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Actuarial Analysis of the Health and Human Services Commission's Fiscal Year 2023 Medicaid Managed Care Rates

August 31, 2022

Members of the Legislative Audit Committee:

Rider 5, page X-7, the General Appropriations Act (87th Legislature) directed the State Auditor's Office to conduct an actuarial analysis of the Health and Human Services Commission's (Commission) fiscal year 2023 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 first of three reports that the State Auditor's Office will release to address the Rider 5 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 2023 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:

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.

- 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.
- Certain Medicaid members residing in long-term care facilities may be liable for a portion of the costs (called "patient liability"). Rates should cover only the Managed Care Organization's (MCO) share of the costs after the member's payment, which may be a different amount for each member. To that end, Milliman included recommendations for the treatment of patient liability in the development of the STAR+PLUS and Dual Demonstration rates, including ensuring the MCOs are not at risk for enrolling individuals with varying levels of patient liability.

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- Trend and programmatic adjustment factors are currently developed and applied to broad categories of service (which are medical, long-term supports and services, pharmacy, and non-emergency medical transportation). Milliman recommended the Commission 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, and other categories.
- The non-benefit expense (such as administrative costs and taxes) assumptions applied in the fiscal year 2023 rates appear reasonable compared to historical program experience; however, 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.

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

Attachment 1

Milliman Report: Review of FY 2023 Texas Medicaid Managed Care Capitation Rate Development Process

MILLIMAN REPORT

Texas State Auditor's Office

Review of FY 2023 Texas Medicaid Managed Care Capitation Rate Development Process

August 31, 2022

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I. INTRODUCTION

The Texas State Auditor's Office ("the Office") contracted with Milliman to conduct an actuarial analysis and review of the Fiscal Year ("FY") 2023 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 2023 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 is specifically reviewing the Commission's oversight of its rate development process and contracted actuary.

This introduction section includes the state authority for the actuarial review, the relevant actuarial standard of practices ("ASOPs") and regulations, the background and importance of actuarial soundness, Milliman's background and review process, and an overview of the report structure.

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 2023 managed care capitation rates.

For any questions related to this report, please contact Lisa Collier, State Auditor, or Lauren Godfrey, Audit Manager 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][5] 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.[6]

This actuarial report that Milliman has written is the first of three reports to address the requirements of the General Appropriations Act. No later than November 1, 2022, the Office shall provide an audit report about the rate setting process used by the Commission.[7] The report the Office must generate needs to identify improvements that can be made to the rate setting process, including identifying significant cost drivers in the rate setting process, and identifying improvements to the process of communicating rates with oversight entities.[8] In evaluating the rate setting process, the

[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, The Legislature, X-7, pg. 985.
[6] Ibid, The Legislature, X-7, pg. 985.
[7] Ibid, The Legislature, X-7, pg. 985.
[8] Ibid, The Legislature, X-7, pg. 985.

Office must determine if the Commission followed appropriate procurement processes in obtaining vendors.[9] The report should be provided to the Speaker of the House, Lieutenant Governor, House Appropriations Committee, and the Senate Finance Committee.[10]

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.[11] These ASOPs describe the procedures an actuary should follow when performing actuarial services and identify what the actuary should disclose when communicating the results of those services.[12] We considered the specific ASOPs below during this review:

- ASOP No. 1 – Introductory Actuarial Standard of Practice[13]
- ASOP No. 5 – Incurred Health and Disability Claims[14]
- ASOP No. 12 – Risk Classification[15]
- ASOP No. 23 – Data Quality[16]
- ASOP No. 25 – Credibility Procedures[17]
- ASOP No. 41 – Actuarial Communications[18]
- ASOP No. 42 – Health and Disability Actuarial Assets and Liabilities Other Than Liabilities for Incurred Claims[19]
- ASOP No. 45 – The Use of Health Status Based Risk Adjustment Methodologies[20]
- ASOP No. 49 – Medicaid Managed Care Capitation Rate Development and Certification[21]
- ASOP No. 56 – Modeling[22]

We also reviewed the FY 2023 capitation rates in the context of the following rate certification and submission requirements per the Final Rule, subsequent amendments, and other guidance:

- Actuarial soundness, 42 CFR § 438.4(a) and (b)[23]
- Actuarial certification to capitation rate per rate cell, 42 CFR § 438.4(b)(4)[24]

[9] Ibid, The Legislature, X-7, pg. 985.
[10] Ibid, The Legislature, X-7, pg. 985.
[11] All Standards - About the Actuarial Standards Board, Actuarial Standards Board, Retrieved from: Standards of Practice - Actuarial Standards BoardActuarial Standards Board.
[12] Ibid.
[13] ASOP No. 1, Introductory Actuarial Standard of Practice, the Actuarial Standards Board, March 2013, Retrieved from: Microsoft Word - asop001_170.doc (actuarialstandardsboard.org).
[14] ASOP No. 5, Incurred Health and Disability Claims, the Actuarial Standards Board, March 2017, Retrieved from: Microsoft Word - asop005_186 (actuarialstandardsboard.org).
[15] ASOP No. 12, Risk Classification, the Actuarial Standards Board, December 2005, Retrieved from: ASOP No. 12, Risk Classification (for All Practice Areas) (actuarialstandardsboard.org).
[16] ASOP No. 23, Data Quality, the Actuarial Standards Board, December 2016, Retrieved from: Microsoft Word - asop023_185 (actuarialstandardsboard.org).
[17] ASOP No. 25, Credibility Procedures, the Actuarial Standards Board, June 2013, Retrieved from: http://www.actuarialstandardsboard.org/wp-content/uploads/2014/03/asop25_2nd_revision_exposure_draft_june2013.pdf.
[18] ASOP No. 41, Actuarial Communications, the Actuarial Standards Board, December 2009, Retrieved from: Microsoft Word - ASOP41 revision_second exposure draft_12-09.doc (actuarialstandardsboard.org).
[19] ASOP No. 42, Health and Disability Actuarial Assets and Liabilities Other Than Liabilities for Incurred Claims, the Actuarial Standards Board, March 2018, Retrieved from: Microsoft Word - asop042_191.docx (actuarialstandardsboard.org).
[20] ASOP No. 45, The Use of Health Status Based Risk Adjustment Methodologies, January 2012, Retrieved from: Microsoft Word - asop045_164.doc (actuarialstandardsboard.org).
[21] ASOP No. 49, Medicaid Managed Care Capitation Rate Development and Certification, March 2015, Retrieved from: https://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049_179.pdf.
[22] ASOP No. 56, Modeling, December 2019, Retrieved from: Microsoft Word - asop056_195.docx (actuarialstandardsboard.org).
[23] 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/subpart-A/section-438.4.
[24] Ibid.

- Capitation rates adequate to meet 42 CFR § 438.206,[25] 42 CFR § 438.207,[26] 42 CFR § 438.208[27]
- Ability to increase or decrease certified capitation rate (per rate cell) by 1.5 percent without a revised rate certification, 42 CFR § 438.7(c)(3)[28]
- Rate development standards, 42 CFR § 438.5[29] (data, trend, non-benefit component of the rate)
- Risk adjustment standards, 42 CFR § 438.5(g)[30]
- Special provisions related to payments, 42 CFR § 438.6[31] (incentive arrangements, withholds, pass through prohibition, etc.)
- CMS approval process changes of the rate certification, 42 CFR § 438.7(a)[32]
- Medical Loss Ratio ("MLR") standards, 42 CFR § 438.8[33]
- Encounter data, 42 CFR § 438.818[34]
- Corresponding CMS guidance
- The 2022-2023 Medicaid Managed Care Rate Development Guide[35]
- Relevant guidance provided by the SOA and the AAA[36]
- COVID-19 regulatory guidance[37]

Lastly, we note the additional relevant federal legislation that applies to Medicaid capitation rate setting:

- Balanced Budget Act of 1997 ("BBA")[38]
- Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA")[39]
- Deficit Reduction Act of 2005 ("DRA")[40]
- Affordable Care Act of 2010 ("ACA")[41]

[25] 42 CFR § 438.206 – Availability of Services, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-D/section-438.206.
[26] 42 CFR § 438.207 – Assurances of adequate capacity and services, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-D/section-438.207.
[27] 42 CFR § 438.208 – Coordination and continuity of care, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-D/section-438.208.
[28] 42 CFR § 438.7 – Rate certification submission, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.7.
[29] 42 CFR § 438.5 – Rate Development Standards, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.5.
[30] Ibid.
[31] 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.
[32] 42 CFR § 438.7 – Rate certification submission, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.7.
[33] 42 CFR § 438.8 – Medical loss ratio (MLR) standards, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.8.
[34] 42 CFR § 438.818 – Enrollee encounter data, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-J/section-438.818.
[35] 2022-2023 Medicaid Managed Care Rate Development Guide, Centers for Medicare and Medicaid Services, April 2022, Retrieved from: 2022-2023 Medicaid Managed Care Rate Development Guide.
[36] Recently Published Research, Society of Actuaries Research Institute, Society of Actuaries, Retrieved from: Recently Published Research | SOA.
[37] Regulations and Guidance, Centers for Medicare & Medicaid Services, Retrieved from: Regulations and Guidance | CMS.
[38] H.R. 2015, Balanced Budget Act of 1997, 105th Congress, August 5, 1997, Retrieved from: H.R.2015 - 105th Congress (1997-1998): Balanced Budget Act of 1997 | Congress.gov | Library of Congress.
[39] H.R. 1, Medicare Prescription Drug, Improvement, and Modernization Act of 2003, 108th Congress, December 8, 2003, Retrieved from: H.R.1 - 108th Congress (2003-2004): Medicare Prescription Drug, Improvement, and Modernization Act of 2003 | Congress.gov | Library of Congress.
[40] Deficit Reduction Act of 2005, Public Law 109-171, February 8, 2006, Retrieved from: E:\PUBLAW\PUBL171.109 (govinfo.gov).
[41] H.R. 3590, Patient Protection and Affordable Care Act, 111th Congress, March 23, 2010, Retrieved from: H.R.3590 - 111th Congress (2009-2010): Patient Protection and Affordable Care Act | Congress.gov | Library of Congress.

- 2016 Medicaid and CHIP Managed Care Final Mega-Rule[42]
- Mental Health Parity Act and Addiction Equity Act of 2008 ("MHPAEA")[43] and its supplemental CMS rules[44]
- Home and Community-Based Services ("HCBS") Final Rule[45]
- The Use of New or Increased Pass-Through Payments in Medicaid Managed Care Delivery Systems Final Rule[46]
- The United States Department of Health and Human Services ("HHS") Office of Inspector General ("OIG") Draft Rule for Removal of Safe Harbor Protection for Rebates Involving Prescription Pharmaceuticals and Creation of New Safe Harbor Protections[47]
- 2020 Changes to the Medicaid and CHIP Managed Care Final Mega-Rule[48]
- The Hospital Price Transparency Rule[49]
- American Rescue Plan Act ("ARPA") of 2021[50]

BACKGROUND ON ACTUARIAL SOUNDNESS

A key component of our review was to assess the actuarial soundness of the FY 2023 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[51]).

[42] Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, Centers for Medicare & Medicaid Services, May 6, 2016, Retrieved from: https://www.govinfo.gov/content/pkg/FR-2016-05-06/pdf/2016-09581.pdf.

[43] Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Federal Register, Vol. 78, No. 219, November 13, 2013, Retrieved from: 2013-27086.pdf (govinfo.gov).

[44] The Mental Health & Substance Use Disorder Parity Task Force, Final Report, October 2016, Retrieved from: The Mental Health & Substance Use Disorder Parity Task Force (hhs.gov).

[45] Medicaid Program; State Plan Home and Community-Based Services, 5 Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers, Federal Register, Vol. 79, No. 11, January 16, 2014, Retrieved from: 2014-00487.pdf (govinfo.gov).

[46] Medicaid Program; The Use of New or Increased Pass-Through Payments in Medicaid Managed Care Delivery Systems, Federal Register, Vol. 82, No. 11, January 18, 2017, Retrieved from: 2017-00916.pdf (govinfo.gov).

[47] Fraud and Abuse; Removal of Safe Harbor Protection for Rebates Involving Prescription Pharmaceuticals and Creation of New Safe Harbor Protection for Certain Point-of-Sale Reductions in Price on Prescription Pharmaceuticals and Certain Pharmacy Benefit Manager Service Fees, Vol. 85, No. 230, November 30, 2020, Retrieved from: 2020-25841.pdf (govinfo.gov).

[48] Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care, Federal Register, Vol. 85, No. 220, November 13, 2020, Retrieved from: 2020-24758.pdf (govinfo.gov).

[49] Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals To Make Standard Charges Public, Federal Register, Vo. 84, No. 229, November 27, 2019, Retrieved from: 2019-24931.pdf (govinfo.gov).

[50] American Rescue Plan Act of 2021, Public Law 117-2, March 11, 2021, Retrieved from: PUBL002.PS (congress.gov).

[51] 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.

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 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.[52]

Furthermore, Medicaid managed care capitation rates for MCOs must be reviewed and approved by CMS as actuarially sound rates.[53] CMS determines whether Medicaid managed care capitation rates are actuarially sound through regulatory mandated provisions.[54] 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.[55] 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.[56]

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.[57] The actuarial soundness requirement is specific to payments for each rate cell underneath the contract.[58] Payments from any rate cell must not cross-subsidize or be cross-subsidized by payments for any other rate cell.[59] The capitation rates must be certified by an actuary.[60] The actuarial soundness of the rates also requires that any applicable state special contract provisions are met.[61] 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.[62] 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.[63]

The managed care regulation requires that states develop valid managed care capitation rates in accordance with generally accepted actuarial principles and practices.[64] The 2022-2023 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, 2022 and June 30, 2023.[65] 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.[66]

[52] 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.

[53] 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.

[54] 42 CFR § 438.4(b)(1-9) - 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.

[55] 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.

[56] Ibid.

[57] 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.

[58] 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.

[59] 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.

[60] 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.

[61] 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.

[62] 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.

[63] 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.

[64] Rate Review and Rate Guides, 2022-2023 Medicaid Managed Care Rate Development Guide, Medicaid.gov, Retrieved from: Rate Review and Rate Guides | Medicaid.

[65] Ibid.

[66] Ibid.

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.[67] 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.

MILLIMAN BACKGROUND AND REVIEW PROCESS

Milliman is an industry leader in the Medicaid managed care space, with over twenty 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 2023 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

The Executive Summary provides the key findings from our review of the FY 2023 rates and rate setting process. We then include an overview of each of the six key Medicaid programs to highlight each program's key characteristics, similarities, and differences. In the next two sections, we discuss our overall approach to identifying risk levels and reviewing each rate setting component: rate structure, base data, trend adjustments, program adjustments, non-benefit expenses, and CMS compliance.

Appendices A to F include additional detail and recommendations for each program related to our review, program details, and key data sources. These Appendices are noted below:

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

CAVEATS AND LIMITATIONS

This report has been prepared for the Texas State Auditor's Office ("the Office") to communicate our review of FY 2023 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.

[67] 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.

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 2023 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 2023 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. Jill Bruckert, Greg Herrle, and John Meerschaert 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. EXECUTIVE SUMMARY

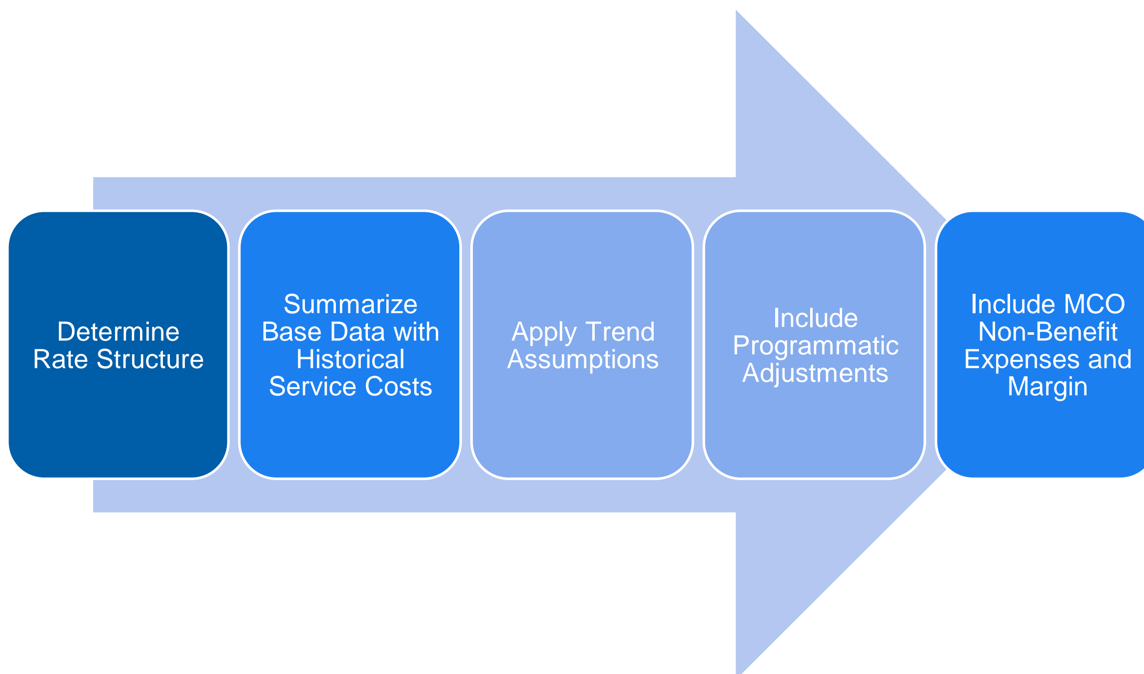
CAPITATION RATE SETTING PROCESS

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.

EVALUATION OF ACTUARIAL SOUNDNESS

While the Introduction section contains the details and 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 2023 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 2023 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 twenty 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 *observations* and *recommendations*.

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.

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.

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

SUMMARY OF OBSERVATIONS AND RECOMMENDATIONS

Exhibits 1 and 2 summarize the observations and recommendations from our review of the FY 2023 capitation rates produced by the Commission. Several of the observations and recommendations 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 observations and recommendations 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 2023 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 2023 capitation rates. In addition, this subcategory is used to flag recommendations where the level of documentation in the FY 2023 actuarial certification does not include the required information listed in the 2022-2023 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 over-funds the capitation rates, shown as (+) in Exhibit 1
- The current methodology under-funds 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. The **STAR+PLUS** and **Dual Demonstration** programs are unique compared to the other programs included in our review, as they cover individuals that need both acute care services and long-term supports and services. A unique aspect of these programs is that individuals who reside in nursing facilities must pay a share of the cost of the nursing facility based upon their personal income, which is largely equal to any Social Security income an individual receives. This amount, commonly referred to as patient liability, must be carefully considered in each step of the capitation rate development to ensure that the capitation rate is appropriate to only reimburse the MCO for the MCO’s share of the cost after the member’s payment. **We include multiple recommendations for the treatment of patient liability in the development of the STAR+PLUS and Dual Demonstration capitation rates in order to be in compliance with CMS requirements.**
3. **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.
4. The **non-benefit expense assumptions** applied in the FY 2023 capitation rates appear reasonable compared to 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.
5. Other specific recommendations to enhance the methodologies used to develop the FY 2023 capitation rates.

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. In addition, 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.

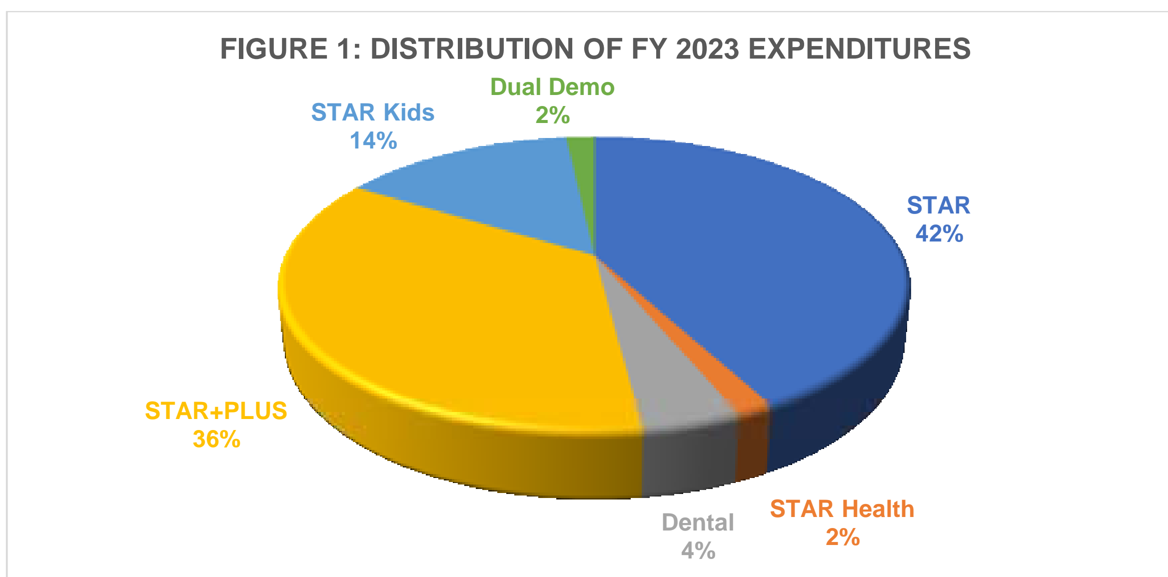
III. PROGRAM SUMMARY OVERVIEW

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.[68] The Commission develops capitation rates on a state fiscal year basis, effective from September to August of each year.[69] The Texas Medicaid program has six certified managed care programs, which are the focus of this concurrent Medicaid capitation rate review report.[70] These managed care programs include the following:

- STAR Managed Care[71]
- STAR Health Managed Care[72]
- Medicaid Dental[73]
- STAR+PLUS Managed Care[74]
- STAR Kids[75]
- Dual-Eligibles Integrated Care Demonstration Project ("Dual Demonstration")[76]

In total, these six programs will cover approximately 4.8 million Medicaid beneficiaries at a total cost of approximately $29.3 billion (excluding directed payments) in FY 2023. Figure 1 shows the distribution of projected FY 2023 expenditures by program.

