison to the individually calculated rates. The rating analysis is performed for each individual MCO and then aggregated at the SDA level. The SDA rating analysis weighs each individual MCO's experience using the projected enrollment to ensure budget neutrality. The report states "The Commission's calculation implies that the average cost of each member is driven more by the MCO in which the member is enrolled rather than the member's acuity and utilization". (Report, page 33) MCO selection and its impact on cost has been observed in the historical claims due to varying provider network composition and provider reimbursement levels. In practice, acuity, utilization and MCO selection impact member cost. As demonstrated by Table 5, changes in MCO composition are relatively small, but must be accounted for in the rate development process. For example, if an MCO that contracts with and utilizes a higher cost provider, i.e., a children's hospital, more than other MCOs in the SDA and that MCOs enrollment mix increases or decreases these changes must be accounted for in the rate development process to properly reflect the expected change in cost. Failing to use the projected enrollment would misallocate the future expenses between the MCOs, albeit to a relatively small degree, given the limited variation in enrollment distribution from year to year.

We disagree with this recommendation as any change to the weighting would violate the budget neutral nature of the rate development.

Action Plan

HHSC Actuarial Analysis and Rudd and Wisdom will consider whether refinements can be made to the rate development process to alleviate this concern while ensuring budget neutrality.

Responsible Manager

Michael Joyner, Chief Actuary, HHSC Actuarial Analysis

Recommendation F

Include supporting documentation for the development of the base period data. Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids
*This recommendation is **modified** from the FY 2023 review*

Management Response

HHSC Actuarial Analysis and Rudd and Wisdom will continue to improve the documentation to further describe the base data development.

Action Plan

As noted in the report, HHSC Actuarial Analysis and Rudd and Wisdom added a new section to the actuarial report describing the base data development which attempted to add details regarding the base data used for rate development. HHSC will expand this section in future actuarial reports to more clearly define the processes used to collect, reconcile and verify the base period data.

Responsible Manager

Michael Joyner, Chief Actuary, HHSC Actuarial Analysis

Observations D - F:

- Summary-level enrollment data and expenditure data are gathered from separate sources. Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids
- Net reinsurance costs should not be included in the base data. Applicable program(s): STAR, STAR+PLUS, STAR Kids
- Certain non-lag expenditures are allocated to risk groups on a PMPM basis instead of reflecting inherent utilization and cost differences. Applicable program(s): STAR, STAR+PLUS, STAR Kids

Management Response:

Observation D

The rating analysis primarily relies on the three data sources for enrollment - i) the Financial Statistical Report (FSR), ii) summary-level enrollment data provided by HHSC Forecasting and iii) detailed eligibility files. The three data sources are compared to ensure consistent results such that the three are considered interchangeable in aggregate. The difference between the three data sources for the base period is less than 0.03% for all Medicaid programs. In addition to being immaterial in aggregate, the differences have been studied by risk group within each program, and the risk group variation is insignificant as well.

Observation E

Both for-profit and not-for-profit MCOs participate in the Texas Medicaid and CHIP programs. Smaller MCOs, such as certain provider-owned plans, require reinsurance to protect against catastrophic claims. In our opinion, the inclusion of a reasonable net cost of reinsurance in the rating model is required in this instance.

The net reinsurance provision is intended to provide a reasonable amount for net reinsurance cost and is the minimum of i) the actual reinsurance premiums and ii) $0.50 PMPM for STAR and STAR+PLUS programs and $2.00 PMPM for STAR Kids.

Overall, this assumption has a minimal impact on the rate development and represents less than 0.1% of total premiums. The table below presents the actual PMPM and the percent of premiums by program attributed to net reinsurance allowance.

Program	PMPM	% of Premium
STAR	0.19	0.073%
STAR+PLUS	0.11	0.007%
STAR Kids	0.41	0.022%

Observation F

Certain sub-capitated expenses such as PCP, behavioral health and vision are allocated to risk groups based on the actual cost (PMPM) as reported by the MCO and verified against their audited FSRs. Other non-lag expenses are allocated to risk groups to the extent possible if risk group level reporting is available. Certain expenses, such as behavioral health subcapitated expenses, which may in theory vary by risk group, do not in practice as the MCOs reimburse their subcapitated vendors using a level premium that in many cases does not vary by risk group. Any adjustments to the non-lag expenditures to allocate the expense by risk group would have no impact on the aggregate premium for the actuarially sound premium rates.