FIGURE 1: DISTRIBUTION OF FY 2023 EXPENDITURES



[68] Managed Care Services, Overview, Texas Health and Human Services, Retrieved from: Managed Care Services | Provider Finance Department (texas.gov).
[69] Ibid.
[70] Managed Care Services, Overview, Texas Health and Human Services, Retrieved from: Managed Care Services | Provider Finance Department (texas.gov).
[71] STAR Managed Care, Rate Setting Actuarial Analysis, Texas Health and Human Services, Retrieved from: STAR Managed Care | Provider Finance Department (texas.gov).
[72] STAR Health Managed Care, Rate Setting Actuarial Analysis, Texas Health and Human Services, Retrieved from: STAR Health Managed Care | Provider Finance Department (texas.gov).
[73] Medicaid Dental, Rate Setting Actuarial Analysis, Texas Health and Human Services, Retrieved from: Medicaid Dental | Provider Finance Department (texas.gov).
[74] STAR+PLUS Managed Care, Rate Setting Actuarial Analysis, Texas Health and Human Services, Retrieved from: STAR+PLUS Managed Care | Provider Finance Department (texas.gov).
[75] STAR Kids, Rate Setting Actuarial Analysis, Texas Health and Human Services, Retrieved from: https://pfd.hhs.texas.gov/managed-care-services/star-kids.
[76] 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).

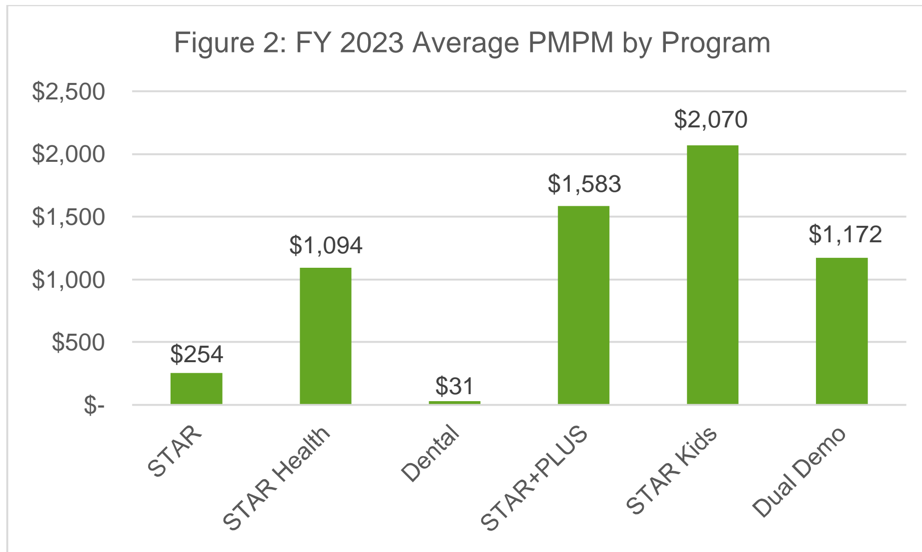
Table 1 below summarizes the FY 2023 estimated enrollment and costs by program, as well as a brief description of the covered population and services.

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

Program	Average Estimated FY 2023 Beneficiaries	Projected FY 2023 Program Costs[A]	Summary of Covered Population	Summary of Covered Services
STAR	4,026,259	$12,279,000,000	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	35,428	$465,000,000	Children in foster care	Primary care, acute care, dental, pharmacy, and NEMT services
Dental[B]	3,709,854	$1,380,000,000	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	550,644	$10,463,000,000	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	168,597	$4,188,000,000	Children younger than 21 with disabilities or dual eligible who necessitate long-term services and supports (LTSS)	Long term care, acute care, pharmacy, and NEMT services
Dual Demo	36,472	$513,000,000	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)	Long term care, acute care, pharmacy, and NEMT services

[A] *Excludes directed payments.*
[B] *Medicaid Dental beneficiaries excluded from 4.8 million total because Dental beneficiaries are included in the beneficiary counts for the other programs that provide their medical and pharmacy benefits. Medicaid Dental FY 2023 estimated beneficiaries and program costs are based on the Commission's projected enrollment. This differs from the projected FY 2023 program costs in the Commission's rate certification ($1.24 billion) because the rate certification excludes projected enrollment for the DHMO added to the program as of September 2020 and reflects the base period mix by risk group instead of the Commission's projected mix by risk group.*

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.[77] The STAR population includes low-income children, pregnant women, and families.[78] Members in the STAR program, who select their health plan from one of the approved MCOs,[79] 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[80]

Some STAR members with special health care needs may receive additional service management to assist with the coordination of Medicaid and non-Medicaid benefits.[81]

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

[77] STAR Medicaid Managed Care Program, Texas Health and Human Services, Retrieved from: STAR Medicaid Managed Care Program | Texas Health and Human Services.
[78] Ibid.
[79] Ibid.
[80] Ibid.
[81] Ibid.

- 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")[82]

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[83]

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.[84] Below are several types of dental health services offered for children and young adults in Medicaid.[85]

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[86]

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[87]

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[88]

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[89]

[82] STAR Health, Texas Health and Human Services, Retrieved from: STAR Health | Texas Health and Human Services.
[83] Ibid.
[84] Medicaid Medical & Dental Policies, Texas Health and Human Services, Retrieved from: Medicaid Medical & Dental Policies | Texas Health and Human Services.
[85] Dental Providers, Texas Health and Human Services, Retrieved from: Dental Providers | Texas Health and Human Services.
[86] Ibid.
[87] Ibid.
[88] Ibid.
[89] Ibid.

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.[90] Adults in STAR+PLUS select their health plan from the MCOs approved to provide Medicaid healthcare and long-term services and supports.[91] Adults with complex medical needs can choose to live and receive care in a home setting instead of a nursing facility.[92]

Within STAR+PLUS, MCOs must have a service coordinator visit with the member within 30 days of enrolling in the program[93] 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")[94]

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[95]

STAR Kids

Effective November 1, 2016, the Commission implemented a new managed care program for disabled children named STAR Kids.[96] 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")[97]

[90] STAR+PLUS, Texas Health and Human Services, Retrieved from: STAR+PLUS | Texas Health and Human Services.
[91] Ibid.
[92] Ibid.
[93] Ibid.
[94] Ibid.
[95] Ibid.
[96] STAR Kids, Rate Setting Actuarial Analysis, Texas Health and Human Services, Retrieved from: https://pfd.hhs.texas.gov/managed-care-services/star-kids.
[97] Ibid.

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).[98] 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.[99] 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.[100] Through an individual being enrolled in a singleMedicare-Medicaid health plan, Medicare and Medicaid benefits work together to better meet the member's health-care needs.[101] The program is voluntary and open to eligible beneficiaries in the following counties: Bexar, Dallas, El Paso, Harris, Hidalgo and Tarrant.[102] 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[103]

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[104]

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[105]

[98] 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).
[99] Ibid.
[100] Dual Eligible Project (MMP), Texas Health and Human Services, Retrieved from: Dual Eligible Project (MMP) | Texas Health and Human Services.
[101] Ibid.
[102] 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).
[103] Dual Eligible Project (MMP), Texas Health and Human Services, Retrieved from: Dual Eligible Project (MMP) | Texas Health and Human Services.
[104] Ibid.
[105] Ibid.

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[106]

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.

[106] 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	Green	Green	Yellow
	Medium	Green	Yellow	Red
	High	Yellow	Red	Red

- 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.

RATE DEVELOPMENT COMPONENTS

We structured our review of the FY 2023 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 2023 rating period

Program Adjustments (med / low)

- The program adjustment component includes additional adjustments to account for changes between the base period and FY 2023, such as provider contracting, changes in covered benefits, policy updates, and the impact of the public health emergency

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

RATE STRUCTURE

Actuarial Policy Authority – Rate Structure

The primary goal of developing capitation rates and making capitation payments at the risk group level is to remove or mitigate the enrollment related selection risks for participating MCOs and align capitation revenue and MCO risk, as outlined in ASOP 49.[107] Without an appropriately designed risk group structure, MCOs may be financially incentivized to selectively market to lower acuity members and not higher acuity members, rather than focusing on providing efficient and effective care to all members.

The cost of providing care to an enrollee can be very different depending upon their characteristics. For example, the cost profiles of children change with their age, as well as if the child is healthy or disabled. Table 2 displays the projected FY 2023 acute care costs for healthy children by age (STAR program) compared to disabled children by age (STAR Kids program) in the Harris SDA. While the total average cost is $192.15 per-person per-month across all children in both programs, the programs and rate cells have varying levels of cost. The presence of this rate structure that separates enrollees into risk groups ensures MCOs are not incentivized to specifically enroll lower cost populations.

Table 2
Projected FY 2023 Acute Care Claims PMPM
Projected FY 2023 PMPMs and Member Months
Harris SDA

	PMPMs			Member Months		
Risk Group	**STAR**	**STAR Kids**	**Total**	**STAR**	**STAR Kids**	**Total**
Under Age 1	$719.50	$5,131.60	$729.97	663,594	1,578	665,173
Ages 1-5	$153.52	$2,353.55	$188.01	2,952,855	47,032	2,999,887
Ages 6-14	$101.17	$692.03	$127.23	4,671,794	215,566	4,887,360
Ages 15-20	$146.72	$547.67	$179.01	1,964,412	172,049	2,136,461
Total	**$165.00**	**$830.30**	**$192.15**	**10,252,655**	**436,226**	**10,688,881**

The two main actuarial considerations in designing an effective rate structure are: (1) defining risk groups to reflect material cost profile differences of members due to risk factors, such as coverage differences, eligibility differences, health status differences, and regional cost differences and (2) the level of credibility, or predictive nature, of future costs of any resulting risk group.[108] A risk group is typically defined as a group of members that a capitation rate is developed for, generally on a per-member-per-month basis. However, a risk group can also be defined as a group of services within a given population that are carved out of the overall per-member-per-month for a population and paid through a one-time payment, commonly referred to as a "kick payment." Kick payments are commonly used for one-time significant costs, such as delivery costs within a risk group that includes pregnant women.

There is a balancing act between the two in designing the most appropriate rate structure for a Medicaid managed care program while maintaining actuarial soundness principles at the risk group level. Generally speaking, a more granular grouping results in better cost profile similarities among members within each group, but smaller group sizes may not be fully credible on their own due to natural fluctuations in costs.

There is no prescribed credibility threshold of the minimum number of enrollees needed at a risk group level for it to be "fully credible" in the development of Medicaid capitation rates. In addition, a reasonable credibility threshold can vary among Medicaid populations. Populations with more variable costs among members (e.g., TANF adults) may require a higher number of enrollees to be credible compared to a population with more stable costs (e.g., individuals residing in a nursing facility). Therefore, it is up to the actuary to determine the level of membership needed to develop a credible risk group; however, there are a few common credibility references / approaches in the industry.

- Program specific credibility thresholds defined by the actuary based upon a review of the variability of historical experience for the given populations.

[107] ASOP No. 49, Medicaid Managed Care Capitation Rate Development and Certification, March 2015, pg. 9, Retrieved from: https://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049_179.pdf.
[108] ASOP No. 25, Credibility Procedures, the Actuarial Standards Board, June 2013, Retrieved from: http://www.actuarialstandardsboard.org/wp-content/uploads/2014/03/asop25_2nd_revision_exposure_draft_june2013.pdf.

- CMS published credibility thresholds for acute care programs vs. long-term care programs for use in determining the credibility of a MCO's MLR.[109] The minimum member months (i.e., the total number of months of enrollment in the given time period) for fully credible MLR calculations is 380,000 for acute care programs and 45,000 for long-term care programs. The MLR calculations are performed at program level and the credibility thresholds may not be appropriate to apply to a risk group level. These MLR thresholds are inherently different than risk group credibility levels as they are used to calculate credibility for determining if MCOs have to pay back premiums due to unexpectedly low service costs, rather than to prospectively set rates based on past experience.

- According to CMS, claims credibility guidelines for CY 2023 Medicare Advantage bid rate setting, full credibility for the Medicare Advantage populations requires a minimum of 24,000 member months.[110] The Medicare Advantage program largely consists of elderly individuals that purchase their Medicare coverage through private insurers. This Medicare Advantage population generally has claim costs higher than most Medicaid populations (except for certain high-cost and LTSS subpopulations), which means it may reach credibility at lower enrollment levels.

The optimal structure can vary by program depending on the program size, regional cost variations, number of participating MCOs, and risk variations among all covered members. In addition, the actuary may use other payment mechanisms, such as risk adjustment, to help align capitation revenue and MCO risk. A review of the risk adjustment mechanisms used in the Texas Medicaid programs is outside of the scope of our review 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.

Approach Used by Milliman for Review – 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 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 2023 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.

[109] Medical Loss Ratio (MLR) Credibility Adjustments, Informational Bulletin, Centers for Medicaid and CHIP Services, July 31, 2017, Retrieved from: DEPARTMENT OF HEALTH & HUMAN SERVICES (medicaid.gov).

[110] Instructions for Completing the Medicare Advantage Bid Pricing Tools for Contract Year 2023, Centers for Medicare and Medicaid Services, CMS-10141, February, 2022, pg. 19, Retrieved from: INSTRUCTIONS FOR COMPLETING THE MEDICARE ADVANTAGE BID PRICING TOOLS FOR CONTRACT YEAR 2023 (cms.gov).

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 2023 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

In order to examine the base data the Commission used for each Texas Medicaid program in the State Fiscal Year ("FY") 2023 capitation rate development, Milliman first looked to the federal regulatory and policy authority from the Centers for Medicare and Medicaid Services ("CMS"), then developed a review process and approach based on the regulatory and policy authority that is outlined below.

Actuarial Policy Authority – Base Data Development

The 2022-2023 Medicaid Managed Care Rate Development Guide[111] published in April 2022, provides the federal standards for rate development, and describes information required from states and their actuaries as part of actuarial rate certification required under 42 C.F.R. §438.7(a).[112]

For rate development standards related to base data, the states and actuaries must follow 42 C.F.R. § 438.5(c).[113] More specifically:

- States must provide all the validated encounter data and / or fee-for-service ("FFS") data and audited financial reports that demonstrates experience for the populations to be served by the managed care plans to the state's actuary developing the capitation rates for at least the three most recent and complete years prior to the rating period.[114]

- States and their actuaries must use the most appropriate base data, from the three most recent and complete years prior to the rating period, for developing capitation rates.[115]

- The base data must be derived from the Medicaid population or, if data on the Medicaid population is not available, derived from a similar population and adjusted to make the utilization and price data comparable to data from the Medicaid population.[116]

To have appropriate documentation, in accordance with 42 C.F.R. § 438.7(b)(1), the state's certifying actuary must include several items in the rate certification.[117]

- There must be a summary of the base data that was requested by the actuary.[118] There also needs to be a summary of the base data that was provided by the state.[119] Then, there needs to be an explanation of why any requested base data was not provided by the state.[120]

- The state's certifying actuary must provide a description of the base data in the rate development summary of the rate certification.[121]

- This includes the sources of data used for the base data, whether that was encounter data, fee-for-service data, or other sources.[122]

[111] "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.
[112] Ibid, pg. 2.
[113] Ibid, pg. 16.
[114] Ibid, pg. 16.
[115] Ibid, pg. 16.
[116] Ibid, pg. 16.
[117] Ibid, pg. 17.
[118] Ibid, pg. 17.
[119] Ibid, pg. 17.
[120] Ibid, pg. 17.
[121] Ibid, pg. 54.
[122] Ibid, pg. 54.

- The state's certifying actuary must give an assurance that the base data is consistent with the requirements in 42 C.F.R. § 438.5(c)(3), or an explanation of why the base data is inconsistent with the regulation including the state's rationale of why an exemption is necessary and a description of the corrective action plan to come into compliance with the base data standards.[123]

- There must be a description of any data quality issues or concerns identified by the actuary.[124]

- The state's certifying actuary must describe any material adjustments that were made to the base data during the rate setting process.[125]

This information from the federal regulations and the Medicaid managed care rate development guide shaped the way in which Milliman conducted the review of the Commission's base data selection and implementation into the FY 2023 managed care capitation rates.

Approach Used by Milliman for Review – 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 for each program that had at least three managed care organizations ("MCOs"), 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.

Non-Emergency Medical Transportation ("NEMT") services were provided through separate contracts with managed transportation organizations ("MTOs") or directly by the Commission through fee-for-service ("FFS") until June 2021. Therefore, encounter and eligibility data provided by the external quality review organization ("EQRO") is the primary data source for NEMT claim costs during the base period since the MCOs were not responsible for these services. Given the data validation performed by the EQRO vendor and the small overall cost of NEMT services relative to other services, we did not perform the same level of review on the NEMT data, but rather reviewed for general reasonability.

Please see the base data section of Appendices A through F for an overview of program specific base data methodology and our observations and recommendations of this methodology.

[123] Ibid, pg. 54.
[124] Ibid, pg. 54.
[125] Ibid, pg. 54.

TREND

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: the change in service utilization, also known as "utilization trend," and the change in service cost on a per unit basis, also known as "unit cost trend." In capitation rate development, trend is applied to the base period PMPM in a compounding manner to produce the projected PMPM cost. In a typical capitation rate development cycle for the Texas Medicaid managed care programs included in this review, the annual trend assumption would be applied for two years as there has historically been a two-year difference between the base period and the rating period. For FY 2023 rate development, however, there is a three-and-a-half-year difference between the base period and the rating period due to the selection of pre-COVID-19 period (March 2019 through February 2020) as the base period data. As a result, any selected annual trend assumption is compounded for three-and-a-half years in the FY 2023 rate development. **This means that a 1 percent difference in the selected annual trend assumption can result in an approximately 3.5 percent difference in the resulting capitation rates.** Such differences are financially significant to both the State and the participating MCOs.

Actuarial Policy Authority - Trend

The regulatory definition of trend is found in 42 CFR § 438.5(d).[126] Each trend must be reasonable and developed in accordance with generally accepted actuarial principles and practices.[127] Trend must be developed primarily from actual experience of the Medicaid population or from a similar population.[128] Trend must also be developed to include other considerations of other factors that may affect projected benefit cost trends throughout the rating period.[129]

Each trend factor, including trend factors to reflect changes in the utilization and unit cost of services, applied to develop the capitation rates must be adequately described with enough detail so CMS or an actuary applying generally accepted actuarial principles and practices can understand and evaluate the following:

1. The calculation of each trend used for the rating period and the reasonableness of the trend for the enrolled population.[130]

2. Any meaningful difference in how a trend differs between the rate cells, service categories, or eligibility categories.[131]

When the actuary submits their rate certification and supporting documentation, they must include a section on projected benefit cost trends (i.e., an estimate of the projected change in benefit costs from the historical base data period to the rating period of the rate certification) in accordance with 42 CFR § 438.7(b)(2).[132] This section of the rate certification must include:

1. Any data used or assumptions made in developing projected benefit cost trends, including a description of the sources of those data and assumptions.[133]

2. The methodologies used to develop projected benefit trends.[134]

[126] 42 CFR § 438.5(d) – Rate Development Standards, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.5.
[127] Ibid.
[128] Ibid.
[129] "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, pg. 19.
[130] 42 CFR § 438.7(b)(2)(i) – Rate Certification Submission, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.7.
[131] 42 CFR § 438.7(b)(2)(ii) – Rate Certification Submission, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.7.
[132] "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, pg. 20.
[133] Ibid, pg. 20.
[134] Ibid, pg. 20.

3. Any comparisons to historical benefit cost trends, or other program benefit cost trends, that were analyzed as part of the development of the trend for the rating period of the rate certification.[135]

4. Documentation supporting the chosen trend rates and explanation of outlier and / or negative trends.[136]

In the rate certification, the projected cost trends must be separated into these components:

1. The projected benefit cost trends should be separated into changes in price and changes in utilization.[137]

2. If the actuary did not develop the projected benefit cost trends using price and utilization components, the actuary should describe and justify the method(s) used to develop projected benefit cost trends.[138]

3. The projected benefit cost trends may include other components as applicable and used by the actuary in developing rates.[139]

Variations in the projected benefit cost trends must be explained by the actuary.[140] Projected benefit cost trends may vary by Medicaid populations, rate cells, and subsets of benefits within a category of services.[141]

Any other material adjustments to projected benefit cost trends must be described in accordance with 42 CFR § 438.7(b)(4), including:

1. A description of the data, assumptions, and methodologies used to determine each adjustment.[142]

2. The cost impact of each material adjustment.[143]

3. Where in the rate setting process the material adjustment was applied.[144]

Any other adjustments to projected benefit costs trends must be listed.[145] CMS also requests the following detail about non-material adjustments:

1. The impact of managed care on the utilization and the unit costs of health care services.[146]

2. Changes to projected benefit costs trend in the rating period outside of regular changes in utilization or unit cost of services.[147]

The rate development summary must include a summary of the project benefit cost trends used to develop the rates, including:

1. The total average projected benefit cost trend assumption.[148]

2. The projected benefit cost trends by category or type of service.[149]

3. The projected benefit cost trends by rate cell (or similar level of detail, such as eligibility category).[150]

4. The projected benefit cost trends separated into price or unit cost trends, and utilization trends.[151]

5. Any adjustments applied to develop the projected benefit cost trends.[152]

[135] Ibid, pg. 20.
[136] Ibid, pg. 20.
[137] Ibid, pg. 21.
[138] Ibid, pg. 21.
[139] Ibid, pg. 21.
[140] Ibid, pg. 21.
[141] Ibid, pg. 21.
[142] Ibid, pg. 21.
[143] Ibid, pg. 21.
[144] Ibid, pg. 21.
[145] Ibid, pg. 21.
[146] Ibid, pg. 21.
[147] Ibid, pg. 21.
[148] Ibid, pg. 55.
[149] Ibid, pg. 55.
[150] Ibid, pg. 55.
[151] Ibid, pg. 55.
[152] Ibid, pg. 55.