For MCOs that subcontract with a related party for certain services such as behavioral health or vision, we require the submission of actual provider reimbursement (or claim payment) by risk group which is used in the rate development in place of the level subcapitated premium. For these arrangements, the actual observed expense by risk group is used, thus reflecting any inherent utilization or cost differences.

The majority of non-lag expenditure and recovery items are allocated at the risk group level for most MCOs. To the extent that risk group level reporting is not available, most commonly for pharmacy TPR, a uniform average is applied across all risk groups for a select number of MCOs.

Trend Assumptions Recommendations and Observations

Recommendation G

Develop medical trend assumptions at more detailed service category level. Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids
This recommendation is unchanged from the FY 2023 review

Management Response

Medical trends were reviewed by component (professional, outpatient, inpatient, etc.); however, 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. There is significant interaction among all categories of service as MCOs may shift cost away from inpatient toward outpatient and looking at an individual category in isolation has the potential to lead to overgeneralizations. 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 trend in future periods. The aggregate analysis performed takes into consideration all service categories and their interactions with one another without sacrificing accuracy.

While it is possible to split the trend analysis into the individual service components, we have no concern that the current approach adequately accounts for expected cost changes over time in aggregate.

Action Plan

The trend analysis is updated annually, and additional consideration was given to splitting the trend assumptions into individual components. Given concerns with historical information since the beginning of the PHE, no further changes were implemented to the trend assumption other than those detailed in the actuarial report. As managed care enrollment and utilization return to "normal" levels post

PHE, we will evaluate whether further changes are warranted in future rate developments.

Responsible Manager

Michael Joyner, Chief Actuary, HHSC Actuarial Analysis

Recommendation H

Develop medical and pharmacy trend assumptions separately by utilization and unit cost components. Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids
*This recommendation is **modified** from the FY 2023 review*

Management Response

Medical experience is analyzed by category of service; however, a single trend assumption has been applied to the average PMPM cost. Trend consists of many components including utilization, unit cost, mix of services, technological advances, change in practice patterns and many other factors. In combination, these factors impact the overall trend in average cost. While separating the trend into multiple components may provide a more granular view of the prospective cost impacts, it does not increase the overall credibility or accuracy of the trend projection as the ultimate comparison statistic is the change in average cost over time. Further changes were not considered for the current rate development process due to data concerns associated with the PHE and the age of data being used in the trend development. As utilization and enrollment begins to stabilize post-PHE, further consideration may be given to adjusting the trend development process.

Pharmacy experience is analyzed separately by utilization and unit cost components and by drug type (brand, generic, specialty). However, as presented in the actuarial report of the various Medicaid programs, the assumed pharmacy trends

have been developed separately by utilization and unit cost components and combined into a single trend assumption.

Action Plan

HHSC Actuarial Analysis and Rudd and Wisdom will continue to update and refine the trend analysis and evaluate whether sufficient, credible information is available to separately identify the utilization and unit cost trend components along with any other factor that influences overall trend in average expenditures. Please note that increasing the granularity of the trend analysis could greatly increase the cost for actuarial consulting services without increasing the overall accuracy of the trend assumption.

Responsible Manager

Michael Joyner, Chief Actuary, HHSC Actuarial Analysis

Recommendation I

Develop and apply pharmacy trends by drug type (i.e., Specialty and Non-Specialty). Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids
This recommendation is unchanged from the FY 2023 review

Management Response

The assumed pharmacy trends have been developed separately by utilization and unit cost components and combined into a single trend assumption. The program has experienced several recent, large-scale revisions to the Preferred Drug List (PDL). These PDL revisions had a significant impact on average cost and utilization shifting from brand to generic and vice versa. Some PDL changes don't shift between brand and generic equivalents but are assumed to shift to preferred drug in the therapeutic class based on market share, which could be any drug type. As

our PDL adjustment analysis does not lend itself to separate factors by drug type, we have developed our pharmacy trends separately by utilization and unit cost component.