6. Comparisons to the previous year's trends.[153]

7. References to where the trends and their development are described in more detail in the certification and any additional documents.[154]

Approach Used by Milliman for Review - 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 2023 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

Programmatic adjustments are applied to reflect any other expected changes in costs between the base period to the rating period that are not accounted for through the trend assumptions. Typical items included in programmatic adjustments include reimbursement changes, changes in covered populations or services, new populations or services, or any other material changes that may impact costs in the program.

Actuarial Policy Authority – Programmatic Adjustments

The regulatory definition of program, or non-trend, adjustments is found in 42 CFR § 438.5(f)[155]:

> Each adjustment must reasonably support the development of an accurate base data set for purposes of rate setting, address appropriate programmatic changes, reflect the health status of the enrolled population, or reflect non-benefit costs, and be developed in accordance with generally accepted actuarial principles and practices.[156]

All adjustments used to develop the capitation rates must be adequately described with enough detail so that CMS, or an actuary applying generally accepted actuarial principles and practices, can understand, and evaluate the following:

1. How each material adjustment was developed and the reasonableness of the material adjustment for the enrolled population.[157]

2. The cost impact of each material adjustment and the aggregate cost impact of non-material adjustments.[158]

3. Where in the rate setting process the adjustment was applied.[159]

4. A list of all non-material adjustments used in the rate development process.[160]

[153] Ibid, pg. 55.
[154] Ibid, pg. 55.
[155] 42 CFR § 438.5(f) – Rate Development Standards, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.5.
[156] Ibid.
[157] 42 CFR § 438.7(b)(4)(i) – Rate Certification Submission, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.7.
[158] 42 CFR § 438.7(b)(4)(ii) – Rate Certification Submission, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.7.
[159] 42 CFR § 438.7(b)(4)(iii) – Rate Certification Submission, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.7.
[160] 42 CFR § 438.7(b)(4)(iv) – Rate Certification Submission, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.7.

The Rate Development Summary in the rate certification must describe any programmatic changes and the impacts they have on the certified capitation rates.[161] Programmatic changes must be documented in the Rate Development Summary in the rate certification including new or changing benefits; changes to provider reimbursement; new or changing populations covered by managed care; new programs or initiatives that affect managed care; new managed care plan(s) or changes in participating managed care plan(s); and any other changes to the managed care program that have a material impact on the rates.[162]

This section of the rate certification must include a description of those changes and the impacts on the rates and must have references to where these are described in more detail in the certification.[163] This information helps to demonstrate to readers that the program changes are consistent with the changes being made to the rates and to identify large or unusual impacts to the rates.[164]

It is important to note that program changes can increase (e.g., increasing provider reimbursement) or decrease (e.g., decreasing provider reimbursement) the overall capitation rates.

Approach Used by Milliman for Review – 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

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 for their members. This also includes a provision for margin intended to account for financial risk, statutory capital requirements, and opportunity cost of capital.

Actuarial Policy Authority – Non-Benefit Expenses

The regulatory definition of non-benefit expenses is found in 42 CFR § 438.5(e)[165]:

> *The development of the non-benefit component of the rate must include reasonable, appropriate, and attainable expenses related to MCO…administration, taxes, licensing and regulatory fees, contribution to reserves, risk margin, cost of capital, and other operational costs associated with the provision of services identified in 42 CFR § 438.3(c)(1)(ii) to the populations covered under the contract.*[166]

[161] "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, pg. 56.
[162] Ibid, 56.
[163] Ibid, 57.
[164] Ibid, 57.
[165] 42 CFR § 438.5(e) – Rate Development Standards, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.5.
[166] Ibid.

The development of the non-benefit component of the rate must be adequately described with enough detail, so CMS or an actuary applying generally accepted actuarial principles and practices can identify each type of non-benefit expense that is included in the rate and evaluate the reasonableness of the cost assumptions underlying each expense.[167]

The actuary may document the non-benefit costs according to the types of non-benefit costs under 42 CFR § 438.5(e).[168] Non-benefit costs may be developed as per-member-per-month costs or as a percentage of projected benefit costs or capitation rates, and different approaches can be taken for different categories of costs.[169] For non-benefit costs that may be difficult to allocate to specific enrollees or groups of enrollees, or for taxes and fees that are assessed as a percentage of premiums, it may be reasonable to calculate those non-benefit costs as a percentage of benefit costs or capitation rates.[170]

In the rate certification, there must be appropriate documentation for the non-benefit expenses. The rate certification and supporting documentation must describe the development of the projected non-benefit costs included in the capitation rates in enough detail, so CMS or an actuary applying generally accepted actuarial principles and practices can identify each type of non-benefit expense that is included in the rate and evaluate the reasonableness of the cost assumptions underlying each expense in accordance with 42 CFR § 438.7(b)(3).[171]

The documentation in the rate certification must include:

1. A description of the data, assumptions, and methodologies used to develop the projected non-benefit costs, and in particular, all material items in developing the projected non-benefit costs.[172]

2. Any material changes to the data, assumptions, and methodologies used to develop projected non-benefit costs since the last rate certification.[173]

3. Other material adjustments including a description of the data, assumptions, and methodologies used to determine each adjustment; where in the rate setting process each adjustment was applied; and the cost impact of each material adjustment.[174]

States and actuaries should estimate the projected non-benefit costs for each of the following categories of costs: administrative costs; taxes, licensing and regulatory fees, and other assessments and fees; contribution to reserves, risk margin, and cost of capital; and other operational costs associated with the provision of services identified in 42 CFR § 438.3(c)(1)(ii) to the populations covered under the contract.[175]

Actuaries should disclose historical non-benefit cost data in the certification to the extent this information was provided by the MCOs and explain how the historical non-benefit cost data was considered in the non-benefit cost assumptions used in rate development.[176]

The Rate Development Summary in the rate certification must summarize non-benefit costs by type or by category (i.e., administrative costs, care management (non-benefit), taxes and fees, and profit margin).[177] The Rate Development Summary in the rate certification should also identify where the non-benefit costs are described in the rate certification and any additional documents, as well as any comparisons to the previous year's non-benefit costs.[178]

This information will be used to verify that the non-benefit costs are reasonable and consistent with the changes being made to the rates (either in the initial certification or in the rate amendment) and to identify costs that are unusual (i.e., significant larger or smaller than typical), or that appear inconsistent with the changes described in the certification or rate amendment.[179]

Approach Used by Milliman for Review – Non-Benefit Expenses

[167] 42 CFR § 438.7(b)(3) – Rate Certification Submission, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.7.
[168] Ibid.
[169] "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, pg. 41.
[170] Ibid, 41.
[171] Ibid, 41.
[172] Ibid, 41.
[173] Ibid, 41.
[174] Ibid, 41.
[175] Ibid, 42.
[176] Ibid, 42.
[177] "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, pg. 56.
[178] Ibid, pg. 56.
[179] Ibid, pg. 56.

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 2023 rate certifications for compliance with the CMS 2022-2023 Medicaid managed care rate setting guidance.[180] 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 2022-2023 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 2022-2023 Medicaid managed care rate setting guidance and compared them against what the Commission submitted in their Medicaid managed care capitation rate certifications.

Actuarial Policy Authority – CMS Compliance and Documentation

In 42 CFR § 438.7, the regulation defines the CMS review and approval of the rate certification.[181] States must submit to CMS for review and approval all MCO rate certifications concurrent with the review and approval process for contracts as specified in 42 CFR § 438.3(a).[182] The State must, upon CMS' request, provide additional information, whether part of the rate certification or additional supplemental materials, if CMS determines that information is pertinent to the approval of the certification under this part.[183] The State must identify whether the information provided in addition to the rate certification is proffered by the State, the actuary, or another party.[184]

CMS issues additional guidance annually, which includes:

1. The Federal standards for capitation rate development.[185]
2. The documentation required to determine that the capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms.[186]
3. The documentation required to determine that the capitation rates have been developed in accordance with the requirements of this part.[187]
4. Any updates or developments in the rate review process to reduce State burden and facilitate prompt actuarial reviews.[188]
5. The documentation necessary to demonstrate that capitation rates competitively bid through a procurement process have been established consistent with the requirements of 42 CFR § 438.4 through 42 CFR § 438.8.[189]

[180] 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.
[181] 42 CFR § 438.7 – Rate Certification Submission, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.7.
[182] 42 CFR § 438.7(a) – Rate Certification Submission, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.7.
[183] 42 CFR § 438.7(d) – Rate Certification Submission, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.7.
[184] Ibid.
[185] 42 CFR § 438.7(e)(1) – Rate Certification Submission, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.7.
[186] 42 CFR § 438.7(e)(2) – Rate Certification Submission, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.7.
[187] 42 CFR § 438.7(e)(3) – Rate Certification Submission, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.7.
[188] 42 CFR § 438.7(e)(4) – Rate Certification Submission, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.7.
[189] 42 CFR § 438.7(e)(5) – Rate Certification Submission, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.7.

The State, through its actuary, must certify the final capitation rate paid per rate cell under each risk contract and document the underlying data, assumptions and methodologies supporting that specific capitation rate.[190]

1. The State may pay each MCO a capitation rate under the contract that is different than the capitation rate paid to another MCO, so long as each capitation rate per rate cell that is paid is independently developed and set in accordance with this regulation.[191]

2. If the State determines that a retroactive adjustment to the capitation rate is necessary, the retroactive adjustment must be supported by a rationale for the adjustment and the data, assumptions and methodologies used to develop the magnitude of the adjustment must be adequately described with enough detail to allow CMS or an actuary to determine the reasonableness of the adjustment.[192] These retroactive adjustments must be certified by an actuary in a revised rate certification and submitted as a contract amendment to be approved by CMS.[193]

3. The State may increase or decrease the capitation rate per rate cell up to 1.5 percent during the rating period without submitting a revised rate certification.[194] However, any changes of the capitation rate within the permissible range must be consistent with a modification of the contract as required in 42 CFR § 438.3(c) and are subject to the requirements at 42 CFR § 438.4(b)(1).[195] CMS may require a State to provide documentation that modifications to the capitation rate comply with the requirements in 42 CFR § 438.3(c) and 42 CFR § 438.4(b)(1).[196]

Adherence by states and their actuaries to the rate development standards and documentation expectations outlined in the rate certification guide, will aid in ensuring compliance with the regulations and in CMS's review and approval of actuarially sound capitation rates and associated federal financial participation.[197] The failure to include appropriate documentation may result in additional CMS questions and / or requests to obtain the information described in the rate certification guide as part of CMS's review.[198] Additionally, as part of the CMS effort to review states' submissions of rate certification as efficiently as possible, CMS implemented an accelerated rate review process.[199]

Section 1903(m)(2) of the Social Security Act (the Act) and 42 CFR § 438.4 require that capitation rates be actuarially sound, meaning that the capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the managed care plan for the time period and the population covered under the terms of the contract.[200] Such capitation rates are developed in accordance with 42 CFR § 438.4(b).[201] In applying the regulation standards, CMS will also use these three principles:

- The capitation rates are reasonable and comply with all applicable laws (statutes and regulations) for Medicaid managed care[202]
- The rate development process complies with all applicable laws (statutes and regulations) for the Medicaid program, including but not limited to eligibility, benefits, financing, any applicable waiver or demonstration requirements, and program integrity[203]
- The documentation is sufficient to demonstrate that the rate development process meets the requirements of 42 CFR part 438 and generally accepted actuarial principles and practices[204]

[190] 42 CFR § 438.7(c) – Rate Certification Submission, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.7.
[191] 42 CFR § 438.7(c)(1) – Rate Certification Submission, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.7.
[192] 42 CFR § 438.7(c)(2) – Rate Certification Submission, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.7.
[193] Ibid.
[194] 42 CFR § 438.7(c)(3) – Rate Certification Submission, Code of Federal Regulations, Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.7.
[195] Ibid.
[196] Ibid.
[197] "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, pg. 2.
[198] Ibid, pg. 2.
[199] Ibid, pg. 2.
[200] Ibid, pg. 2.
[201] Ibid, pg. 2.
[202] Ibid, pg. 2.
[203] Ibid, pg. 2.
[204] Ibid, pg. 3.

CMS provides the specific elements to be included in the rate certification to ensure compliance with the regulations, consistency in the material that is submitted and transparency for what is included in federal review.[205] Following CMS guidance included within this guide is more likely to result in a faster CMS review and reduce the number of questions.[206] At this time, CMS does not prescribe a specific format for supplying this information in the rate certification although each of the relevant sections below must be discussed in sufficient detail in the rate certification, including those specified in 42 CFR § 438.7.[207]

Approach Used by Milliman for Review – CMS Compliance and Documentation

The Commission provided us with the final FY 2023 rate certification report for all six programs included in our review. We relied on these documents, as well as the publicly available CMS 2022-2023 Medicaid Managed Care Rate Setting Guide, to conduct our compliance and documentation review. 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.

[205] Ibid, pg. 3.
[206] Ibid, pg. 3.
[207] Ibid, pg. 3.

Exhibit 1
Texas Managed Medicaid Capitation Rate Review
Summary of Recommendations

	Applicable Program(s)						Recommendation Basis			Directional Impact of Current Methodology on Capitation Rates
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	X			X	X		X			Potential Risk Group or SDA Impact
B: Review current structure of patient liability in the capitation rates				X		Relies on STAR+PLUS	X	X	X	Unknown
C: Consider combining risk groups to enhance credibility and reduce annual volatility					X		X			Potential Risk Group or SDA Impact
Base Data Development										
D: Use state encounter data as the primary base data source for expenditure data	X	X	X	X	X		X			Potential Risk Group or SDA Impact
E: Use the state capitation payment file as the primary base data source for enrollment data	X		X	X	X		X			Potential Risk Group or SDA Impact
F: Consider the inclusion of patient liability in the base data development				X		Relies on base data from STAR+PLUS	X	X		Unknown
G: Develop base period for each SDA by weighting each MCO's experience with actual enrollment instead of projected enrollment	X			X	X		X	X		Unknown
H: Include supporting documentation for the development of the base period data	X	X	X	X	X				X	No Financial Impact
I: Include new DHMO in projected FY 2023 membership and expenditures			X				X	X		Unknown
Trend Assumptions										
J: Develop medical trend assumptions at more detailed service category level	X	X		X	X		X	X		Unknown
K: Develop medical and pharmacy trend assumptions separately by utilization and unit cost component	X	X	X	X	X		X	X		Unknown
L: Apply separate trends to patient liability and remaining net state costs				X		Relies upon STAR+PLUS medical trend analyses	X	X		(+)
M: Do not introduce changes in SDA distribution between Year 1 and Year 2 of the calculation when using statewide trend assumptions	X			X	X		X	X		(+)
N: Develop and apply pharmacy trends by drug type (i.e., Specialty and Non-Specialty)	X	X		X	X		X	X		(-)
O: Consider the impact of recently approved and upcoming pipeline drugs for each population	X	X		X	X		X	X		Unknown
P: Evaluate pharmacy trends at the therapeutic class level	X	X		X	X		X	X		Unknown
Programmatic Adjustments										
Q: Remove member months periods for members ages 21 through 64 who have an IMD stay in excess of 15 days during any month	X			X		Relies on STAR+PLUS	X	X	X	(-)
R: Calculate the nursing facility COVID-19 add-on impact gross of patient liability				X			X	X		(-)
S: Evaluate the impact of medical service utilization differences in the recently extended eligibility period for pregnant women	X						X			Unknown
T: Evaluate the impact of the recently extended eligibility period for pregnant women		X					X			Unknown
Non-Benefit Expenses										
U: Include supporting documentation for the development of the administrative costs	X	X	X	X	X	X		X	X	No Financial Impact
V: Review administrative allocations across risk groups to remove incentives to enroll higher cost risk groups				X		Relies on STAR+PLUS	X	X		Potential Risk Group or SDA Impact
CMS Compliance										
W: Include supporting documentation for the development of the administrative costs	X	X	X	X	X	X			X	No Financial Impact
X: Enhance supporting documentation to describe the methodology for estimating FY 2023 projected enrollment used in the rate development			X						X	No Financial Impact
Y: The Commission should reconcile actual patient liability amounts compared to rating assumptions for each MCO				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 Observations

Observation	Applicable Program(s)					
	STAR	STAR Health	Dental	STAR+ PLUS	STAR Kids	Dual Demo
Rate Structure						
A: Rates are developed individually by MCO rather than across all MCOs	X				X	
B: LTC rates developed separately for nursing facility and community residents				X		Relies on STAR+PLUS
Base Data Development						
C: Summary-level enrollment data and expenditure data are gathered from separate sources	X	X	X	X	X	Relies on base data from STAR+PLUS
D: There is not a clear process for the treatment of MCO self-reported TPR data	X	X		X	X	
E: Net reinsurance costs should not be included in the base data	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	X			X	X	
G: Member selection adjustment does not capture current duration of members						X
Trend Assumptions						
H: Prospective medical trends are developed using a purely formulaic approach	X	X	X	X	X	Relies on STAR+PLUS
I: Medical trends are not consistently applied to sub-capitated and service coordination cost	X			X	X	
J: The data source used for quantitative medical trend analysis does not enable more granular analysis	X	X		X	X	
K: Historical CPI trend used for NEMT trends does not reflect actual time period of projection	X	X		X	X	
Programmatic Adjustments						
L: Reimbursement changes are included as programmatic adjustments, regardless of their materiality	X	X		X	X	Relies on STAR+PLUS
M: The FQHC wrap payment removal relies on base data aggregation using projected enrollment	X		X	X	X	
N: Programmatic adjustments are not developed at a service category level	X	X	X	X	X	
O: The PHE related cost adjustment uses the same formulaic approach across all Medicaid populations, which may not produce reasonable results for all risk groups.	X	X	X	X	X	
P: Some programmatic adjustments vary by at least 5% among risk group / SDA combinations but appear reasonable	X				X	
Non-Benefit Expenses						
Q: Administrative expense assumptions are developed separately for the medical, pharmacy, and NEMT rate components	X	X		X	X	Relies on STAR+PLUS
R: 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				X	X	
S: Final non-benefit expense assumptions are not clearly identified	X				X	
T: The non-benefit expense PMPM for pharmacy services in the Dual Demo program is from 2015 without trend applied						X
CMS Compliance						
U: Supporting documentation does not clearly indicate that IMD costs are removed but associated member months remain (Programmatic Recommendation #1)	X			X		
V: Supporting documentation indicates pharmacy trends are set by drug type, which is inconsistent with the actual methodology used	X	X		X	X	
W: Supporting documentation should describe methodology for estimating FY 2023 projected enrollment used in the rate development			X			

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 4.0 million beneficiaries in FY 2023 at a program cost of roughly $12.3 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 2023 capitation rate development for the STAR program by reviewing the actuarial report and rate development model created by the Commission. For a high-level description of the regulatory and policy authority to be followed when designing the rate structure of a program, please see the Review Process section in the Main Report.

Description of State Fiscal Year (FY) 2023 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 1-5
- Children Ages 6 -14
- Children Ages 15-18
- Children Ages 19-20
- Temporary Assistance for Needy Families (TANF) Adults
- Pregnant Women
- Adoption Assistance or Permanency Care Assistance (AAPCA)

The Commission noted that Children Ages 19-20 are combined with Children Ages 15-18 for rate development due to the small number of members and significant cost variation in the older age group, so the FY 2023 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 2023 rates:

- Step One: Develop MCO-specific FY 2023 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 2023 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 2023 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 2023, 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 4.6% of revenues.

APPENDIX A: STAR

Table 1 Texas Medicaid Managed Care Rate Review STAR Program – Rate Structure FY 2023 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%	0%	100%
> 7% and ≤ 9%	0%	100%
> 9% and ≤ 12%	0%	100%
> 12%	0%	100%

Review Conclusions

In this section we include commentary related to the reasonableness of the resulting rate structure. We further categorize our review conclusions into observations and recommendations.

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.

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.

Several of our conclusions apply to multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

Reasonableness of Resulting Rate Structure

The Commission's STAR risk group definitions, which primarily use a combination of eligibility group and age, are generally consistent with commonly observed practices for similar programs in other states. We do not have significant concerns about the assumed credibility levels due to sufficient historical average enrollment in each risk group and SDA grouping.

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.

The following table summarizes the average enrollment associated with each risk group and SDA combination.

Table 2
Texas Medicaid Managed Care Rate Review
STAR Program – Rate Structure
March 2019 through February 2020 Average Enrollment

SDA	Under Age 1	Age 1-5	Age 6-14	Age 15-20	TANF-Adults	Pregnant Women	AAPCA
Bexar	19,189	67,351	100,965	33,105	13,385	11,568	10,169
Dallas	30,082	104,782	161,670	50,237	10,568	15,042	6,081
El Paso	7,801	29,943	49,184	19,144	4,605	4,626	875
Harris	54,339	193,183	290,785	91,396	23,469	27,056	10,700
Hidalgo	22,657	89,158	146,740	53,615	10,895	11,965	1,195
Jefferson	6,293	21,990	32,336	9,856	4,001	3,760	1,507
Lubbock	5,989	19,386	30,050	9,280	3,488	3,815	2,666
Nueces	6,419	23,085	35,500	11,916	4,486	4,208	1,469
Tarrant	21,276	70,837	108,328	33,759	9,649	11,569	5,322
Travis	11,827	38,925	58,596	17,903	5,808	5,894	4,628
MRSA Central	10,477	37,692	55,874	17,474	6,743	6,517	3,851
MRSA Northeast	12,698	44,966	69,338	21,899	7,000	7,768	4,089
MRSA West	13,174	40,009	59,334	18,587	6,692	7,894	3,805

Observations

We note the following observation related to the STAR program:

Observation #1: Rates are developed individually by MCO rather than across all MCOs
Applicable program(s): STAR, STAR Kids

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

Recommendations

We note the following recommendations related to the STAR program:

Recommendation #1: Consider consolidating SDAs for the purpose of rate development
Applicable program(s): STAR, STAR+PLUS, STAR Kids

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.

APPENDIX A: STAR

BASE DATA DEVELOPMENT

We gained a detailed understanding of the Commission's FY 2023 base data development approach used for the STAR program based on a detailed review and replication of FY 2023 base data development for Travis, the sample Service Delivery Area ("SDA"), in conjunction with the Commission's responses to our base data review questions. 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) 2023 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 2023 capitation rate setting process:

Base Data Selection

- The Commission selected the most recent 12-month period (March 2019 through February 2020) prior to the COVID-19 public health emergency as the base period for both the enrollment data and the service expenditure data. Other than the carve-in of NEMT services as previously provided by MTOs or FFS and the extension of eligibility for pregnant women from two months to six months post-partum as of September 1, 2021,[6] the populations and services covered by the STAR program during FY 2023 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

  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 2023.

- The Commission reconciled MCO reported supplemental data to the MCO reported Financial Statistical Reports ("FSR") expenditures for overall consistency, in aggregate, across all risk groups at the MCO and SDA level for the base period (March 2019 through February 2020). The FSRs are self-reported data prepared by the MCOs under the terms and conditions of the Uniformed Managed Care Contract and the Uniform

[6] Tex. H.B. 133, 87(R) Leg., (2021), Effective September 1, 2021, Retrieved from: 87(R) HB 133 - Enrolled version (texas.gov).

Managed Care Manual. For more information on the FSRs please refer to the Texas Health and Human Services website.[7]

- 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 2019 and FY 2020 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 2022 for the base period (March 2019 through February 2020) were adjusted for claims, which have been incurred but not reported ("IBNR"). Please note, the IBNR assumption by the Commission is $0 given there are 24 months of additional payment runout in the data.
  - 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.

[7] Medicaid & CHIP Financial Statistical Reports: Fiscal Year 2020: Sept. 1, 2019, to May 31, 2020, 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 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, including Uniform Hospital Rate Increase Payment ("UHRIP"), Quality Incentive Payment Program ("QIPP"), and Network Access Improvement Program ("NAIP"). The Commission accounted for these payments outside the main capitation rates as special rate adjustments.
  - Pharmacy Benefit Manager ("PBM") discount and rebate settlements were deducted by the Commission in the base data development. These adjustments were not reported through the MCO supplemental data but were based on information provided separately to the Commission.

▪ 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 TPR was explicitly noted in Part 4 of the FSR. Otherwise, the Commission assumed the reported reimbursement amounts were already included in the claims and other expenses, so the Commission did not offset other expenditures as reported in the MCO supplemental data by the reported reimbursement amounts.

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

- Medical costs for certain 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.
- Medical and pharmacy costs for hemostatic drugs.
- Pharmacy costs for Hepatitis C drugs.

▪ The Commission did not adjust the base data to remove the impact of any changes in eligibility or covered services between the base period and FY 2023. Instead, the Commission reflected the expected impact of these changes on expenditures 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 2023.

APPENDIX A: STAR

Data Available 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 2019 Final (September 2018 through August 2019) with runout through August 2020.
    - FY 2020 Final (September 2019 through August 2020) with runout through August 2021.
  - MCO supplemental expenditure data:
    - FY 2019 – FY 2020 (September 2018 through August 2020) with runout through February 2021.
    - FY 2020 – FY 2021 (September 2019 through August 2021) with runout through February 2022.
  - The Commission provided summarized monthly enrollment files by each MCO and risk group:
    - Actual enrollment was provided for the period from September 2012 to December 2021.
    - Projected enrollment was provided for the period from January 2022 to August 2027.
- 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 (March 2019 through February 2020).
  - 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 2019 and FY 2020.
- The Commission's documentation of base data development in the FY 2023 actuarial report.
- The Commission's responses to ad hoc questions from Milliman.

Review Conclusions

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.

APPENDIX A: STAR

In this section we include commentary related to the technical accuracy of the base data development. We further categorize our review conclusions into *observations* and *recommendations*.

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.

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.

Several of our conclusions apply to multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

Technical Accuracy

The development of the final medical and pharmacy base period data is technically accurate for each risk group and each MCO in the sample SDA. Using the raw enrollment data as reported by the Commission and the raw expenditure data as reported by the MCOs, Milliman was able to replicate the calculation of the final medical and pharmacy base data using the Commission's approach within a margin of rounding difference at the risk group level for the sample SDA. Please refer to the sample SDA base data reconciliation Exhibit A-1 for details.

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 the most recent pre-COVID period (March 2019 through February 2020) as the base period
- Use of validated MCO self-reported expenditure data as the primary base expenditure data
- Use of the MCO financial data (i.e., FSR) and the encounter data for expenditure data validation
- Assumed $0 adjustment for IBNR, given the significant length of paid data runout included in the base period data
- 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 lag-expenditure and non-lag expenditure data, to the extent applicable

We note the following observations related to the STAR program:

Observation #1: Summary-level enrollment data and expenditure data are gathered from separate sources
Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids

The Commission collected summarized base period enrollment data and expenditure data separately from different entities (e.g., the Commission and the MCOs). 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.

Although the likelihood of retroactive eligibility changes and subsequent risk group assignment changes for members enrolled in this program is less than in other programs, such potential inconsistencies can introduce risks on a PMPM basis.

Observation #2: There is not a clear process for the treatment of MCO self-reported TPR data
Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

TPR was collected by the Commission as part of the MCO supplemental data as a standalone cost recovery item. In the MCO supplemental data request template and instructions, the Commission did not specifically request information from the MCOs about the nature of these TPRs and whether the reported reimbursement amounts have already been accounted for in expenditures or recoveries reported in other sections of the MCO supplemental data. For the sample SDA reviewed, the Commission's treatment of MCO reported TPR ranges from being fully reflected in other sections to not being reflected in other sections at all. The Commission explained that the decision to include or exclude TPR from the base data development was primarily based on a manual review of relevant FSR reporting notes in Part 4 and the expenditure comparison between the FSR and MCO supplemental data. In general, the Commission did not use reported TPR for base data development unless TPR was mentioned in the FSR reporting notes in Part 4. Given the self-reporting nature of the FSRs and the potential for incomplete notes, this approach can lead to an artificial inflation of base period expenditures to the extent that TPR was not appropriately noted or included in the FSRs. At a minimum, the Commission may consider obtaining explicit clarifications from the MCOs to inform appropriate treatment of MCO-reported TPR amounts in the base data development, or the Commission may consider adding direct questions to the MCO supplemental data collection template to remove the manual nature of this adjustment and obtain consistent information and reporting from all MCOs.

Observation #3: Net reinsurance costs should not be included in the base data

Applicable program(s): STAR, STAR+PLUS, STAR Kids

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 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.

Observation #4: 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

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 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.

Recommendations

We note the following recommendations related to the STAR program:

Recommendation #1: Use state encounter data as the primary base data source for expenditure data

Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids

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 for more sophisticated actuarial cost modeling. Using encounter data also enables member level matching of risk group assignment between enrollment and claims data. While encounter data can play a primary role in the base data development, the MCO FSRs and the MCO 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 2022-2023 Medicaid Managed Care Rate Development Guide[8] 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. For the development of the FY 2023 capitation rates, given the base period is March 2019 through February 2020, our understanding is that the detailed encounter data would have been available to use 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 once the Commission returns to using a more recent base period.

Recommendation #2: Use the state capitation payment file as the primary base data source for enrollment data
Applicable program(s): STAR, Dental, STAR+PLUS, STAR Kids

For an established managed care program like STAR, 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 capitation payments at the risk group level. When enrollment is provided without the member level details, i.e., how the Commission provided the enrollment file, such consistency will be at risk.

Recommendation #3: 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

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[9] 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 2023 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. While the financial impact of this weighting methodology in the development of the community rate can go both ways, as shown in Table 3, 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.

If the Commission determines it is appropriate to apply an adjustment to reflect changes between the base period and rating period due to changes in the overall provider contracting levels, the Commission may consider applying this adjustment as a programmatic adjustment so that 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. The current approach introduces the risk of double counting any persistent historical shifts that may also be reflected in trends, as well as removing cost differences beyond provider reimbursement levels (e.g., underlying differences in member demographics or required levels of care).

[8] "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.
[9] 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.

Table 3
Texas Medicaid Managed Care Rate Review
STAR Program – Base Data
Difference in SDA-level PMPMs using Base Period Membership vs. Projected Membership Weighting

	Medical + Pharmacy Percentage Difference							
SDA	**Under Age 1**	**Age 1-5**	**Age 6-14**	**Age 15-20**	**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%**

Recommendation #4: Include supporting documentation for the development of the base period data
Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids

The rate certification includes the following information to support the development of the base period data used for the FY 2023 capitation rates:

- Data sources
- High level information about each of the main three data sources: MCO 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:

- The specific use of each of the three data sources in the base data development
- An overview of the Commission's reconciliation processes between the MCO supplemental data and FSRs and whether a different approach is used for lag vs. 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 experience into overall program experience

APPENDIX A: STAR

TREND

We gained a detailed understanding of the Commission's FY 2023 medical and pharmacy trend development approach used for the STAR program. We relied on underlying data provided by the Commission, as well as responses to our specific trend review questions.

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 2023 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) 2023 Trend Development

Our detailed understanding of the trend development for FY 2023 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 2023 (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 FFS claim payments amounts were adjusted to reflect managed care pharmacy reimbursement provisions. Historical data and calculations were developed separately by drug type (i.e., brand, generic, and specialty) for utilization and unit cost, but the Commission ultimately used the PMPM level data to develop the selected pharmacy trends.

- 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) claims for demand response services[3] (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) by risk group for each 12-month period from March 2016 through February 2020.
- The Commission multiplied the statewide incurred pharmacy claims PMPM by the annual PDL adjustment factors. The adjusted PMPMs estimate the 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.

[3] https://www.transit.dot.gov/sites/fta.dot.gov/files/docs/Demand_Response_Fact_Sheet_Final_with_NEZ_edits_02-13-13.pptx

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 2 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 2019 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 4
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 trend at the risk group level by weighting the historical annual statewide trends for each risk group as follows:

Table 5
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

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 Available for Trend Review

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

- Historical medical claim experience for September 2017 through February 2022 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 medical trend development working files for all risk group and SDA combinations, including:
  - Summarized FY 2017 – FY 2020 managed care PMPM trends.
  - Programmatic adjustment factors for material changes between FY 2017 and FY 2021.
  - 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 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 trends by risk group based on a weighted average of historical annual trends in incurred claims PMPM adjusted for PDL changes.

- The Commission's documentation of trend development in the FY 2023 actuarial report.

- The Commission's responses to ad hoc questions.

Review Conclusions

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.

In this section we include commentary related to the reasonableness of resulting trend assumptions. We further categorize our review conclusions into *observations* and *recommendations*.

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.

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.

Several of our conclusions apply to multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

Reasonableness of Resulting Trend Assumptions

Medical Trends

The Commission's overall annual prospective PMPM trend at the program level of 4.3% appears to be somewhat high based on our experience working with other states, especially given that the provider reimbursement and other program changes are not accounted for through this trend assumption. 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. 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.

We also reviewed the stability of the Commission's trend calculation methodology. Table 6 displays the volatility in observed annual trends in the medical data provided for our review.

Table 6
Texas Medicaid Managed Care 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]**	**Total**
FY2017*	3.3%	-2.1%	2.4%	3.2%	4.7%	0.3%		1.6%
FY2018*	5.6%	5.7%	4.8%	3.1%	1.6%	-0.3%		4.0%
FY2019*	4.6%	6.3%	5.5%	6.6%	8.7%	1.0%	7.2%	5.1%
FY2020 H1*	8.3%	11.1%	11.5%	10.3%	6.8%	2.0%	3.7%	8.6%
Selected Trend	**5.1%**	**4.4%**	**5.3%**	5.2%	5.3%	0.6%	6.0%	4.3%

** Data included in selected trend.*
[1] Based on 6-month periods from September through February; Final trend based on different weighted average.

We did not evaluate the drivers of the historical 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, new alternative treatments for existing conditions, and changes in average member demographics and acuity. Table 6 is 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 assumption.

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, the Commission's overall annual prospective PMPM trend at the program level of 1.2% per year, included in Table 7 below, 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 March 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 2023 pharmacy PMPM was more than 10% higher than any historical pharmacy PMPMs for the TANF Adult risk group and more than 10% lower than any historical pharmacy PMPMs for the AAPCA risk group. The rate Commission's rate certification and the work files do not include any explanation to support the FY 2023 pharmacy PMPMs for some risk groups being materially higher or lower than historical experience.

We also reviewed the stability of the Commission's trend calculation methodology over time. 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. We summarized historical trends during the PHE, but we did not evaluate alternative trend calculation periods that include the PHE because we do not expect experience during the PHE to be representative of future trends.

Table 7 displays the volatility in observed annual trends by risk group in the pharmacy data provided for our review. The same methodology produces materially different results at a risk group level depending on the years used in the calculation, such as shifting the time periods used as shown in Table 7.

Table 7
Texas Medicaid Managed Care Rate Review
STAR Program – Trend Development
Historical Annual Trend in Total Pharmacy PMPM (Adjusted for PDL Changes)

	Risk Groups							
Year Ending	**Under Age 1**	**1-5**	**6-14**	**15-20**	**TANF-Adult**	**Pregnant Women**	**AAPCA[1]**	**Total[2]**
3/16 through 2/17	-6.5%	-8.5%	-2.2%	-1.7%	9.4%	17.0%		-0.6%
3/17 through 2/18*	3.9%	1.3%	0.3%	1.4%	8.0%	4.8%		2.8%
3/18 through 2/19*	-6.5%	-1.3%	-1.0%	0.2%	10.0%	-2.3%	2.1%	0.3%
3/19 through 2/20*	-1.5%	-0.1%	1.0%	3.8%	5.0%	-0.4%	-3.0%	1.3%
3/20 through 2/21	-23.1%	-35.8%	-21.4%	-8.3%	-6.4%	-27.6%	-6.8%	-16.6%
3/21 through 2/22	32.5%	11.6%	8.3%	3.4%	-3.6%	-16.0%	2.3%	7.2%
Selected Trend	**-2.3%**	-0.3%	0.2%	2.2%	7.2%	-0.2%	-1.3%	1.2%
Final Trend if Underlying Years Shift								
Years of Shift								
1 Year Backward	-3.0%	-1.7%	-0.7%	0.3%	9.2%	3.3%		1.0%

** Data included in selected trend.*
[1] Based on 6-month periods from September through February; Final trend based on different weighted average.
[2] Excluding AAPCA risk group.

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 alternative treatments for existing conditions, and changes in average member demographics and acuity.

Depending on expected changes in drug mix and utilization, it may be reasonable for the FY 2023 pharmacy trends to be higher or lower than previous observed pharmacy trends. Table 7 is 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 assumption.

NEMT Trends

As noted in the Risk Level Classification section of the Main Report, 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.

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 the STAR program:

Observation #1: Prospective medical trends are developed using a purely formulaic approach
Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids

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 2023.

Observation #2: Medical trends are not consistently applied to sub-capitated and service coordination cost
Applicable program(s): STAR, STAR+PLUS, STAR Kids

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 2023 rate development.

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.

Observation #3: The data source used for quantitative medical trend analysis does not enable more granular analysis
Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

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.

Observation #4: 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, Duals

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 and does not reflect the actual time period of the projection.

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 ten years ending February 2020 (based on this typical approach) is 0.9%. The Commission calculated each month's annual trend for the most recent 120 months 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%.

Additionally, the resulting trend is applied to reflect anticipated CPI changes from the base period (March 2019 to February 2020) to FY 2023. It may be more appropriate to use *actual observed* CPI changes from the base period to present day (i.e., March 2022 when setting FY 2023 rates) and then recently observed averages from present day to FY 2023. This approach would ensure historical periods from 5 to 10 years ago are not used at the expense of recent market conditions.

Recommendations

We note the following recommendations related to the STAR program:

Recommendation #1: Develop medical trend assumptions at more detailed service category level
Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

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
- 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.

Recommendation #2: Develop medical and pharmacy trend assumptions separately by utilization and unit cost components

Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids

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 help validate how historical provider reimbursement changes (that are separately identified in the prior rate development) compare to historical unit cost trends. Such a comparison will provide insights about the provider contracting dynamics at the major service category level. It will also provide an understanding of the drivers of observed recent 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 the trend development.

The Commission produced an analysis of historical utilization and unit cost trends for medical and pharmacy services, but this analysis was not explicitly used to develop distinct utilization and unit cost trends for the rate development. Other states often select distinct utilization and unit cost trends. A more granular approach for selecting trends allows for trends that are better aligned with each population's projected costs and program goals.

Recommendation #3: Do not introduce changes in SDA distribution between Year 1 and Year 2 of the calculation when using statewide trend assumptions

Applicable program(s): STAR, STAR+PLUS, STAR Kids

As described above, the Commission followed a generally accepted process to calculate annual medical PMPM trends for each SDA. The Commission then aggregated these SDA trends into a statewide annual PMPM trend using the year 2 aggregate dollars by SDA. The Commission's calculation approach produced a higher result than weighting the SDA trends by the year 1 costs, which would produce the actual historical statewide PMPM trend (alternatively calculated as the one-year trend in statewide PMPM amounts). The selection of year two aggregate dollars places a larger reliance on SDA trends that are higher than the average statewide trend (i.e., an SDA with a higher than average trend receives additional weight due to having higher costs in year two than in year one) and smaller reliance on SDA trends that are lower than the average statewide trend. As a result, this weighting methodology will always produce a trend that is greater than the actual observed statewide trend unless trends by SDA are identical.

Table 8 summarizes our analysis of the difference between the aggregation approaches (i.e., year 1 costs, year 2 costs) at the risk group level and in total for the STAR program.

Table 8
Texas Medicaid Managed Care Rate Review
STAR – Trend Development
Analysis of Medical Trend Aggregation Approach

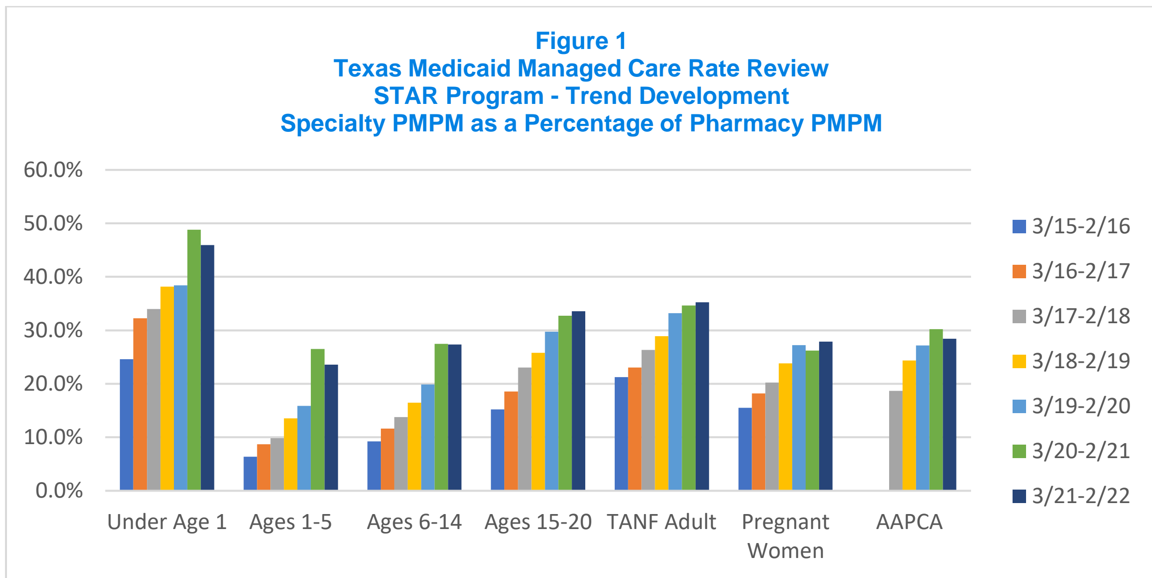
	Annualized Trends			
Risk Group	**Aggregated Based on Year 2 Costs (Used for FY 2023 Capitation Rates)**	**Aggregated Based on Year 1 Costs (Actual Historical Statewide Trend)**	**Annualized Difference**	**Applied Trend Impact (3.5 years of trend)**
Under Age 1	5.1%	4.7%	0.4%	1.6%
Ages 1-5	4.4%	4.3%	0.1%	0.4%
Ages 6-14	5.3%	5.1%	0.2%	0.8%
Ages 15-20	5.2%	4.8%	0.4%	1.6%
TANF Adults	5.3%	5.1%	0.2%	0.8%
Pregnant Women	0.6%	0.5%	0.0%	0.4%
AAPCA	6.0%	5.4%	0.7%	2.4%
Total	**4.3%**	**4.1%**	**0.2%**	**0.8%**

As displayed in Table 8, the Commission's aggregation method (using year 2 costs for the historical statewide trend calculation) results in the overall final prospective annual trend being roughly 0.2% higher than the actual observed historical trend (using year 1 costs). Applying the selected annual trend assumption from the base period (March 2019 through February 2020) to the FY 2023 rating period (i.e., a total of 3.5 years) results in an overall difference of roughly 0.8% between the two aggregation approaches.

We recommend that the Commission composites the trends using the year 1 SDA cost distribution when relying on historical statewide trends to develop prospective trend assumptions. This aggregation methodology will produce the same result as calculating the statewide average historical trend.

Recommendation #4: Develop and apply pharmacy trends by drug type (i.e., Specialty and Non-Specialty)
Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

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. Figure 1 shows the historical change in the specialty PMPM included in the trend analysis as a percentage of the total pharmacy PMPM included in the trend analysis (net of the exclusions, noted above).



[1] *Based on 6-month periods from September through February.*

Given the general increase in specialty drug mix in recent years, relying on historical aggregate trends likely understates future trends by undervaluing the impact of higher-than-average specialty drug trends on the current drug mix included in the base period.

To illustrate this, we reviewed the selected FY 2023 pharmacy trends for each risk group relative to estimated one-year trends based on separate specialty / non-specialty trends composited using the base period mix. Table 9 includes the comparison of these two trend approaches.