Action Plan

HHSC Actuarial Analysis and Rudd and Wisdom will evaluate the pharmacy experience and consider developing pharmacy trends by drug type in future rate development cycles based on the impact of PDL revisions.

Responsible Manager

Michael Joyner, Chief Actuary, HHSC Actuarial Analysis

Recommendation J

Consider the impact of recently approved and upcoming pipeline drugs for each population. Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids
This recommendation is unchanged from the FY 2023 review

Management Response

HHSC has a process in place to review upcoming pipeline drugs to consider for non-risk status to reduce pricing risk for both MCOs and the state. The 2022-2023 General Appropriation Act, S.B.1, 87th Legislature Session, 2021, Article II, Special Provisions Relating to all Health and Human Services Agencies, Section 12.b. states "HHSC shall provide notification of a new or increased rate for an orphan drug within 60 calendar days following the addition of the drug as a payable benefit if managed care capitation rates are to be adjusted or the annual fiscal impact to fee-for-service expenditures is expected to exceed $500,000 in General Revenue Funds". HHSC evaluates recently approved and upcoming pipeline drugs by therapeutic class and population level and estimates the fiscal impact for each drug. This information is shared with HHSC Actuarial Analysis and Rudd and Wisdom.

Drugs that have a material cost impact are considered for non-risk status. Adulhelm is the most recent drug added to non-risk status through this process. In addition, we monitor upcoming first-time generic drugs. The Texas Medicaid program currently has a single PDL where all MCOs are required to follow the PDL developed by HHSC. Unlike commercial plans where utilization is expected to shift to generic immediately upon release, utilization is not expected to shift to generic drugs until HHSC changes the PDL, which can occur years after generic release. We work closely with HHSC Vendor Drug Program to identify PDL changes that will have a material impact and determine rating adjustment factors.

Action Plan

HHSC Actuarial Analysis and Rudd and Wisdom will continue to evaluate recently approved and upcoming pipeline drugs to consider for non-risk status.

Responsible Manager

Michael Joyner, Chief Actuary, HHSC Actuarial Analysis

Recommendation K

Evaluate pharmacy trends at the therapeutic class level. Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids
This recommendation is unchanged from the FY 2023 review

Management Response

HHSC Actuarial Analysis and Rudd and Wisdom agree that analyzing pharmacy experience at the therapeutic class level would provide additional granularity on cost drivers by program or risk group level. We periodically analyze experience by therapeutic class level to determine cost and utilization patterns. For example, we analyze and evaluate the cost impact at the therapeutic level for every Preferred Drug List (PDL) change to determine if a rating adjustment is necessary. In addition, the pharmacy trend for the MBCCP risk group is significantly higher than other risk groups. After analyzing the experience by therapeutic class level, we

determined that the primary driver in the high trend for the MBCCP risk group is utilization in the specialty drug category, specifically the drug Ibrance. Ibrance is a treatment for breast cancer and represents about 30% of total pharmacy cost and specialty drugs represent about 75% of total pharmacy cost for the MBCCP risk group. The utilization and unit cost trend of specialty drugs is higher than average rate.

The pharmacy trend was developed separately by utilization and inflation components. We have considered developing pharmacy trends on a more detailed level (therapeutic class, for example) but concluded that doing so would increase the variance of the result without any material improvement to the rate development.

Action Plan

HHSC Actuarial Analysis and Rudd and Wisdom will continue to evaluate cost at the therapeutic class and drug level to determined cost drivers and top drug spend for each Medicaid program.

Responsible Manager

Michael Joyner, Chief Actuary, HHSC Actuarial Analysis

Observations G - J:

- Prospective medical trends are developed using a purely formulaic approach. Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids
- Medical trends are not consistently applied to sub-capitated and service coordination cost. Applicable program(s): STAR, STAR+PLUS, STAR Kids
- The data source used for quantitative medical trend analysis does not enable more granular analyses. Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids
- Historical CPI trend used for NEMT trends does not reflect actual time period of projection. Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

Management Response:

Observation G

Medical trends have been developed using a formulaic approach in order to allow for an unbiased, quantifiable calculation of this assumption. The calculation relies on historical trend information specific to each managed care program and risk group which is the most relevant, credible statistic of cost patterns. While there are many other sources of trend information, no other source is specific to the demographics, providers, benefits and reimbursement terms experienced with the Texas Medicaid programs. The formula is evaluated for reasonableness and developed in a manner such that the trend calculations are transparent, verifiable and objective. It would be inappropriate to adjust the formula with the singular goal of increasing or decreasing the selected trend assumption. Application of the formulaic approach does not assume that "future experience will conform exactly with historical experience" (Report, page 46) but rather acknowledges that historical experience of the exact population being rated is the best indicator of future experience.

Observation H

Sub-capitated and service coordination expenditures are included in the rate development based on the most recently reported expenses including knowledge of their changes over time.

Subcapitated expenses account for the following percentage of total medical expenses by program:

STAR: 3.5%
STAR+PLUS: 0.4%
STAR Kids: 0.6%

STAR Health: 4.3%

These expenses are handled on a case-by-case basis for each MCO and each subcapitated expense. In general, these expenses have demonstrated very little cost growth over extended periods of time. As a result, we have concluded that the application of trend would be immaterial for these expense items.

Service coordination expenses account for the following percentage of total medical expenses by program:

STAR: 0.0%
STAR+PLUS: 3.6%
STAR Kids: 4.0%
STAR Health: 6.2%

When applying the service coordination assumption in the rate development, we review the most recent reported service coordination expenses included in the audited FSRs along with knowledge of HHSC contractual changes. In addition, there is interaction between the administrative expense and the service coordination expense assumptions. The administrative expense assumption naturally varies as overall costs vary, i.e., with trend and other contractual changes.

Given the relatively small size of these expenses and the interaction with the administrative cost assumption, we do not believe a trend adjustment is necessary. If applied, the trend adjustment would increase the overall cost of all programs but likely by an immaterial amount.

Observation I

As previously noted, the rate development process requires the use of three primary data sources – MCO submitted claims information, audited FSRs and encounter data. The three data sources are reconciled such that there is reasonable consistency across all three ensuring that the information can be used for varying components of the rate development process. To date, the encounter

data has not been used as the primary data source for the medical trend analysis due to the following reasons:

- The encounter data does not allow for the evaluation of more recent, emerging trend information. For example, the encounter data is typically provided mid-way through the rate development process for the fiscal year two years preceding the rating period. Prior to the pandemic, the rating process would incorporate trend information for the first 4-6 months of the fiscal year immediately preceding the rating period. Use of the encounter data would not allow for the inclusion of this more recent information.
- The encounter data is a point-in-time snapshot of the claims data and may not include retroactivity or claims adjustments.
- The encounter data includes limited runout (typically limited to 2-3 months) which requires greater estimation of incurred but unpaid claims. MCO submitted claims data and FSR data typically include a minimum of 6 months of runout.
- MCOs can have issues submitting encounter data that is reconciled with the audited FSRs. Errors in this submission can take weeks to months to repair which would delay the rating process. MCO submitted claims and FSR data can be corrected and resubmitted in a matter of hours or days.

Please note that increasing the granularity of the trend analysis could greatly increase the cost for actuarial consulting services without increasing the overall accuracy of the trend assumption.

Observation J

There are a number of ways to analyze the CPI trend, i.e., 1-month change, 3-month change, 12-month change, etc. all resulting in reasonable range for inflation trend assumption. The historical CPI inflation trend was determined based on the 12-month percent change for each month for the 10-year period March 2010 through February 2020, resulting in an average annual inflation trend of 1.6%.

Programmatic Adjustments Recommendations and Observations

Recommendation L

Remove member months periods for members ages 21 through 64 who have an IMD stay in excess of 15 days during any month.
Applicable program(s): STAR, STAR+PLUS
This recommendation is unchanged from the FY 2023 review

Management Response

As noted during the FY2023 rate development process, this is a policy issue that must be resolved before adjustments can be made to the rate development. Although the expenditure for members ages 21 through 64 who have an IMD stay in excess of 15 days during any month are excluded for rate development purposes per CMS regulations, these members are not removed from managed care and remain enrolled in their health plan.