Table 9
Texas Medicaid Managed Care Rate Review
STAR Program - Trend Development
Estimated Impact of Applying Distinct Trends to Specialty and Traditional Pharmacy Costs

Risk Group	Final FY 2023 Trend	Estimated Composite Trend Based on Distinct Trends[1]	(Under) / Over-Statement of Historical Weighted Trend
Under Age 1	-2.3%	-2.3%	0.0%
Ages 1-5	-0.3%	0.5%	(0.8%)
Ages 6-14	0.2%	1.2%	(1.0%)
Ages 15-20	2.2%	3.4%	(1.2%)
TANF Adult	7.2%	8.2%	(1.0%)
Pregnant Women	-0.2%	0.4%	(0.6%)
AAPCA	-1.3%	-0.5%	(0.8%)

[1] *Based on applying the Commission's historical weighing approach to historical specialty and traditional trends separately.*

Table 9 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.

We note, that 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 these two 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 9, 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 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 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.

Recommendation #5: Consider the impact of recently approved and upcoming pipeline drugs for each population

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

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 2023 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. Examples of some of these drugs that could materially impact program costs include:

- Ubrelvy (approved December 2019) for acute treatment of migraine
- Oxbryta (approved December 2019) to treat sickle cell disease
- Trikafta (approved October 2019) to treat cystic fibrosis

The Commission reimburses the MCOs for certain newly approved drugs through non-risk arrangements, however, the three drugs listed above are not on the non-risk drug payment list[10] as of July 11, 2022, but they are included on either the Texas preferred drug list[11] effective January 27, 2022 or the March 2022 Texas specialty drug list (SDL).[12] Although these drugs were approved during the base period, the base period would reflect a limited amount of claims.

In addition, many oncology drugs have been newly approved or approved for expanded indications since 2019. Each of these drugs alone may not materially impact trends, but the combined impact of these drug approvals has materially increased utilization within the therapeutic class in other states.

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

[10] "Vendor Drug Program, Non-Risk Drugs," Texas Health and Human Services, Retrieved from: https://www.txvendordrug.com/resources/managed-care/non-risk-drugs.
[11] "Vendor Drug Program, Preferred Drugs," Texas Health and Human Services, Retrieved from: https://www.txvendordrug.com/formulary/prior-authorization/preferred-drugs.
[12] "Vendor Drug Program, Specialty Drugs," Texas Health and Human Services, Retrieved from: https://www.txvendordrug.com/formulary/specialty-drugs.

impact of new drugs and expanded indications on pharmacy costs in the STAR program 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 populations.

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.

Recommendation #6: Evaluate pharmacy trends at the therapeutic class level

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

In conjunction with recommendation #5, 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.

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PROGRAMMATIC ADJUSTMENTS

We gained a detailed understanding of the Commission's FY 2023 programmatic adjustment development approach used for the STAR program based on a review and analysis of the FY 2023 programmatic adjustment development, in conjunction with the Commission's responses to our programmatic adjustment review questions. Our review approach varied based on the assessed risk of each adjustment. For a full description of the approach used to review the programmatic adjustments, as well as a high-level description of the regulatory and policy authority to be followed in the development of the programmatic adjustments, please see the Review Process section in the Main Report.

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 2023 NEMT programmatic adjustments to become comfortable in the context of overall rate soundness.

Description of State Fiscal Year (FY) 2023 Programmatic Adjustment Development

The Commission developed and applied programmatic adjustments separately for each itemized change as applicable to the FY 2023 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 2023

Programmatic Adjustment Factor Development Approach

The Commission applied 32 programmatic adjustments in the FY 2023 STAR program capitation rate development, including:

- 22 adjustments to the medical rate component
- 6 adjustments to the pharmacy rate component
- 4 adjustments 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 2023 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
- *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 2023

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
- Medical and pharmacy costs for hemostatic drugs
- Pharmacy costs for Hepatitis C drugs

The Commission used different methodologies to address eligibility changes and the PHE related cost adjustment, as noted below:

- Eligibility changes
  - The Commission estimated the impact of program eligibility changes on base period claims.
  - The Pregnant Women risk group is the only risk group with an eligibility change between the base period and FY 2023. The eligibility change adjustment was applied to the Pregnant Women risk group for the pharmacy and NEMT components. Due to interactions with the Delivery Supplemental Payment budget-neutral case rate that reimburses MCOs for costs related to childbirth (see the Rate Structure section of this Appendix), the Commission developed a single adjustment to address the eligibility changes and the PHE impact on the case rate. Therefore, the adjustment factor for the medical component was applied to risk groups in which members have delivery claims, which includes all risk groups except Under Age 1 and Age 1-5.
- PHE related cost adjustment (medical and pharmacy components)
  - The Commission estimated the impact of the PHE on program costs by comparing actual monthly costs per member in March through August 2021 (net of COVID-related costs) to expected costs during that period. The expected costs were calculated by projecting actual March through August 2019 costs forward two years with assumed trend and programmatic adjustments.
  - The Commission compared actual to expected costs for each 3-month period between March and August 2021 and averaged the ratios to derive the impact of the PHE.
  - The Commission dampened the final PHE impact by 75% to account for an assumption that the PHE will end in October 2022 and will affect costs for one quarter (through November 2022).
  - Table 10 provides an example of the PHE adjustment calculation for the TANF Adults risk group in Travis.

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Table 10 Texas Medicaid Managed Care Rate Review STAR Program - Programmatic Adjustment Development FY 2023 Public Health Emergency Adjustment Factor Development			
	Actual FY 2019 PMPM Trended for 2 years and Adjusted for Programmatic Changes	**Actual FY 2021 PMPM**	**FY 2021 PMPM / Trended and Adjusted FY 2019 PMPM**
March through May	$309.17	$250.76	0.8111
June through August	$293.14	$266.08	0.9077
Average			0.8594
PHE Impact		= 1 - 0.8594	14.06%
Dampened PHE Impact		= 14.06% x (1 - 0.75)	3.51%
Final PHE Adjustment Factor		= 1 - 3.51%	0.9649

The Commission's PHE adjustment reduced the projected FY 2023 costs by 3.51% for this sample risk group / SDA combination.

Data Available 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
- 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 2023 actuarial report
- The Commission's responses to ad hoc questions from Milliman

Review Conclusions

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.

In this section we include commentary related to the reasonableness of resulting programmatic adjustments. We further categorize our review conclusions into observations and recommendations.

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.

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.

Several of our conclusions apply to multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

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Reasonableness of Resulting Programmatic Adjustment Assumptions

Table 11 summarizes the programmatic adjustment factors used by the Commission to develop the FY 2023 STAR program rates 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). The adjustment descriptions in Table 11 are consistent with the titles of the Commission's exhibits in Attachments 5, 6, and 7 of the FY 2023 rate certification.

Table 11
Texas Medicaid Managed Care Rate Review
STAR Program - Programmatic Adjustment Development
Summary of FY 2023 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					
Delivery Cost Distribution*	-7.57%	-26.44%	0.00%	26.44%	Methodology review
PHE Related Cost*	-5.12%	-14.30%	1.67%	15.97%	Methodology review
Removal of FQHC Wrap Payments	-2.90%	-15.12%	-0.19%	14.93%	Reconciliation to MCO submissions
Hospital Reimbursement Changes - DRG Grouper Update	0.57%	-0.27%	2.69%	2.96%	Reasonableness
Rural Hospital Outpatient Reimbursement Changes	0.50%	0.00%	5.20%	5.20%	Reasonableness
Vaccine Administration	0.28%	0.01%	0.86%	0.85%	Reasonableness
Therapy Assistant	0.27%	0.00%	1.60%	1.60%	Reasonableness
Non-State Clinical Lab Reimbursement	-0.26%	-0.67%	-0.04%	0.63%	Reasonableness
Evaluation and Management Reimbursement	0.25%	0.12%	0.41%	0.29%	Reasonableness
Limit Reimbursement to Related Parties	-0.23%	-4.95%	0.00%	4.95%	Reasonableness
Outpatient Behavioral Health Reimbursement	0.16%	0.00%	1.15%	1.15%	Reasonableness
Potentially Preventable Complication (PPC)	-0.15%	-0.70%	0.76%	1.46%	Reasonableness
Hospital Reimbursement Changes - Standard Dollar Amount	-0.12%	-1.59%	7.15%	8.74%	Reasonableness
Quality Improvement – Potentially Preventable Readmission (PPR) Reduction	-0.09%	-0.79%	-0.02%	0.77%	Reasonableness
Radiology Reimbursement	0.07%	0.00%	0.49%	0.49%	Reasonableness
Hemostatic Drug Carve-Out	-0.06%	-1.44%	0.00%	1.44%	Reasonableness
Potentially Preventable Readmission (PPR)	0.03%	-0.16%	0.35%	0.51%	Reasonableness
Medicated Assisted Therapy Reimbursement	0.02%	0.00%	1.17%	1.17%	Reasonableness
Private Duty Nursing (PDN)	0.01%	0.00%	0.48%	0.48%	Reasonableness
Remove Invalid Clinician-Administered Drug (CAD) Encounters	-0.01%	-0.40%	0.00%	0.40%	Reasonableness
ASC/HASC Reimbursement Adjustments	0.01%	-0.01%	0.32%	0.33%	Reasonableness
Removal of Cost for Members with IMD in excess of 15 days in a Month	0.00%	-0.17%	0.36%	0.53%	Methodology review
Pharmacy Rate Component Programmatic Adjustments					
Hemostatic Drug Carve-Out	-3.92%	-22.22%	0.00%	22.22%	Reasonableness
PHE Related Cost*	-3.11%	-13.59%	25.69%	39.28%	Methodology review
Preferred Drug List Change	1.20%	-0.72%	7.74%	8.46%	Reasonableness
HB 133 Impact – Extending Coverage for Additional 5 Months to Pregnant Women Risk Group*	-0.82%	-9.87%	0.00%	9.87%	Methodology review
Hepatitis-C Drug Carve-Out	-0.31%	-11.35%	0.00%	11.35%	Reasonableness
IMD Adjustment Factor	0.00%	-0.04%	0.00%	0.04%	Methodology review
NEMT Rate Component Programmatic Adjustments					
PHE Related Cost*	-13.74%	-17.20%	-6.44%	10.76%	General review
HB 133 Impact – Extending Coverage for Additional 5 Months to Pregnant Women Risk Group*	-1.61%	-11.74%	0.00%	11.74%	General review
Mileage Reimbursement	1.46%	0.09%	7.06%	6.97%	General review
TNC Adjustment	0.12%	0.00%	0.44%	0.44%	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.*

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Table 11 shows 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 the STAR program. Therefore, we cannot offer a definitive assessment of the programmatic adjustments used by the Commission to develop the FY 2023 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 the programmatic change's impact across risk groups and SDAs (e.g., the adjustment factor for the Rural Hospital Outpatient should disproportionately impact SDAs in more rural areas of the state)

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
- Use of actual vs expected analysis with emerging FY 2021 data to estimate PHE related impact
- Developing programmatic adjustments at the risk group and SDA level

We note the following observations related to the STAR program:

Observation #1: Reimbursement changes are included as programmatic adjustments, regardless of their materiality

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

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. This 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 #2: The FQHC wrap payment removal relies on base data aggregation using projected enrollment

Applicable program(s): STAR, Dental, STAR+PLUS, STAR Kids

As described in the Base Data Development section of this Appendix, the Commission excluded FQHC wrap payment costs from the capitation rate development because MCOs 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, as noted in the Base Data Development section of this Appendix (Recommendation #3). 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 #3: Programmatic adjustments are not developed at a service category level

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

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. 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 is materially different than the service mix at the SDA level, the MCO's projected FY 2023 costs may not accurately reflect the adjustment for a particular programmatic change.

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 section of this Appendix, one of the benefits of introducing this level of granularity in the development of the capitation rates is to help the State and MCOs 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, if the trend assumptions and programmatic adjustments are developed and applied at a detailed category of service level, Table 12 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 12
Texas Medicaid Managed Care Rate Review
STAR Program - Programmatic Adjustment Development
Illustrative Programmatic vs. 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 2023 PMPM[4]
Professional	$37.52	1.053	0.9476	$42.60
Emergency Room	$6.66	1.053	0.9476	$7.56
Outpatient Facility	$11.39	1.053	0.9476	$12.93
Inpatient Facility	$10.62	1.053	0.9476	$12.05
Other	$10.58	1.053	0.9476	$12.01
Total	$76.76			$87.15

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 2023 PMPM[4]	Difference to Scenario 1
Professional	$37.52	1.060	0.8934	$41.10	-$1.50
Emergency Room	$6.66	1.040	1.0000	$7.64	$0.08
Outpatient Facility	$11.39	1.070	1.0000	$14.43	$1.50
Inpatient Facility	$10.62	1.020	1.0000	$11.38	-$0.67
Other	$10.58	1.051	1.0000	$12.60	$0.59
Total	$76.76			$87.15	$0.00

Illustrative FY 2023 PMPMs = Base Period PMPM x [Annual Trend Assumption Factor ^ 3.5 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 2023.*
[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.*

Observation #4: The PHE related cost adjustment uses the same formulaic approach across all Medicaid populations, which may not produce reasonable results for all risk groups.

Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids

The PHE adjustment applied by the Commission in the development of the FY 2023 capitation rates uses a formulaic approach to review actual versus expected PMPMs from March 2021 to August 2021 at a risk group and SDA level. The Commission calculates the expected PMPM as March 2019 to August 2019 claims trended for two years and adjusted for programmatic changes, as described earlier in this section. Based on this analysis, as well as experience we have observed in other states during the PHE, some populations are more insulated from the impact of the PHE on a PMPM basis due to the underlying acuity of the population or the type of services that these populations utilize. For example, in Under Age 1, a large percentage of the costs within this risk group are the costs associated with delivery services, which are not impacted by the PHE, whereas a population, such as Ages 6-14 observed a larger PHE related decrease due to normal professional services being delayed or foregone and less spread of infections during COVID-19.

The overall approach taken by the Commission to estimate the impact on costs during the PHE is reasonable and comparable to how this adjustment has been calculated in other states. Due to the changes in enrollment and service utilization occurring throughout the PHE, the Commission's decision to use the last six months of available experience to evaluate the impact of the PHE is reasonable. However, calculating the adjustment at a risk group and SDA level can introduce normal fluctuations in this more granular level of data, particularly when developing the adjustment using six months of data. This approach leads to inconsistent results within risk groups at the SDA level. For example, the PHE adjustment factor is greater than 1.0 for the Under Age 1 risk group in three SDAs. In addition, both the Ages 1-5 risk group and the AAPCA risk group have one SDA with a PHE adjustment factor greater than 1.0. We do not expect PHE adjustment factors greater than 1.0 because the PHE is not expected to increase costs, particularly since COVID-related expenditures, such as testing and treatment are excluded from the capitation rates.

The Commission may consider whether the results from this formulaic adjustment are reasonable based on expected PHE impacts and not inadvertently skewed by observed differences in experience versus assumed trend, programmatic changes, or other non-PHE related variances (e.g., credibility issues due to using only six months of data in smaller SDAs).

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

Applicable program(s): STAR, STAR Kids

As shown in Table 11, 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.

- Standard dollar amount adjustment:[13] The biggest impact from changes to this inpatient hospital add-on payment is for the Pregnant Women risk group in certain rural SDAs. This 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.

- Rural Hospital Outpatient adjustment: The magnitude of this adjustment varies at the SDA level. The adjustment has a larger impact in certain rural SDAs, which is consistent with the description of the programmatic adjustment.

- PDL list change: This adjustment primarily varies by risk group, with the largest impact for AAPCA and Ages 6-14 and the smallest impact for Under Age 1 and Ages 1-5. The rate certification notes that the drug Focalin, an ADHD treatment, is a key driver of the PDL adjustment. Although we did not review drug-level detail, the impact by risk group is consistent with our observation of ADHD drug utilization patterns in other states.

- Hemostatic and Hepatitis C carve-outs: These adjustments primarily vary by risk group. Although we did not review drug-level detail, the impact by risk group is reasonable.

[13] "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.

Recommendations

We note the following recommendations related to the STAR program:

Recommendation #1: 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

In 42 CFR § 438.6(e),[14] 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.

Recommendation #2: Evaluate the impact of medical service utilization differences in the recently extended eligibility period for pregnant women

Applicable program(s): STAR

The Commission evaluated the impact of pharmacy and NEMT utilization (labeled as the Pregnant Women HB 133 adjustments in the rate certification) in the third through sixth months post-partum to develop programmatic adjustments for those two rate components. Due to interactions with the Delivery Supplemental Payment (DSP), the Commission combined the medical adjustment for the extended eligibility period with the delivery mix adjustment. However, the Commission's rate certification did not include any separate analysis to illustrate how the medical service utilization in the third through sixth months post-partum compare to the previously covered months for pregnant women. We recommend including an analysis of impact of utilization differences in the third through sixth month in the rate certification to provide more transparency into the drivers of the overall delivery mix adjustment.

[14] 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.

NON-BENEFIT EXPENSES

We examined the Commission's FY 2023 non-benefit expense development approach used for the STAR program. We relied on 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 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 2023 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) 2023 Non-Benefit Expense Development

Our detailed understanding of the non-benefit expense development for FY 2023 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 13.

Table 13
Texas Medicaid Managed Care Rate Review
STAR 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:

- $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 Available 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 summary
- 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[15] and maintenance taxes.[16]

Review Conclusions

Within the scope of our review, we reviewed 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.

In this section we include commentary related to the reasonableness of resulting non-benefit expense adjustments. We further categorize our review conclusions into observations and recommendations.

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.

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.

Several of our conclusions apply to multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

Reasonableness of Resulting Non-Benefit Expense Assumptions

Per the Commission's administrative expense review, the FY 2023 program-wide administrative allowance (net of taxes and fees) in the capitation rates for medical and pharmacy is $21.88 PMPM. 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 2023 administrative expense load for the medical and pharmacy components to historical program-wide administrative expenses PMPM reported by the MCOs. The FY 2023 program-wide assumption appears to be generally consistent with median MCO experience from FY 2018 through FY 2020. The administrative expense PMPM decreased in FY 2021 and FY 2022, which is consistent with the increase in enrollment during the PHE that resulted in fixed costs being spread over many more members.

MCOs in many states are reporting emerging increases in administrative costs due to increases in wages and general inflation. The Commission noted that the current formula provides a reasonable allowance to address MCO concerns regarding these increasing costs. However, as noted above, the program-wide FY 2023 assumption of $21.88 PMPM is consistent with actual pre-PHE administrative costs, so it may not explicitly account for both an increase in wages and general inflation and the expected reduction in enrollment following the expiration of the PHE. Table 14 below shows the historical administrative expenses PMPM from the Commission's FY 2023 STAR program rate certification.

Table 14
Texas Medicaid Managed Care Rate Review
STAR Program - Non-Benefit Expense Development
Historical Medical and Pharmacy Administrative Expense PMPM

Period	PMPM
FY 2018	$18.79
FY 2019	$21.46
FY 2020	$21.12
FY 2021	$20.28
FY 2022	$19.27
5 Year Average	$20.18
FY 2018 - FY 2020 Average	$20.46

[15] "Insurance Premium Tax (Licensed Insurers)," Texas Comptroller of Public Accounts, Retrieved from: https://comptroller.texas.gov/taxes/insurance/licensed.php.
[16] "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.

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 2021 research report[17] shows the actual administrative PMPMs net of taxes and fees for calendar year 2021 across the country. These PMPMs include all types of managed care programs, including those with higher acuity populations than the STAR program population. We would expect the STAR program to be near the lower end of the range due to the average expected acuity of enrollees. The actual administrative PMPMs net of taxes and fees for calendar year 2021 for 80% of managed care organizations included in the report (between the 10th and 90th percentiles) were between $24.64 and $55.93.

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 to cover the uncertain costs related to provide defined benefits and administration duties as specified in the MCO contracts under fixed capitation rates. Nationally, the risk margin assumptions range from 1.0% to 2.0% for most comprehensive Medicaid managed care programs. The Commission's explicit risk margin of 1.5% is within the reasonable range and deemed to be appropriate for the covered population and covered benefits within this program.

The experience rebate adjustments discussed in the Rate Structure section of this Appendix provide some protection to the Commission if actual experience in FY 2023 deviates substantially from projected costs reflected in the capitation rates. Despite the uncertainty regarding the PHE and current market conditions, we do not have material concerns regarding the FY 2023 non-benefit expense assumptions given the existence of broader risk mitigation mechanisms (e.g., the experience rebate adjustments).

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 the STAR program:

Observation #1: Administrative expense assumptions are developed separately for the medical, pharmacy, and NEMT rate components

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

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.

[17] "Medicaid Managed Care Financial Results for 2021," Milliman Research Report, Retrieved from: https://jp.milliman.com/-/media/milliman/pdfs/2022-articles/7-8-22_medicaid-managed-care-financial-results-2021.ashx.

Observation #2: Final non-benefit expense assumptions are not clearly identified
Applicable program(s): STAR, STAR Kids

The Commission's final capitation rates paid to MCOs for the medical and pharmacy service groupings are based on the lesser of 108% of the individual MCO experience rate or the risk-adjusted community rate. The Commission does not indicate how the 108% factor or the risk adjustment factor are 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.

Recommendations

We note the following recommendation related to the STAR program:

Recommendation #1: Include supporting documentation for the development of the administrative costs
Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids, Dual Demo

As noted above, the administrative costs assumptions applied by the Commission in the FY 2023 capitation rates appear reasonable compared to historical program experience; however, it is not clear how the Commission determined the specific parameters used in the administrative assumption formulas. We recommend the Commission expand their documentation to include additional documentation so that CMS or another actuary could reasonably understand the development of these parameters.

APPENDIX A: STAR

CMS COMPLIANCE AND DOCUMENTATION

We reviewed the Commission's FY 2023 rate certification for compliance with the CMS 2022-2023 Medicaid managed care rate setting guidance.[18] 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 2022-2023 Medicaid managed care rate setting guidance and provided sufficient documentation to comply with actuarial standards of practice. We reviewed the CMS 2022-2023 Medicaid managed care rate setting guidance and compared them against what the Commission submitted in their Medicaid managed care capitation rate certification for the STAR 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) 2023 CMS Compliance and Documentation

Section I. Medicaid Managed Care Rates

The Commission has answered all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2022-2023 Medicaid managed care rate setting guidance.