The member months associated with these members are insignificant and their removal will not impact the actuarially sound rates. During the base period used for the FY2024 rate development, the number of member months meeting these criteria were:

- STAR: 146 member months, .0003% of the 41.8 million total member months
- STAR+PLUS: 1,495 member months, 0.022% of the 6.8 million total member months

Action Plan

HHSC Actuarial Analysis and Rudd and Wisdom will continue to monitor this issue and determine if further adjustments are necessary.

Responsible Manager

Michael Joyner, Chief Actuary, HHSC Actuarial Analysis

Recommendation M

Adjust the NEMT rate component to account for the anticipated impact of disenrollment related to the expiration of the PHE.
Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids
*This recommendation is **new** from the FY 2023 review*

Management Response

Effective June 1, 2021, NEMT services were provided by the MCOs. Prior to this, NEMT services was provided by the Medical Transportation Organization (MTOs). The change in delivery of NEMT services had a significant impact on NEMT utilization. The impact of disenrollment related to the PHE ending was considered for NEMT; however, an adjustment was not applied for the following reasons.

1) Some of the MCOs capitate NEMT services, and the subcapitated rate may not change after the end of the PHE.

2) 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. The average cost for NEMT services during the base period is higher than that for the pre-PHE period March 2019 through February 2020.

3) 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.

Rather than apply a PHE adjustment to NEMT services based on broad actuarial judgement as suggested in the report, the base period for NEMT service was adjusted for NEMT service. The base period for medical and pharmacy was September 1, 2021 through August 31, 2022 (FY2022). The base period for NEMT is different than medical and pharmacy and defined as July 1, 2022 through

December 31, 2022 to reflect more recent NEMT experience. Given that NEMT services account for less than 0.9% of total managed care expenditures any further adjustment would be immaterial.

Action Plan

HHSC Actuarial Analysis and Rudd and Wisdom will continue to monitor the NEMT experience and determine if further adjustments are necessary as more data is available under the MCO carve-in model.

Responsible Manager

Michael Joyner, Chief Actuary, HHSC Actuarial Analysis

Observations K - O:

- Reimbursement changes are included as programmatic adjustments, regardless of their materiality. Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids
- The FQHC wrap payment removal relies on base data aggregation using projected enrollment. Applicable program(s): STAR, Dental, STAR+PLUS, STAR Kids
- Programmatic adjustments are not developed at a service category level. Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids
- The weighting factor for PHE adjustment reflects disenrollment net of new entrants. Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids.
- Some programmatic adjustments vary by at least 5% among risk group/SDA combinations, but appear reasonable. Applicable program(s): STAR, STAR Kids.

Management Response:

Observation K

The managed care programs are constantly undergoing changes to benefits, provider reimbursement and policies which have a direct impact on managed care costs. The rate development generally adjusts for those programmatic changes that (a) materially impact cost, (b) are direct changes from the legislature that require monitoring or separate identification or (c) some combination of (a) and (b). Each adjustment impacts the programs, SDAs and risk groups differently and the rate development is as exhaustive as possible to maximize transparency. We acknowledge that there are changes that have been included that may be considered by some to be immaterial; however, such adjustments have only been included based on a specific analysis of the cost impact for that specific change. On the other hand, there are other changes that are excluded due to materiality concerns and are considered a component of the trend. This includes adjustments that have both a positive and a negative cost impact and are handled on a case-by-case basis. We typically do not consider items with an aggregate projected impact of less than $5 million for an explicit adjustment. Given the very small size of these adjustments and the fact that they are both positive and negative, there is very little concern of double counting within the rate development. Furthermore, this observation is counter to other observations that are intended to increase the granularity of the rate development. Limiting the application of programmatic changes to a smaller subset would reduce the granularity and provide less insight into the impact of certain programmatic adjustments that are of interest to various stakeholders.

Observation L

The FQHC wrap payment varies by MCO depending on each MCO's provider network composition. As a result, the FQHC wrap payment adjustment was determined and applied at the individual MCO level as opposed to the SDA level. The adjustment file does not rely on base data aggregation using projected enrollment because the adjustment factor is applied at the individual MCO level. The information presented in the actuarial report for the community rating provides the average SDA

adjustment factor which is applied in a budget neutral manner ensuring that the community rates are exactly equal to the sum of the individually developed MCO rates. The application at the MCO level due to varying network configurations requires the budget neutral application as applied in the current methodology.

Observation M

Programmatic adjustments are developed at the procedure code level based on actual utilization data during the base period by program, SDA and risk group. Procedure codes are used to identify each impacted adjustment. For each adjustment, the base period encounter data was repriced using the reimbursement rate in place during the base period, the reimbursement rate that will be in place during the rating period and the cost impact determined. The estimated impact is then aggregated for each individual adjustment and applied at the total cost level. Allocating the adjustment at the service category level would be budget neutral and have no impact on aggregate expenses.

HHSC and Rudd and Wisdom monitor actual costs at more granular levels than used in the rate development. This level of granularity is used for ad-hoc analysis to evaluate emerging costs for certain categories of services; however, this level of detail is not necessary for the aggregated rate development in which the MCOs are paid a single premium rate intended to provide for costs across all categories of service.

Observation N

The development of the PHE adjustment required extensive assumptions regarding disenrollment timing, total disenrollments, average cost of disenrolled members and several other unwinding related issues. While we acknowledge that additional refinements could be made to this process the refinements would require additional layers of assumptions regarding an event that has no precedent. The PHE

adjustment factor was weighted based on net enrollment changes which allows for the use of a quantifiable statistic that can be measured against actual results. HHSC Actuarial Analysis and Rudd and Wisdom will be evaluating the PHE unwind process to determine if mid-year rating adjustments are necessary in the event that actual results deviate significantly from those assumed in the rate development process.

Observation O

Certain adjustment factors have larger impacts than others and can vary significantly by SDA and risk group. For example, standard dollar amount changes heavily impacted deliveries to hospitals in rural service areas. As a result, the inpatient SDA adjustment is much larger in the MRSA SDAs for the pregnant women risk group than for other risk groups in the other SDAs.

Non-Benefit Expenses Recommendations and Observations

There were no recommendations related to the Commission's development of non-benefit expenses.

Observations P - R:

- Administrative expense assumptions are developed separately for the medical, pharmacy, and NEMT rate components. Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids
- The service coordination component is applied to each risk group on a uniform PMPM basis rather than being appropriately varied to account for the potential service coordinator staffing ratio variances among risk groups. Applicable program(s): STAR+PLUS, STAR Kids
- The non-benefit expense PMPM for pharmacy services in the Dual Demo program is from 2015 without trend applied. Applicable program(s): Dual Demo

Management Response:

Observation P

The total premium rates for each component (medical, pharmacy and NEMT) are developed separately as documented in the rate certification. Each component has varying levels of administrative cost that can be separately identified and accounted for. This approach has been used to increase the granularity and most accurately allocate administrative dollars to the applicable service component.

Observation Q

The service coordination component of the rates has been developed based on the amounts reported by the MCOs in the audited FSRs in addition to information regarding recent contractual changes and requirements made by HHSC. This information is reported in aggregate and is not separately identified by risk group. We have attempted to collect and review the information by risk group in prior rate setting periods; however, the information has been deemed unreliable at the risk group level as the variation across MCOs has been unreasonably large.

Based on discussions with the MCOs, they have difficulty breaking down the aggregate service coordination expense into risk group level due to the nature of the expense. A majority of the expense is associated with salaries for service coordinators who serve in a variety of roles assisting many members; these expenses are not isolated to individual risk groups. While an adjustment to the service coordination expense assumption may be warranted to allocate the expense by risk group, this would require arbitrary allocation of the aggregate expense in a budget neutral manner and have no impact on the aggregate premium paid to the MCOs. We believe the uniform assumption currently utilized is appropriate for the following reasons:

- It is applied in a transparent manner based on actual reported expenses without the need for further assumptions to allocate the expense by risk group.