Data – The Commission has answered all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2022-2023 Medicaid managed care rate setting guidance.

Projected Benefit Costs and Trends – The Commission has answered all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2022-2023 Medicaid managed care rate setting guidance.

Special Contract Provisions Related to Payment – The Commission has answered 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 2022-2023 Medicaid managed care rate setting guidance.

Projected Non-Benefit Costs – The Commission has answered all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2022-2023 Medicaid managed care rate setting guidance.

Risk Adjustment and Acuity Adjustments – The Commission has answered all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2022-2023 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 available for CMS Compliance and Documentation Review

The Commission provided us with the final FY 2023 rate certification report for the STAR program. We relied on this document, as well as the publicly available CMS 2022-2023 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.

Review Conclusions

We categorize our review conclusions into *observations* and *recommendations*.

[18] 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.

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.

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.

Several of our conclusions apply to multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

Observations

We note the following observations related to the STAR program:

Observation #1: Supporting documentation does not clearly indicate that IMD costs are removed, but associated member months remain

Applicable program(s): STAR, STAR+PLUS

In 42 CFR § 438.6(e),[19] 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.

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.

Observation #2: Supporting documentation indicates pharmacy trends are set by drug type, which is inconsistent with the actual methodology used

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

The FY 2023 STAR rate certification describes the pharmacy trend development as follows:

> *The STAR pharmacy trend assumptions for the period March 2020 through FY2023 were developed by risk group using the following formula. For each risk group / drug type combination, the utilization and cost per service trend assumptions were set equal to one sixth of the experience trend rate for the 12-month period ending February 2018 plus two sixths of the experience trend rate for the 12-month period ending February 2019 plus three sixths of the experience trend rate for the 12-month period ending February 2020. The final cost trend assumptions were then determined by applying the assumed utilization and cost per service trends by individual drug type to actual experience for the 12-month period ending February 2020 and combining the results into a single trend assumption for each risk group.*

The Commission developed separate trends at the drug type and utilization / unit cost level, without adjustment for historical PDL changes, and included these calculations in the rate certification. However, these trends were not used to determine the final trend, nor were they used in the final rate development.

[19] 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 Commission's actual trend development for the FY 2023 capitation rates set the trend assumption by calculating the historical annual PMPM trend for each risk group, adjusted for historical PDL changes. The Commission's final trend assumption for each risk group was set equal to one sixth of the experience PMPM trend rate for the 12-month period ending February 2018 plus two sixths of the experience PMPM trend rate for the 12-month period ending February 2019 plus three sixths of the experience PMPM trend rate for the 12-month period ending February 2020.

As illustrated in the Trend section of this Appendix, the difference between the approach described in the Commission's rate certification and the Commission's actual approach can produce materially different results in some instances, particularly for risk groups where the mix between drug types is shifting. The Commission may consider describing the trend development in the rate certification in a manner that is consistent with the actual methodology used to develop the trend assumptions.

Recommendations

We note the following recommendation related to the STAR program:

Recommendation #1: Include supporting documentation for the development of the administrative costs
Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids, Dual Demo

The rate certification includes the following information to support the administrative costs included in the FY 2023 capitation rates:

- Fixed and variable administrative costs assumptions by rate component (medical, pharmacy, and NEMT)
- 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 (excluding NEMT, which was added to the STAR Health program effective July 1, 2021)

The Commission noted in the rate certification that the administrative costs are developed from historical Financial Statistic Reports and the Commission believes the resulting administrative costs for FY 2023 are reasonable compared to historical program experience. However, the rate certification does 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:

- Base period experience
- Trend assumptions
- Population adjustments, if applicable
- Allocation methodology between fixed and variable administrative costs
- 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

Exhibit A-1
Texas Medicaid Managed Care Rate Review
STAR Program - Base Data Review
Reconciliation of Travis SDA Across All MCOs

Table 1: Raw Base Period (3/1/2019 - 2/29/2020) Enrollment and Expenditure Data As Reported

Risk Group	Enrollment	Medical_FFS	Rx_FFS	Capitation	Net Reinsurance	Other Medical Expenditures	TPR (Medical)	TPR (Rx)	Total Benefit Cost
Under Age 1	141,927	$110,756,144	$1,884,558	$909,886	$30,891	-$7,446,341	-$16,703	-$36,072	$106,082,363
Age 1-5	467,104	$66,070,280	$7,298,091	$2,978,397	$119,589	-$6,162,809	-$18,296	-$114,549	$70,170,701
Age 6-14	703,155	$58,651,447	$20,375,151	$4,021,677	$178,963	-$5,309,658	-$56,789	-$194,439	$77,666,352
Age 15-18	212,603	$22,439,591	$6,646,515	$1,234,306	$52,954	-$1,173,506	-$18,461	-$58,833	$29,122,567
Age 19-20	2,232	$379,394	$77,374	$13,806	$460	-$59,680	-$217	-$636	$410,500
TANF Adult	69,691	$23,364,495	$8,046,232	$488,956	$14,588	-$1,878,777	-$50,925	-$22,460	$29,962,110
Pregnant Women	70,723	$61,096,653	$3,407,870	$487,716	$9,979	-$4,721,972	-$129,128	-$31,889	$60,119,229
Adoption Assistance	55,533	$9,350,206	$3,756,599	$342,534	$20,439	-$373,258	-$4,591	-$23,410	$13,068,519
Total	**1,722,968**	**$352,108,209**	**$51,492,390**	**$10,477,278**	**$427,864**	**-$27,126,000**	**-$295,111**	**-$482,288**	**$386,602,342**

Table 2: Data Adjustments

Risk Group	Enrollment	Medical_FFS	Rx_FFS	Capitation	Net Reinsurance	Other Medical Expenditures	TPR (Medical)	TPR (Rx)	Total Benefit Cost
Under Age 1		-$17,531,198		-$217,977		$7,234,906	$151	$70	-$10,514,049
Age 1-5		-$1,377,322		-$670,303		$5,762,000	$114	-$127	$3,714,361
Age 6-14		-$1,381,410		-$1,115,711		$5,057,540	$102	-$222	$2,560,298
Age 15-18		-$1,277,545		-$336,066		$957,081	-$75	-$455	-$657,060
Age 19-20		-$51,831		-$3,602		$57,254	-$1	-$5	$1,815
TANF Adult		-$3,917,919		-$99,038		$1,276,133	$32	-$119	-$2,740,913
Pregnant Women		-$12,700,325		-$116,102		$3,357,136	-$24	$267	-$9,459,048
Adoption Assistance		-$295,472		-$65,016		$210,376	$24	-$108	-$150,197
Total		**-$38,533,024**		**-$2,623,816**		**$23,912,424**	**$321**	**-$699**	**-$17,244,794**

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

Risk Group	Enrollment	Medical_FFS	Rx_FFS	Capitation	Net Reinsurance	Other Medical Expenditures	TPR (Medical)	TPR (Rx)	Total Benefit Cost
Under Age 1	141,927	$93,224,945	$1,884,558	$691,909	$30,891	-$211,435	-$16,552	-$36,001	$95,568,314
Age 1-5	467,104	$64,692,958	$7,298,091	$2,308,094	$119,589	-$400,810	-$18,183	-$114,676	$73,885,062
Age 6-14	703,155	$57,270,036	$20,375,151	$2,905,966	$178,963	-$252,118	-$56,688	-$194,661	$80,226,650
Age 15-18	212,603	$21,162,046	$6,646,515	$898,240	$52,954	-$216,425	-$18,536	-$59,288	$28,465,507
Age 19-20	2,232	$327,563	$77,374	$10,203	$460	-$2,426	-$218	-$641	$412,315
TANF Adult	69,691	$19,446,575	$8,046,232	$389,918	$14,588	-$602,644	-$50,894	-$22,580	$27,221,197
Pregnant Women	70,723	$48,396,328	$3,407,870	$371,614	$9,979	-$1,364,837	-$129,152	-$31,621	$50,660,180
Adoption Assistance	55,533	$9,054,735	$3,756,599	$277,518	$20,439	-$162,882	-$4,568	-$23,518	$12,918,323
Total	**1,722,968**	**$313,575,185**	**$51,492,390**	**$7,853,462**	**$427,864**	**-$3,213,576**	**-$294,790**	**-$482,987**	**$369,357,548**

Footnotes:

1. *In Table 1, historical enrollment data was summarized based on the forecasting file as 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_FFS and Rx_FFS) was calculated based on the monthly expenditure data as reported in SFY20-21 MCO supplemental data report with runout through February 2022*
4. *In Table 1, base period non-lag expenditure data (Capitation, Net Reinsurance Cost, Other Medical Expenditure, and TPR) was calculated using a composite of the first six-month (3/1/2019-8/31/2019) expenditure data as reported in SFY19-20 (9/1/2018-8/31/2020) MCO supplemental data report with runout through February 2021 and the second six-month (9/1/2019-2/29/2020) expenditure data as reported in SFY20-21 (9/1/2019-8/31/2021) MCO supplemental data report with runout through February 2022*
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 UHRIP State directed payments*

APPENDIX B

STAR HEALTH

APPENDIX B: STAR HEALTH

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 35,000 beneficiaries in FY 2023 at a program cost of roughly $465 million.

[1] STAR Health, Texas Health and Human Services, Retrieved from: STAR Health | Texas Health and Human Services.
[2] Ibid.

APPENDIX B: STAR HEALTH

RATE STRUCTURE

We evaluated the Commission's rate structure for the FY 2023 capitation rate development for the STAR Health program by reviewing the actuarial report and rate development model created by the Commission. For a high-level description of the regulatory and policy authority to be followed when designing the rate structure of a program, please see the Review Process section in the Main Report.

Description of State Fiscal Year (FY) 2023 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 programs.

Rate Development Process

The Commission followed the following steps to develop all FY 2023 rates:

- Step One: Develop FY 2023 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 2023, 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 4.6% of revenues.

Table 1
Texas Medicaid Managed Care Rate Review
STAR Health Program – Rate Structure
FY 2023 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%	0%	100%
> 7% and ≤ 9%	0%	100%
> 9% and ≤ 12%	0%	100%
> 12%	0%	100%

APPENDIX B: STAR HEALTH

Review Conclusions

In this section we include commentary related to the reasonableness of the resulting rate structure. We further categorize our review conclusions into observations and recommendations.

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.

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.

Several of our conclusions apply to multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

Reasonableness of Resulting Rate Structure

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 32,000 members (389,987 member months) in the base period (March 2019 through February 2020).

Observations

We do not have any specific observations related to rate structure for the STAR Health program.

Recommendations

We do not have any specific recommendations related to rate structure for the STAR Health program.

APPENDIX B: STAR HEALTH

BASE DATA DEVELOPMENT

We gained a detailed understanding of the Commission's FY 2023 base data development approach used for the STAR Health program based on a detailed review and replication of FY 2023 base data development, in conjunction with the Commission's responses to our base data review questions. Given that STAR Health is only operated by one MCO and the capitation rate is paid on a statewide basis, our review included all base data rather than a sampling approach as used for other programs. 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) 2023 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 2023 capitation rate setting process:

Base Data Selection

- The Commission selected the most recent 12-month period (March 2019 through February 2020) prior to the COVID-19 public health emergency as the base period for both the enrollment data and the service expenditure data. Other than the carve-in of NEMT services as previously provided by MTOs or FFS, the populations and services covered by the STAR Health program during FY 2023 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

  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 2023.

- The Commission reconciles the MCO reported supplemental data to the MCO reported Financial Statistical Reports ("FSR") expenditures for overall consistency in aggregate across all risk groups at the MCO and SDA level for the base period (March 2019 through February 2020). 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 at the risk group level for FY 2019 and FY 2020 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 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 2022 for the base period (March 2019 through February 2020) were adjusted for claims which have been incurred but not reported ("IBNR"). Please note, the IBNR assumption by the Commission is $0 given there are 24 months of additional payment runout in the data.

- 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

[3] Medicaid & CHIP Financial Statistical Reports: Fiscal Year 2020: Sept. 1, 2019, to May 31, 2020, Texas Health and Human Services, Retrieved from: Medicaid & CHIP Financial Statistical Reports | Texas Health and Human Services.

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, including Uniform Hospital Rate Increase Payment ("UHRIP"), Quality Incentive Payment Program ("QIPP"), and Network Access Improvement Program ("NAIP"). The Commission accounted for these payments outside the main capitation rates as special rate adjustments.

- Pharmacy Benefit Manager ("PBM") discount and rebate settlements were deducted by the Commission in the base data development. These adjustments were not reported through the MCO supplemental data but were based on information provided separately to the Commission.

- 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 TPR was explicitly noted in Part 4 of the FSR. Otherwise, the Commission assumed the reported reimbursement amounts were not already included in the claims and other expenses, so the Commission did not offset other expenditures as reported in the MCO supplemental data by the reported reimbursement amounts.

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

- The Commission did not adjust the base data to remove the impact of any changes in eligibility or covered services between the base period and FY 2023. Instead, the Commission reflected the expected impact of these changes on expenditures through programmatic adjustments.

Base Data Aggregation

- Because the STAR Health program is operated by a single MCO, the Commission does not perform additional base data aggregation to reflect projected changes in MCO enrollment during FY 2023, as is done for the other managed care programs.

Data Available 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 2019 Final (September 2018 through August 2019) with runout through August 2020.
    - FY 2020 Final (September 2019 through August 2020) with runout through August 2021.
  - MCO supplemental expenditure data:
    - FY 2019 – FY 2020 (September 2018 through August 2020) with runout through February 2021.
    - FY 2020 – FY 2021 (September 2019 through August 2021) with runout through February 2022.
  - The Commission provided summarized monthly enrollment files:
    - Actual enrollment was provided for the period from September 2012 through December 2021.
    - Projected enrollment was provided for the period from January 2022 through August 2027.
- 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 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:

        - 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 the base period (March 2019 through February 2020).

    - A comparison of reported lag expenditures across the commission provided encounters, MCO FSRs, and MCO supplemental expenditure data for FY 2019 and FY 2020.

- The Commission's documentation of base data development in the FY 2023 actuarial report.

- The Commission's responses to ad hoc questions from Milliman.

Review Conclusions

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.

In this section we include commentary related to the technical accuracy of the base data development. We further categorize our review conclusions into *observations* and *recommendations*.

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.

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.

Several of our conclusions apply to multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

Technical Accuracy

The development of the final medical and pharmacy base period data is technically accurate for each risk group. Using the raw enrollment data as reported by the Commission and the raw expenditure data as reported by the MCO, Milliman was able to replicate the calculation of the final medical and pharmacy base data using the Commission's approach within a margin of rounding difference at the risk group level. Please refer to the base data reconciliation Exhibit B-1 for details.

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 the most recent pre-COVID period (March 2019 through February 2020) as the base period

- Use of validated MCO self-reported expenditure data as the primary base expenditure data

- Use of the MCO financial data (i.e., FSR) and the encounter data for expenditure data validation
- Assumed $0 adjustment for IBNR, given the significant length of paid data runout included in the base period data
- Accounting for any known or anticipated changes of eligibility and / or covered services between the base period and the rating period through programmatic adjustments

We note the following observations related to the STAR Health program:

Observation #1: Summary-level enrollment data and expenditure data are gathered from separate sources.
Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids

The Commission collected summarized base period enrollment data and expenditure data separately from different entities (e.g., the Commission and the MCOs). 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.

Although the potential impact of mismatches between the enrollment and expenditure data is likely much smaller than the risks from these mismatches in other programs, such potential inconsistencies can introduce risks on a PMPM basis.

Observation #2: There is not a clear process for the treatment of MCO self-reported TPR data.
Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

TPR was collected by the Commission as part of the MCO supplemental data as a standalone cost recovery item. In the MCO supplemental data request template and instructions, the Commission did not specifically request information from the MCO about the nature of these TPRs and whether the reported reimbursement amounts have already been accounted for in expenditures or recoveries reported in other sections of the MCO supplemental data. The Commission explained that the decision to include or exclude TPR from the base data development was primarily based on a manual review of relevant FSR reporting notes in Part 4 and the expenditure comparison between the FSR and MCO supplemental data. Given the self-reporting nature of the FSRs and the potential for incomplete notes, this approach can lead to an artificial inflation of base period expenditures to the extent that TPR was not appropriately noted or included in the FSRs. At a minimum, the Commission may consider obtaining explicit clarifications from the MCO to inform appropriate treatment of MCO-reported TPR amounts in the base data development, or the Commission may consider adding direct questions to the MCO supplemental data collection template to remove the manual nature of this adjustment and obtain consistent information and reporting from the MCO.

Recommendations

We note the following recommendations related to the STAR Health program:

Recommendation #1: Use state encounter data as the primary base data source for expenditure data.
Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids

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 External Quality Review Organization ("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 for more sophisticated actuarial cost modeling. Using encounter data also enables member level matching of risk group assignment between enrollment and claims data. While encounter data can play a primary role in the base data development, the MCO FSRs and the MCO 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 2022-2023 Medicaid Managed Care Rate Development Guide[4] 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. For the development of the FY 2023 capitation rates, given the base period is March 2019 through February 2020, our understanding is that the detailed encounter data would have been available to use 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 once the Commission returns to using a more recent base period.

Recommendation #2: Include supporting documentation for the development of the base period data
Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids

The rate certification includes the following information to support the development of the base period data used for the FY 2023 capitation rates:

- Data sources
- High level information about each of the main three data sources: MCO 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:

- The specific use of each of the three data sources in the base data development
- An overview of the Commission’s reconciliation processes between the MCO supplemental data and FSRs and whether a different approach is used for lag vs. non-lag data
- The types of adjustments made to the raw data as of a result of the reconciliation process

[4] “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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TREND

We gained a detailed understanding of the Commission's FY 2023 medical and pharmacy trend development approach used for the STAR Health program. We relied on underlying data provided by the Commission, as well as responses to our specific trend review questions.

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 2023 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 Revie Process section in the Main Report.

Description of State Fiscal Year (FY) 2023 Trend Development

Our detailed understanding of the trend development for FY 2023 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 2023 (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 and calculations were developed separately by drug type (i.e., brand, generic, and specialty) for utilization and unit cost, but the Commission ultimately used the PMPM level data to develop the selected pharmacy trends.

- Adjustment factors for material preferred drug list (PDL) changes from FY 2018 through FY 2020.

NEMT Trends

- Historical PMPM NEMT managed transportation organization (MTO) 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:

[5] 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 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) for each 12-month period from March 2016 through February 2020.
- The Commission multiplied the statewide incurred pharmacy claims PMPM are multiplied by annual PDL adjustment factors. The adjusted PMPMs estimate the 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.

NEMT Trends

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

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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 trend 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

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 Available for Trend Review

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

- Historical medical claim experience for September 2018 through February 2022 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 medical trend development working files, including:
  - Summarized FY 2017 – FY 2022 (through December 2021) PMPM trends
  - Programmatic adjustment factors for material changes between FY 2017 and FY 2022
  - 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 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
- The Commission's documentation of trend development in the FY 2023 actuarial report
- The Commission's responses to ad hoc questions

Review Conclusions

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 for 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.

In this section we include commentary related to the reasonableness of resulting trend assumptions. We further categorize our review conclusions into *observations* and *recommendations*.

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.

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.

Several of our conclusions apply to multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

Reasonableness of Resulting Trend Assumptions

Medical Trends

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 not accounted for through this trend assumption. 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. 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.

We also reviewed the stability of the Commission's trend calculation methodology. Table 4 displays the volatility in observed annual trends in the medical data provided for our review.

Table 4
Texas Medicaid Managed Care Rate Review
STAR Health Program - Trend Development
Historical Annual Trend in Total Medical PMPM (Adjusted for Programmatic Changes)

Fiscal Year	Annual Trend
FY2017*	-2.8%
FY2018*	5.2%
FY2019*	9.3%
FY2020 (9/19-2/20)*	9.7%
FY2020	1.2%
FY2021	-17.1%
Selected Trend	**4.7%**

** Data included in selected trend*

We did not evaluate the drivers of the historical 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, new alternative treatments for existing conditions, and changes in average member demographics and acuity. Table 4 is 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 assumption.

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, the Commission's overall annual prospective program PMPM trend at the program level of 1.5% per year, included in Table 5 below, 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 PMPM in the trend analysis to historical statewide pharmacy PMPMs provided in the trend analysis (from March 2012 through February 2022). The Commission's projected FY 2023 pharmacy PMPM is within the range of monthly historical PMPMs.

We also reviewed the stability of the Commission's trend calculation methodology over time. We summarized historical trends during the PHE, but we did not evaluate alternative trend calculation periods that include the PHE because we do not expect experience during the PHE to be representative of future trends.

Table 5 displays the volatility in observed annual trends by risk group in the pharmacy data provided for our review. The same methodology produces materially different results depending on the years used in the calculation, such as shifting the time periods used as shown in Table 5.

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Table 5 Texas Medicaid Managed Care Rate Review STAR Health Program - Trend Development Historical Annual Trend in Total Pharmacy PMPM (Adjusted for PDL Changes)	
Year Ending	**Annual Trend**
3/16 through 2/17	-5.4%
3/17 through 2/18*	-1.2%
3/18 through 2/19*	3.8%
3/19 through 2/20*	0.9%
3/20 through 2/21	-21.2%
3/21 through 2/22	-16.0%
Selected Trend	**1.5%**
Final Trend if Underlying Years Shift:	
Years of Shift	
1 Year Backward	**0.6%**

** Data included in selected trend.*

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 alternative treatments for existing conditions, and changes in average member demographics and acuity.

Depending on expected changes in drug mix and utilization, it may be reasonable for the FY 2023 pharmacy trends to be higher or lower than previous observed pharmacy trends. Table 5 is 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 appropriateness of the final trend assumption.

NEMT Trends

As noted in the Risk Level Classification section of the Main Report, 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.

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)
- 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 the STAR Health program:

Observation #1: Prospective medical trends are developed using a purely formulaic approach
Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids

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 2023.

Observation #2: The data source used for quantitative medical trend analysis does not enable more granular analysis

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

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. This data also does not appear to provide assurance that the reported units are defined accurately and consistently. 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.

Observation #3: 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

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 and does not reflect the actual time period of the projection.

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 ten years ending February 2020 (based on this typical approach) is 0.9%. The Commission calculated each month's annual trend for the most recent 120 months 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%.

Additionally, the resulting trend is applied to reflect anticipated CPI changes from the base period (March 2019 to February 2020) to FY 2023. It may be more appropriate to use *actual observed* CPI changes from the base period to present day (i.e., March 2022 when setting FY 2023 rates) and then recently observed averages from present day to FY 2023. This approach would ensure historical periods from 5 to 10 years ago are not used at the expense of recent market conditions.

Recommendations

We note the following recommendations related to the STAR Health program:

Recommendation #1: Develop medical trend assumptions at more detailed service category level

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

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 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.

Recommendation #2: Develop medical and pharmacy trend assumptions separately by utilization and unit cost component

Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids

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 help validate how historical provider reimbursement changes (that are separately identified in the prior rate development) compare to historical unit cost trends. Such a comparison will provide insights about the provider contracting dynamics at the major service category level. It will also provide an understanding of the drivers of observed recent 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 the trend development.

The Commission produced an analysis of historical utilization and unit cost trends for medical and pharmacy services, but this analysis was not explicitly used to develop distinct utilization and unit cost trends for the rate development. Other states often select distinct utilization and unit cost trends. A more granular approach for selecting trends allows for trends that are better aligned with each population's projected costs and program goals.

Recommendation #3: Develop and apply pharmacy trends by drug type (i.e., Specialty and Non-Specialty)

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

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. Figure 1 shows the historical change in the specialty PMPM included in the trend analysis as a percentage of the total pharmacy PMPM included in the trend analysis (net of the exclusions, noted above).

Given the general increase in specialty drug mix in recent years, relying on historical aggregate trends likely understates future trends by undervaluing the impact of higher-than-average specialty drug trends on the current drug mix included in the base period.

To illustrate this, we reviewed the selected FY 2023 pharmacy trends for each risk group relative to estimated one-year trends based on separate specialty / non-specialty trends composited using the base period mix. Table 6 includes the comparison of these two trend approaches.

Table 6
Texas Medicaid Managed Care Rate Review
STAR Health Program - Trend Development
Estimated Impact of Applying Distinct Trends to Specialty and Non-Specialty Pharmacy Costs

	Final FY 2023 Trend	Estimated Composite Trend Based on Distinct Trends[1]	(Under) / Over-Statement of Historical Weighted Trend
STAR Health	1.5%	3.9%	(2.4%)

[1] Based on applying the Commission's historical weighing approach to historical specialty and non-specialty trends separately.

Table 6 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.

We note that 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 these two 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 6, 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 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 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.

Recommendation #4: Consider the impact of recently approved and upcoming pipeline drugs for each population

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

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 2023 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. Examples of some of these drugs that could materially impact program costs include:

- Ubrelvy (approved December 2019) for acute treatment of migraine
- Oxbryta (approved December 2019) to treat sickle cell disease
- Trikafta (approved October 2019) to treat cystic fibrosis

The Commission reimburses the MCOs for certain newly approved drugs through non-risk arrangements, however, the three drugs listed above are not on the non-risk drug payment list[6] as of July 11, 2022, but they are included on either the Texas preferred drug list[7] effective January 27, 2022 or the March 2022 Texas specialty drug list (SDL).[8] Although these drugs were approved during the base period, the base period would reflect a limited amount of claims.
In addition, many oncology drugs have been newly approved or approved for expanded indications since 2019. Each of these drugs alone may not materially impact trends, but the combined impact of these drug approvals has materially increased utilization within the therapeutic class in other states.

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 in the STAR Health program 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 populations.

[6] "Vendor Drug Program, Non-Risk Drugs," Texas Health and Human Services, Retrieved from: https://www.txvendordrug.com/resources/managed-care/non-risk-drugs.
[7] "Vendor Drug Program, Preferred Drugs," Texas Health and Human Services, Retrieved from: https://www.txvendordrug.com/formulary/prior-authorization/preferred-drugs.
[8] "Vendor Drug Program, Specialty Drugs," Texas Health and Human Services, Retrieved from: https://www.txvendordrug.com/formulary/specialty-drugs.

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 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.

Recommendation #5: Evaluate pharmacy trends at the therapeutic class level

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

In conjunction with recommendation #4, 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.

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PROGRAMMATIC ADJUSTMENTS

We gained a detailed understanding of the Commission's FY 2023 programmatic adjustment development approach used for the STAR Health program based on a review and analysis of the FY 2023 programmatic adjustment development in conjunction with the Commission's responses to our programmatic adjustment review questions. Our review approach varied based on the assessed risk of each adjustment. For a full description of the approach used to review the programmatic adjustments, as well as a high-level description of the regulatory and policy authority to be followed in the development of the programmatic adjustments, please see the Review Process section in the Main Report.

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 2023 NEMT programmatic adjustments to become comfortable in the context of overall rate soundness.

Description of State Fiscal Year (FY) 2023 Programmatic Adjustment Development

The Commission developed and applied programmatic adjustments separately for each itemized change as applicable to the FY 2023 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 2023

Programmatic Adjustment Factor Development Approach

The Commission applied 8 programmatic adjustments in the FY 2023 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.
- 2 adjustments to the pharmacy rate component, excluding the 2 adjustments with no impact
- 3 adjustments 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 2023 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 2023
- *Hospital reimbursement adjustment*, such as hospital fee schedule changes and hospital quality initiatives

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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
- Medical and pharmacy costs for hemostatic drugs
- Pharmacy costs for Hepatitis C drugs

The Commission notes in the rate certification that there were no hemostatic or Hepatitis C drug claims in the base period for STAR Health, so no adjustments were applied for these costs in the FY 2023 rate development.

The Commission used a different methodology to address the PHE related cost adjustment, as noted below:

- PHE related cost adjustment (medical and pharmacy components)
  - The Commission estimated the impact of the PHE on program costs by comparing actual monthly costs per member in March through August 2021 (net of COVID-related costs) to expected costs during that period. The expected costs were calculated by projecting actual March through August 2019 costs forward two years with assumed trend and programmatic adjustments.
  - The Commission compared actual to expected costs for each 3-month period between March and August 2021 and averaged the ratios to derive the impact of the PHE.
  - The Commission dampened the final PHE impact by 75% to account for an assumption that the PHE will end in October 2022 and will affect costs for one quarter (through November 2022).
  - Table 7 shows how the PHE adjustment was calculated.

Table 7
Texas Medicaid Managed Care Rate Review
STAR Health Program - Programmatic Adjustment Development
FY 2023 Public Health Emergency Adjustment Factor Development

	Actual FY 2019 PMPM Trended for 2 years and Adjusted for Programmatic Changes	Actual FY 2021 PMPM	FY 2021 PMPM / Trended and Adjusted FY 2019 PMPM
March through May	$842.13	$598.77	0.7110
June through August	$776.38	$591.52	0.7619
Average			0.7365
PHE Impact		= 1 - 0.7365	26.35%
Dampened PHE Impact		= 26.35% x (1 - 0.75)	6.59%
Final PHE Adjustment Factor		= 1 - 6.59%	0.9341

The Commission's PHE adjustment reduced the projected FY 2023 costs by 6.59% for the STAR Health program.

Data Available 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
- 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 2023 actuarial report
- The Commission's responses to ad hoc questions from Milliman

Review Conclusions

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.

In this section we include commentary related to the reasonableness of resulting programmatic adjustments. We further categorize our review conclusions into *observations* and *recommendations*.

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.

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.

Several of our conclusions are consistent across multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

Reasonableness of Resulting Programmatic Adjustment Assumptions

Table 8 summarizes the programmatic adjustment factors used by the Commission to develop the FY 2023 STAR Health program rates and our level of review for each adjustment. The adjustments are grouped by rate component and then sorted in descending order based on the largest impact for that component (positive or negative). The adjustment descriptions in Table 8 are consistent with the titles of the Commission's exhibits in Attachments 4 and 5 of the FY 2023 rate certification.

Table 8
Texas Medicaid Managed Care Rate Review
STAR Health Program - Programmatic Adjustment Development
Summary of FY 2023 Programmatic Adjustments

Adjustment Description	Statewide Adjustment Factor	Level of Review
Medical Rate Component Programmatic Adjustments		
PHE Related Cost Adjustment	-6.59%	Methodology review
Provider Reimbursement Adjustment	1.31%	Reasonableness
Hospital Reimbursement Adjustment	-0.56%	Reasonableness
Pharmacy Rate Component Programmatic Adjustments		
PHE Related Cost Adjustment	-8.12%	Methodology review
Prescription Drug List Change	1.50%	Reasonableness
NEMT Rate Component Programmatic Adjustments		
PHE Related Cost Adjustment	-14.17%	General review
Mileage Reimbursement	3.48%	General review
TNC Adjustment	0.05%	General review

Several 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.

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Within the scope of our review, we did not gather the claim detail necessary to independently develop programmatic adjustment factors for the STAR Health program. Therefore, we cannot offer a definitive assessment of the programmatic adjustments used by the Commission to develop the FY 2023 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

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
- Use of actual vs expected analysis with emerging FY 2021 data to estimate PHE related impact

We note the following observations related to the STAR Health program:

Observation #1: Reimbursement changes are included as programmatic adjustments, regardless of their materiality

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

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. This 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 #2: Programmatic adjustments are not developed at a service category level

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

The Commission generally calculated the programmatic adjustment factors by dividing the estimated impact of the adjustment by the aggregate base period data. Many of the programmatic adjustments are applicable to a specific service category, such as inpatient experience. In other programs with multiple MCOs, the MCO's projected FY 2023 costs may not accurately reflect the adjustment for a particular programmatic change to the extent the service mix for an MCO is materially different than the service mix at the aggregate level. 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.

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As discussed in the Trend section of this Appendix, one of the benefits of introducing this level of granularity in the development of the capitation rates is to help the State and MCOs monitor actual costs at the service category level compared to the estimated costs in the capitation rates. If the trend assumptions and programmatic adjustments are developed and applied at a detailed category of service level, Table 9 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 9
Texas Medicaid Managed Care Rate Review
STAR Health Program - Programmatic Adjustment Development
Illustrative Programmatic vs. Trend Assumptions Granularity

Scenario 1: Current Approach: Aggregate Trend and Programmatic Assumptions

Category of Service	Base Period PMPM[1]	Annual Trend Assumption	Hospital Reimbursement Adjustment Factor	FY 2023 PMPM[4]
Professional	$241.27	1.047	0.994	$281.76
Emergency Room	$19.37	1.047	0.994	$22.62
Outpatient Facility	$33.18	1.047	0.994	$38.75
Inpatient Facility	$198.90	1.047	0.994	$232.28
Vision	$3.71	1.047	0.994	$4.34
Other	$254.06	1.047	0.994	$296.69
Total	$750.49	1.047	0.994	$876.43

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]	Hospital Reimbursement Adjustment Factor[3]	FY 2023 PMPM[4]	Difference to Scenario 1
Professional	$241.27	1.060	1.000	$295.85	$14.09
Emergency Room	$19.37	1.040	1.000	$22.22	-$0.40
Outpatient Facility	$33.18	1.070	1.000	$42.05	$3.30
Inpatient Facility	$198.90	1.020	0.979	$207.21	-$25.07
Vision	$3.71	1.010	1.000	$3.84	-$0.49
Other	$254.06	1.054	1.000	$305.26	$8.57
Total	$750.49	1.047	0.994	$876.43	$0.00

Illustrative FY 2023 PMPMs = Base Period PMPM x [Annual Trend Assumption Factor ^ 3.5 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 2023.
[3] Hospital reimbursement adjustment if the full adjustment is applied to the Inpatient Facility category of service.
[4] Does not include all programmatic adjustments; only reflects Hospital reimbursement adjustments for illustrative purposes.

Observation #3: The PHE related cost adjustment uses the same formulaic approach across all Medicaid populations, which may not produce reasonable results for all risk groups

Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids

The PHE adjustment applied by the Commission in the development of the FY 2023 capitation rates uses a formulaic approach to review actual versus expected PMPMs from March 2021 to August 2021. The Commission calculates the expected PMPM as March 2019 to August 2019 claims trended for two years and adjusted for programmatic changes, as described earlier in this section. Based on this analysis, as well as experience we have observed in other states during the PHE, some populations are more insulated from the impact of the PHE on a PMPM basis due to the underlying acuity of the population or the type of services that these populations utilize.
The overall approach taken by the Commission to estimate the impact on costs during the PHE is reasonable and comparable to how this adjustment has been calculated in other states. Due to the changes in enrollment and service utilization occurring throughout the PHE, the Commission's decision to use the last six months of available experience to evaluate the impact of the PHE is reasonable. We compared the PHE related costs adjustments for STAR Health to the AAPCA risk group in the STAR program as a reasonability check due to similarities between these populations, and the adjustment factors appear to be relatively comparable overall.

The Commission may consider whether the results from this formulaic adjustment are reasonable based on expected PHE impacts and not inadvertently skewed by differences in experience versus assumed trend, programmatic changes, or other non-PHE related variances.

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Recommendations

We note the following recommendation related to the STAR Health program:

Recommendation 1: Evaluate the impact of the recently extended eligibility period for pregnant women
Applicable program(s): STAR Health

The Commission did not evaluate whether the extension of eligibility for pregnant women from two months to six months post-partum as of September 1, 2021[9] impacts the STAR Health program. Based on our discussions with the Commission, we understand that STAR Health enrollees who become pregnant will remain in the STAR Health program, rather than transfer to a different program (e.g., STAR). While it is possible that the impact of this eligibility change is immaterial to the STAR Health program, the Commission's FY 2023 rate certification did not address whether the STAR Health program is impacted at all.

[9] Tex. H.B. 133, 87(R) Leg., (2021), Effective September 1, 2021, Retrieved from: 87(R) HB 133 - Enrolled version (texas.gov).

APPENDIX B: STAR HEALTH

NON-BENEFIT EXPENSES

We examined the Commission's FY 2023 non-benefit expense development approach used for the STAR Health program. We relied on 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 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 2023 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”) 2023 Non-Benefit Expense Development

Our detailed understanding of the non-benefit expense development for FY 2023 capitation rates is summarized below.

Data Used for Non-Benefit Expense Development

The Commission's non-benefit expense assumption developed by the Commission 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.

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	\$30.00 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 \$30.00 PMPM medical administrative expense load as follows:

- \$15.00 for general administration expenses
- \$15.00 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 Available 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 summary
- 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[10] and maintenance taxes.[11]

Review Conclusions

Within the scope of our review, we reviewed 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.

In this section we include commentary related to the reasonableness of resulting non-benefit expense adjustments. We further categorize our review conclusions into observations and recommendations.

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.

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.

Several of our conclusions apply to multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

Reasonableness of Resulting Non-Benefit Expense Assumptions

Per the Commission's administrative expense review, the FY 2023 administrative allowance (net of taxes and fees) in the capitation rates for medical and pharmacy is $83.66. To evaluate the reasonableness of the administrative component of the non-benefit expense assumption, we reviewed the Commission's comparison of the average FY 2023 administrative expense load for the medical and pharmacy components to historical administrative expenses PMPM reported by the MCOs. The FY 2023 assumption appears to be generally consistent with average MCO experience from FY 2018 through FY 2020. The administrative expense PMPM decreased in FY 2021 and FY 2022, which is consistent with the increase in enrollment during the PHE that resulted in fixed costs being spread over many more members.

MCOs in many states are reporting emerging increases in administrative costs due to increases in wages and general inflation. The Commission noted that the current formula provides a reasonable allowance to address MCO concerns regarding these increasing costs. However, as noted above, the program-wide FY 2023 assumption is consistent with actual pre-PHE administrative costs, so it may not explicitly account for both an increase in wages and general inflation and the expected reduction in enrollment following the expiration of the PHE. Table 11 below shows the historical administrative expenses PMPM from the STAR Health program rate certification.

Table 11
Texas Medicaid Managed Care Rate Review
STAR Health Program – Non-Benefit Expense Development
Historical Medical and Pharmacy Administrative Expenses

FY 2018	$84.19
FY 2019	$78.19
FY 2020	$86.40
FY 2021	$84.61
FY 2022	$76.11
5 Year Average	$81.90
FY 2018 - FY 2021 Average	$83.35

[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 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.

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 2021 research report[12] shows the actual administrative PMPMs net of taxes and fees for calendar year 2021 across the country. These PMPMs include all types of managed care programs, including those with lower acuity populations than the STAR Health program population. It is not unreasonable that the STAR Health program's administrative expenses 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 Health, so the experience reflected in the research report is heavily weighted toward lower-cost enrollees. The actual administrative PMPMs net of taxes and fees for calendar year 2021 for 80% of managed care organizations included in the report (between the 10th and 90th percentiles) were between $24.64 and $55.93.

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 to cover the uncertain costs related to provide defined benefits and administration duties as specified in the MCO contracts under fixed capitation rates. Nationally, the risk margin assumptions range from 1.0% to 2.0% for most comprehensive Medicaid managed care programs. The Commission's explicit risk margin of 1.5% is within the reasonable range and deemed to be appropriate for the covered population and covered benefits within this program.

The experience rebate adjustments discussed in the Rate Structure section of this Appendix provide some protection to the Commission if actual experience in FY 2023 deviates substantially from projected costs reflected in the capitation rates. Despite the uncertainty regarding the PHE and current market conditions, we do not have material concerns regarding the FY 2023 non-benefit expense assumptions given the existence of broader risk mitigation mechanisms (e.g., the experience rebate adjustments).

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 observation related to the STAR Health program:

Observation #1: Administrative expense assumptions are developed separately for the medical, pharmacy, and NEMT rate components

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

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.

[12] "Medicaid Managed Care Financial Results for 2021," Milliman Research Report, Retrieved from: https://jp.milliman.com/-/media/milliman/pdfs/2022-articles/7-8-22_medicaid-managed-care-financial-results-2021.ashx.

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Recommendations

We note the following recommendation related to the STAR Health program:

Recommendation #1: Include supporting documentation for the development of the administrative costs

Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids, Dual Demo

As noted above, the administrative costs assumptions applied by the Commission in the FY 2023 capitation rates appear reasonable compared to historical program experience; however, it is not clear how the Commission determined the specific parameters used in the administrative assumption formulas. We recommend the Commission expand their documentation to include additional documentation so that CMS or another actuary could reasonably understand the development of these parameters.

APPENDIX B: STAR HEALTH

CMS COMPLIANCE AND DOCUMENTATION

We reviewed the Commission's FY 2023 rate certification for compliance with the CMS 2022-2023 Medicaid managed care rate setting guidance.[13] 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 2022-2023 Medicaid managed care rate setting guidance and provided sufficient documentation to comply with actuarial standards of practice. We reviewed the CMS 2022-2023 Medicaid managed care rate setting guidance and compared them against what the Commission submitted in their Medicaid managed care capitation rate certification for the STAR Health 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) 2023 CMS Compliance and Documentation

Section I. Medicaid Managed Care Rates

The Commission has answered all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2022-2023 Medicaid managed care rate setting guidance.

Data - The Commission has answered all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2022-2023 Medicaid managed care rate setting guidance.

Projected Benefit Costs and Trends - The Commission has answered all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2022-2023 Medicaid managed care rate setting guidance.

Special Contract Provisions Related to Payment - The Commission has answered 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 2022-2023 Medicaid managed care rate setting guidance.

Projected Non-Benefit Costs - The Commission has answered all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2022-2023 Medicaid managed care rate setting guidance.

Risk Adjustment and Acuity Adjustments - The Commission has answered all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2022-2023 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 available for CMS Compliance and Documentation Review

The Commission provided us with the final FY 2023 rate certification report for the STAR Health program. We relied on this document, as well as the publicly available CMS 2022-2023 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.

Review Conclusions

We categorize our review conclusions into *observations* and *recommendations*.

[13] 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.

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.

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.

Several of our conclusions apply to multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

Observations

We note the following observation related to the STAR Health program:

Observation #1: Supporting documentation indicates pharmacy trends are set by drug type, which is inconsistent with the actual methodology used

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

The FY 2023 STAR Health report describes the pharmacy trend development as follows:

> *The STAR Health pharmacy trend assumptions for the period March 2020 through FY2023 were developed by risk group using the following formula. For each risk group / drug type combination, the utilization and cost per service trend assumptions were set equal to one sixth of the experience trend rate for the 12-month period ending February 2018 plus two sixths of the experience trend rate for the 12-month period ending February 2019 plus three sixths of the experience trend rate for the 12-month period ending February 2020. The final cost trend assumptions were then determined by applying the assumed utilization and cost per service trends by individual drug type to actual experience for the 12-month period ending February 2020 and combining the results into a single trend assumption for each risk group.*

The Commission developed separate trends at the drug type and utilization / unit cost level, without adjustment for historical PDL changes, and included these calculations in the rate certification. However, these trends were not used to determine the final trend, nor were they used in the final rate development.

The Commission's actual trend development for the FY 2023 capitation rates set the trend assumption by calculating the historical annual PMPM trend for each risk group, adjusted for historical PDL changes. The Commission's final trend assumption for each risk group was set equal to one sixth of the experience PMPM trend rate for the 12-month period ending February 2018 plus two sixths of the experience PMPM trend rate for the 12-month period ending February 2019 plus three sixths of the experience PMPM trend rate for the 12-month period ending February 2020.

As illustrated in the Trend section of this Appendix, the difference between the approach described in the Commission's rate certification and the Commission's actual approach can produce materially different results in some instances, particularly for risk groups where the mix between drug types is shifting. The Commission may consider describing the trend development in the rate certification in a manner that is consistent with the actual methodology used to develop the trend assumptions.