- The enrollment distribution by MCO across the various risk groups does not change significantly over time, meaning the average by MCO during the observed historical periods is likely to be consistent with the average during the rating period.

We will continue to monitor this assumption annually and attempt to collect credible information by risk group.

Observation R

This estimate was provided by HHSC and was the estimated per-capita cost to administer pharmacy services for dual-eligible members under the state's TMHP contract at the time Dual Demonstration was implemented (FY2015). It is correct that the administrative expense provision has not been revised since that time. We have made no such change to the Dual Demonstration cost as such a change was deemed immaterial.

CMS Compliance and Documentation Recommendations and Observations

Recommendation N

Include supporting documentation for the development of the administrative costs. Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids, Dual Demo
*This recommendation is **modified** from the FY 2023 review*

Management Response

HHSC Actuarial Analysis and Rudd and Wisdom believe the supporting documentation included within the rate certification includes sufficient information to adhere to CMS requirements but will continue to update and expand the information in future periods to be as transparent as possible.

Action Plan

The applicable documentation was updated with additional information included in the FY2024 actuarial reports. HHSC Actuarial Analysis and Rudd and Wisdom will continue to update the documentation with the goal of being as transparent as possible while meeting all CMS requirements.

Responsible Manager

Michael Joyner, Chief Actuary, HHSC Actuarial Analysis

Recommendation O

Include documentation in the rate certification that clearly identifies which MCO final rates are based on 108% of individual MCO experience and how the 8% is allocated between benefit and non-benefit costs. Applicable program(s): STAR, STAR Kids
*This recommendation is **new** from the FY 2023 review*

Management Response

In future actuarial reports HHSC Actuarial Analysis and Rudd and Wisdom will identify the basis on which each MCO's rates are determined.

Action Plan

The information recommended above will be included in the FY2025 actuarial report.

Responsible Manager

Michael Joyner, Chief Actuary, HHSC Actuarial Analysis

Recommendation P

Reconcile actual patient liability amounts compared to rating assumptions for each MCO. Applicable program(s): STAR+PLUS, Dual Demo.
*This recommendation is **modified** from the FY 2023 review*

Management Response

Based on information provided by the MCOs regarding patient liability by month, risk group and SDA, the variation between MCOs and across fiscal years is relatively small. To date, CMS has not included any questions or concerns regarding the impact of patient liability on the STAR+PLUS or Dual Demo managed care rates. HHSC Actuarial Analysis and Rudd and Wisdom implemented additional adjustments in the FY2024 rate development intended to account for variations in patient liability and believe that a reconciliation would be administratively complex and result in an immaterial shift in premiums amongst MCOs.

Action Plan

HHSC Actuarial Analysis and Rudd and Wisdom will continue to evaluate the availability of credible patient liability data for the STAR+PLUS program and determine if further adjustments to the current rating methodology are appropriate.

Responsible Manager

Michael Joyner, Chief Actuary, HHSC Actuarial Analysis

Observations S - T:

- Supporting documentation does not clearly indicate that IMD costs are removed and associated member months remain. Applicable program(s): STAR, STAR+PLUS

- Supporting documentation does not clearly describe the PHE weighting factor development. Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids

Management Response:

Observation S

We believe this is a policy issue that must be resolved before adjustments can be made to the rate development. Although the expenditures for members ages 21 through 64 who have an IMD stay in excess of 15 days during any month are excluded for rate development purposes per CMS regulations, these members are not removed from managed care and remain enrolled in their health plan. The member months associated with these members are insignificant and their removal will not impact the actuarially sound rates. During the base period used for the FY2023 rate development the number of member months meeting these criteria were:

- STAR: 146 member months, .0003% of the 41.8 million total member months
- STAR+PLUS: 1,495 member months, 0.022% of the 6.8 million total member months

Observation T

The PHE description included in the rate development attempted to provide sufficient documentation regarding the development of this assumption. If this assumption is required in future rate development, additional documentation will be included regarding the weighting factor development.