Recommendations

We note the following recommendation related to the STAR Health program:

Recommendation #1: Include supporting documentation for the development of the administrative costs

Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids, Dual Demo

The rate certification includes the following information to support the administrative costs included in the FY 2023 capitation rates:

- Fixed and variable administrative costs assumptions by rate component (medical, pharmacy, and NEMT)

- 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 (excluding NEMT, which was added to the STAR Health program effective July 1, 2021)

The Commission noted in the rate certification that the administrative costs are developed from historical Financial Statistic Reports and the Commission believes the resulting administrative costs for FY 2023 are reasonable compared to historical program experience. However, the rate certification does 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:

- Base period experience
- Trend assumptions
- Population adjustments, if applicable
- Allocation methodology between fixed and variable administrative costs
- 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

Exhibit B-1
Texas Medicaid Managed Care Rate Review
STAR Health Program - Base Data Review
Reconciliation Statewide

Table 1: Raw Base Period (3/1/2019 - 2/29/2020) Enrollment and Expenditure Data As Reported

	Enrollment	Medical_FFS	Rx_FFS	Capitation	Net Reinsurance	Other Medical Expenditures	Other Pharmacy Expenditures	TPR	Total Benefit Cost
Total	**389,987**	**$292,681,092**	**$38,401,732**	**$17,654,185**	**$33,929**	**-$2,143,158**	**$0**	**-$340,457**	**$346,287,323**

Table 2: Data Adjustments

	Enrollment	Medical_FFS	Rx_FFS	Capitation	Net Reinsurance	Other Medical Expenditures	Other Pharmacy Expenditures	TPR	Total Benefit Cost
Total				**-$1,192,834**	**-$33,929**	**$4,377,784**	**-$446,367**	**$8,968**	**$2,713,622**

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

	Enrollment	Medical_FFS	Rx_FFS	Capitation	Net Reinsurance	Other Medical Expenditures	Other Pharmacy Expenditures	TPR	Total Benefit Cost
Total	**389,987**	**$292,681,092**	**$38,401,732**	**$16,461,351**	**$0**	**$2,234,626**	**-$446,367**	**-$331,489**	**$349,000,945**

Footnotes:

1. In Table 1, historical enrollment data was summarized based on the SFY 2023 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 (Medical_FFS and Rx_FFS) was calculated based on the monthly expenditure data as reported in SFY20-21 MCO supplemental data report with runout through February 2022

4. In Table 1, base period non-lag expenditure data was calculated using a composite of the first six-month (3/1/2019-8/31/2019) expenditure data as reported in SFY19-20 (9/1/2018-8/31/2020) MCO supplemental data report with runout through February 2021 and the second six-month (9/1/2019-2/29/2020) expenditure data as reported in SFY20-21 (9/1/2019-8/31/2021) MCO supplemental data report with runout through February 2022

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

APPENDIX C

DENTAL

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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 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 3.7 million beneficiaries in FY 2023 at a program cost of roughly $1.4 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.

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RATE STRUCTURE

We evaluated the Commission's rate structure for the FY 2023 capitation rate development for the Dental program by reviewing the actuarial report and rate development model created by the Commission. For a high-level description of the regulatory and policy authority to be followed when designing the rate structure of a program, please see the Review Process section in the Main Report.

Description of State Fiscal Year (FY) 2023 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 1-5
- Children Ages 6-14
- Children Ages 15-18
- Children Ages 19-20

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 2023 rates:

- Step One: Develop FY 2023 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 for July 2021 through December 2021 ("2021 H2") 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 2021 H2 PMPM for the new DHMO or the continuing DHMOs combined, respectively, divided by the statewide 2021 H2 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 6-14 in Table 1

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Table 1 Texas Medicaid Managed Care Rate Review Dental Program - Rate Structure FY 2023 Risk Score Development					
			(1) **New DHMO**	**(2)** **Existing DHMOs**	**(3)** **All DHMOs Combined**
Average PMPM - 2021 H2	i		$26.27	$25.99	$26.01
Acuity Factor	ii	= i (1) *or* i (2) / i (3)	1.01025	0.99948	
Credibility Blended Acuity Factor	iii	= ii * 50% + 1 * 50%	1.00512	0.99974	
Budget Neutral Factor	iv		0.99991	0.99991	
Budget Neutral Acuity Adjustment	**v**	**= iii * iv**	**1.00503**	**0.99965**	

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 2023 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 2023, 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.

Review Conclusions

In this section, we include commentary related to the reasonableness of the resulting rate structure. We further categorize our review conclusions into observations and recommendations.

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.

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.

Several of our conclusions apply across multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

Reasonableness of Resulting Rate Structure

The Commission's Dental risk group definitions, which use a combination of eligibility group (i.e., Medicaid or CHIP) and age, are generally consistent with commonly observed practices for similar programs in other states. We do not have significant concerns about the assumed credibility levels for the Medicaid rates due to sufficient historical average enrollment in each risk group.

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The following table summarizes the number of average enrollment associated with each risk group.

Table 2 Texas Medicaid Managed Care Rate Review Dental Program – Rate Structure March 2019 through February 2020 Experience Period Average Enrollment (Medicaid Only)				
Under Age 1	**Ages 1-5**	**Ages 6-14**	**Ages 15-18**	**Ages 19-20**
172,571	812,412	1,320,176	448,743	39,091

Observations

We do not have any specific observations related to rate structure for the Dental program.

Recommendations

We do not have any specific recommendations related to rate structure for the Dental program.

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BASE DATA DEVELOPMENT

We gained a detailed understanding of the Commission's FY 2023 base data development approach used for the Dental program based on a detailed review and replication of FY 2023 base data development, in conjunction with the Commission's responses to our base data review questions. 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) 2023 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 2023 capitation rate setting process:

Base Data Selection

- The Commission selected the most recent 12-month period (March 2019 through February 2020) prior to the COVID-19 public health emergency 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 2023.

- 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 (March 2019 through February 2020). 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 2019 and FY 2020 separately for all DHMOs.

[7] Medicaid & CHIP Financial Statistical Reports: Fiscal Year 2020: Sept. 1, 2019, to May 31, 2020, 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 (March 2019 through February 2020) were adjusted for claims which have been incurred but not reported ("IBNR"). Please note, the IBNR assumption by the Commission is $0 given there are 24 months of additional payment runout in the data.
- 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 2023. Because one DHMO joined the Dental program as of September 2020 and did

not have base period PMPMs, the Commission aggregated the base period PMPMs based on projected enrollment for the two DHMOs with base period experience.

- The Commission calculated the projected FY 2023 enrollment for the two DHMOs with base period experience by multiplying the DHMO's projected enrollment by the risk group's percentage of the DHMO's enrollment in the base period. In other words, the total projected enrollment for each DHMO matches the monthly enrollment file, but the distribution of enrollment across risk groups is based on the base period distribution.

- The Commission did not include any projected FY 2023 enrollment for the new DHMO in the base data aggregation.

Data Available 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 2019 Final (September 2018 through August 2019) with runout through August 2020.
    - FY 2020 Final (September 2019 through August 2020) with runout through August 2021.
  - DHMO supplemental expenditure data:
    - FY 2019 – FY 2020 (September 2018 through August 2020) with runout through February 2021.
    - FY 2020 – FY 2021 (September 2019 through August 2021) with runout through February 2022.
  - The Commission provided summarized monthly enrollment files by each DHMO and risk group:
    - Actual enrollment was provided for the period from September 2012 through March 2022.
    - Projected enrollment was provided for the period from April 2022 through August 2023.
- 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 for the base period (March 2019 through February 2020).
  - A comparison of reported lag expenditures at the DHMO and risk group level across the commission provided encounters, DHMO FSRs, and DHMO supplemental expenditure data for FY 2019 and FY 2020.

- The Commission's documentation of base data development in the FY 2023 actuarial report.
- The Commission's responses to ad hoc questions from Milliman.

Review Conclusions

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.

In this section we include commentary related to the technical accuracy of the base data development. We further categorize our review conclusions into *observations* and *recommendations*.

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.

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.

Several of our conclusions apply to multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

Technical Accuracy

The development of the final base period data is technically accurate for each risk group and each DHMO. Using the raw enrollment data as reported by the Commission and the raw expenditure data as reported by the DHMOs, Milliman was able to replicate the calculation of the final base data using the Commission's approach within a margin of rounding difference at the risk group level. Please refer to the base data reconciliation Exhibit C-1 for details.

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 the most recent pre-COVID period (March 2019 through February 2020) as the base period
- Use of validated DHMO self-reported expenditure data as the primary base expenditure data
- Use of the DHMO financial data (i.e., FSR) and the encounter data for expenditure data validation
- Assumed $0 adjustment for IBNR, given the significant length of paid data runout included in the base period data
- 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 DHMO lag-expenditure and non-lag expenditure data, to the extent applicable

We note the following observation related to the Dental program:

Observation #1: Summary-level enrollment data and expenditure data are gathered from separate sources
Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids

The Commission collected summarized base period enrollment data and expenditure data separately from different entities (e.g., the Commission and the 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.

Although the likelihood of retroactive eligibility changes and subsequent risk group assignment changes for members enrolled in this program is less than in other programs, such potential inconsistencies can introduce risks on a PMPM basis.

Recommendations

We note the following recommendations related to the Dental program:

Recommendation #1: Use state encounter data as the primary base data source for expenditure data
Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids

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 External Quality Review Organization ("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 DHMOs for more sophisticated actuarial cost modeling. Using encounter data also enables member level matching of risk group assignment between enrollment and claims data. While encounter data can play a primary role in the base data development, the DHMO FSRs and the 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 2022-2023 Medicaid Managed Care Rate Development Guide[8] 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. For the development of the FY 2023 capitation rates, given the base period is March 2019 through February 2020, our understanding is that the detailed encounter data would have been available to use 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 once the Commission returns to using a more recent base period.

Recommendation #2: Use the state capitation payment file as the primary base data source for enrollment data
Applicable program(s): STAR, Dental, STAR+PLUS, STAR Kids

For an established managed care program like Dental, 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 member 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 DHMO capitation payments at the risk group level. When enrollment is provided without the member level details, i.e., how the Commission provided the enrollment file, such consistency will be at risk.

Recommendation #3: Include new DHMO in projected FY 2023 membership and expenditures
Applicable program(s): Dental

It is reasonable that the Commission excluded projected enrollment for the new DHMO from the base data aggregation because the new DHMO did not have base period experience. However, the Commission did not include the new DHMO's projected enrollment in the projected FY 2023 membership and expenditures in the rate certification. While this exclusion will not affect the PMPM capitation rates, it is inconsistent with the Commission's representation that the total FY 2023 membership and expenditures shown in the rate certification reflect the projected FY 2023 enrollment.

[8] "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.

According to the monthly enrollment file, the projected FY 2023 enrollment for the new DHMO is approximately 4.3 million member months, or 350,000 members annually. We estimate the projected FY 2023 total cost in the rate certification is understated by more than $120 million based on this projected enrollment. We recommend the new DHMO's enrollment be included in the projected enrollment used to calculate projected FY 2023 expenditures.

Recommendation #4: Include supporting documentation for the development of the base period data

Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids

The rate certification includes the following information to support the development of the base period data used for the FY 2023 capitation rates:

- Data sources
- High level information about each of the main three data sources: 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:

- The specific use of each of the three data sources in the base data development
- An overview of the Commission's reconciliation processes between the DHMO supplemental data and FSRs and whether a different approach is used for lag vs. 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 DHMO experience into overall program experience

APPENDIX C: DENTAL

TREND

We gained a detailed understanding of the Commission's FY 2023 trend development approach used for the Dental program. We relied on underlying data provided by the Commission, as well as responses to our specific trend review questions.

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) 2023 Trend Development

Our detailed understanding of the trend development for FY 2023 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

APPENDIX C: DENTAL

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 Available for Trend Review

We received the following primary data items from the Commission for the 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 documentation of trend development in the FY 2023 actuarial report
- The Commission's responses to ad hoc questions

Review Conclusions

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.

In this section we include commentary related to the reasonableness of resulting trend assumptions. We further categorize our review conclusions into *observations* and *recommendations.*

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.

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.

APPENDIX C: DENTAL

Several of our conclusions apply to multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

Reasonableness of Resulting Trend Assumptions

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 2023 dental trends to be higher or lower than previous observed dental trends.

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
- Normalizing historical experience in the trend analysis to remove program and PDL changes

We note the following observation related to the Dental program:

Observation #1: Prospective dental trends are developed using a purely formulaic approach

Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids

As described above, the Commission calculated historical trends for multiple years and then formulaically blended the years to develop a singular dental 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 dental 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 2023.

Recommendations

We do not have any specific recommendations related to trend adjustments for the Dental program.

APPENDIX C: DENTAL

PROGRAMMATIC ADJUSTMENTS

We gained a detailed understanding of the Commission's FY 2023 programmatic adjustment development approach used for the Dental program based on a review and analysis of the FY 2023 programmatic adjustment development, in conjunction with the Commission's responses to our programmatic adjustment review questions. Our review approach varied based on the assessed risk of each adjustment. For a full description of the approach used to review the programmatic adjustments, as well as a high-level description of the regulatory and policy authority to be followed in the development of the programmatic adjustments, please see the Review Process section in the Main Report.

Description of State Fiscal Year (FY) 2023 Programmatic Adjustment Development

The Commission developed and applied programmatic adjustments separately for each itemized change as applicable to the FY 2023 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 2023 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 2023 enrollment) divided by the final base period claims.

The Commission used a different methodology to address the PHE related cost adjustment, as noted below:

- PHE related cost adjustment
  - The Commission estimated the impact of the PHE on program costs by comparing actual monthly costs per member in March through August 2021 (net of COVID-related costs) to expected costs during that period. The expected costs were calculated by projecting actual March through August 2019 costs forward two years with assumed trend and programmatic adjustments.
  - The Commission compared actual to expected costs for each 3-month period between March and August 2021 and averaged the ratios to derive the impact of the PHE.
  - The Commission dampened the final PHE impact by 75% to account for an assumption that the PHE will end in October 2022 and will affect costs for one quarter (through November 2022).
  - Table 4 provides an example of the PHE adjustment calculation for the Ages 6-14 risk group.

Table 4 Texas Medicaid Managed Care Rate Review Dental Program - Programmatic Adjustment Development FY 2023 Public Health Emergency Adjustment Factor Development			
	Actual FY 2019 PMPM Trended for 2 years and Adjusted for Programmatic Changes	**Actual FY 2021 PMPM**	**FY 2021 PMPM / Trended and Adjusted FY 2019 PMPM**
March through May	$30.78	$27.17	0.8828
June through August	$33.80	$28.10	0.8313
Average			0.8571
PHE Impact		= 1 - 0.8571	14.29%
Dampened PHE Impact		= 14.29% x (1 - 0.75)	3.57%
Final PHE Adjustment Factor		= 1 - 3.57%	0.9643

The Commission's PHE adjustment reduced the projected FY 2023 costs by 3.57% for this sample risk group.

Data Available 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 2023 actuarial report.
- The Commission's responses to ad hoc questions from Milliman

Review Conclusions

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.

In this section we include commentary related to the reasonableness of resulting programmatic adjustments. We further categorize our review conclusions into observations and recommendations.
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.

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.

Several of our conclusions apply to multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

Reasonableness of Resulting Programmatic Adjustments

Table 5 summarizes the programmatic adjustment factors used by the Commission to develop the FY 2023 Dental program rates and our level of review for each adjustment. The adjustments are sorted in descending order based on the largest impact for that component (positive or negative) on any risk group. The adjustment descriptions in Table 5 are consistent with the titles of the Commission's exhibits in Attachments 4 and 5 of the FY 2023 rate certification.

Table 5
Texas Medicaid Managed Care Rate Review
Dental Program - Programmatic Adjustment Development
Summary of FY 2023 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	-4.49%	-3.57%	0.92%	Methodology review
FQHC Wrap Payment Rate Adjustment	-1.43%	-0.57%	0.86%	Reconciliation to DHMO submissions

Because we evaluate actuarial soundness at the risk group level, our level of review was primarily driven by the magnitude of the largest impact on any risk group. The Removal of FQHC Wrap programmatic adjustment is attributable to changes that are typically simple to isolate and measure. Although this adjustment can be material at the risk group level, it has little risk of error or concerns regarding the Commission's methodology.

Within the scope of our review, we reviewed 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 distribution and range of the programmatic change's impact across risk groups

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
- Use of actual vs expected analysis with emerging FY 2021 data to estimate PHE related impact
- Developing programmatic adjustments at the risk group level

We note the following observations related to the Dental program:

Observation #1: The FQHC wrap payment removal relies on base data aggregation using projected enrollment
Applicable program(s): STAR, Dental, STAR+PLUS, STAR Kids

As described in the Base Data Development section of this Appendix, the Commission excluded FQHC wrap payment costs from the capitation rate development because 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, as noted in the Base Data Development section of this Appendix. 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 #2: Programmatic adjustments are not developed at a service category level

Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids

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 level. Many of the programmatic adjustments are applicable to a specific service category, such as diagnostic experience. To the extent the service mix for a DHMO is materially different than the service mix at the community level, the DHMO's projected FY 2023 costs may not accurately reflect the adjustment for a particular programmatic change.

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 PMPM level. 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 section of this Appendix, one of the benefits of introducing this level of granularity in the development of the capitation rates is to help the State 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 "Ages 6-14" risk group, if the trend assumptions and programmatic adjustments are developed and applied at a detailed category of service level, Table 6 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 6
Texas Medicaid Managed Care Rate Review
Dental Program - Programmatic Adjustment Development
Illustrative Programmatic vs. Trend Assumptions Granularity
Ages 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 2023 PMPM[4]
Diagnostic	$8.42	1.005	0.9943	$8.52
Preventive	$8.82	1.005	0.9943	$8.93
Restorative	$10.85	1.005	0.9943	$10.97
Orthodontic	$0.05	1.005	0.9943	$0.05
All Others	$2.35	1.005	0.9943	$2.41
Total	$30.52			$30.88

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 2023 PMPM[4]	Difference to Scenario 1
Diagnostic	$8.42	1.009	0.9795	$8.51	-$0.01
Preventive	$8.82	1.000	1.0000	$8.82	-$0.10
Restorative	$10.85	1.007	1.0000	$11.11	$0.14
Orthodontic	$0.05	1.015	1.0000	$0.05	$0.00
All Others	$2.35	1.000	1.0000	$2.38	-$0.03
Total	$30.52			$30.88	-$0.00

Illustrative FY 2023 PMPMs = Base Period PMPM x [Annual Trend Assumption Factor ^ 3.5 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 2023.
[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.

Observation #3: The PHE related cost adjustment uses the same formulaic approach across all Medicaid populations, which may not produce reasonable results for all risk groups.

Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids

The PHE adjustment applied by the Commission in the development of the FY 2023 capitation rates uses a formulaic approach to review actual versus expected PMPMs from March 2021 to August 2021 at a risk group and SDA level. The Commission calculates the expected PMPM as March 2019 to August 2019 claims trended for two years and adjusted for programmatic changes, as described earlier in this section. Based on this analysis, as well as experience we have observed in other states during the PHE, some populations are more insulated from the impact of the PHE on a PMPM basis due to the underlying acuity of the population or the type of services that these populations utilize.

The overall approach taken by the Commission to estimate the impact on costs during the PHE is reasonable and comparable to how this adjustment has been calculated in other states. Due to the changes in enrollment and service utilization occurring throughout the PHE, the Commission's decision to use the last six months of available experience to evaluate the impact of the PHE is reasonable. However, calculating the adjustment at a risk group level can introduce normal fluctuations in this more granular level of data, particularly when developing the adjustment using six months of data.

The Commission may consider whether the results from this formulaic adjustment are reasonable based on expected PHE impacts and not inadvertently skewed by observed differences in experience versus assumed trend, programmatic changes, or other non-PHE related variances.

Recommendations

We do not have any specific recommendations related to programmatic adjustments for the Dental program.

APPENDIX C: DENTAL

NON-BENEFIT EXPENSES

We examined the Commission's FY 2023 non-benefit expense development approach used for the Dental program. We relied on data and analysis provided by the Commission, as well as responses to our specific non-benefit expense review questions.

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) 2023 Non-Benefit Expense Development

Our detailed understanding of the non-benefit expense development for FY 2023 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 2023 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 Available 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 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[9] and maintenance taxes[10]

Review Conclusions

Within the scope of our review, we reviewed 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.

In this section we include commentary related to the reasonableness of resulting non-benefit expense adjustments. We further categorize our review conclusions into observations and recommendations.

[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.

APPENDIX C: DENTAL

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.

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.

Several of our conclusions apply to multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

Reasonableness of Resulting Non-Benefit Expense Assumptions

Per the Commission's administrative expense review, the FY 2023 program-wide administrative allowance (net of taxes and fees) in the capitation rates is $1.75 PMPM. 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 2023 administrative expense load to historical program-wide administrative expenses PMPM reported by the DHMOs. The FY 2023 program-wide assumption appears to be generally consistent with average DHMO experience in FY 2019 through FY 2020. The administrative expense PMPM increased in FY 2021 despite the increase in enrollment during the PHE that we would expect to result in fixed costs being spread over more members.

DHMOs in many states are reporting emerging increases in administrative costs due to increases in wages and general inflation. The Commission noted that the current formula provides a reasonable allowance to address DHMO concerns regarding these increasing costs. However, as noted above, the program-wide FY 2023 assumption is consistent with actual pre-PHE administrative costs and about 4.4% less than actual FY 2021 administrative costs, so it may not explicitly account for both an increase in wages and general inflation and the expected reduction in enrollment following the expiration of the PHE. Table 8 below shows the historical administrative expenses PMPM from the Commission's FY 2023 Dental program rate certification.

Table 8
Texas Medicaid Managed Care Rate Review
Dental Program – Non-Benefit Expense Development
Historical Administrative Expenses

Year	Amount
FY 2019	$1.71
FY 2020	$1.79
FY 2021	$1.83

Administrative expenses can vary among states, programs, and populations for many reasons, including differences in operational requirements, reporting requirements, taxes, and labor markets. Furthermore, dental benefits can be covered by standalone dental programs, like this program, or through more comprehensive programs, as is the case in the STAR Health program. The administrative expense assumption is generally consistent with the administrative expense PMPM in standalone dental programs based on our experience working with other states.

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 DHMOs to cover the uncertain costs related to provide defined benefits and administration duties as specified in the DHMO contracts under fixed capitation rates. Nationally, the risk margin assumptions range from 1.5% to 2.0% for stand-alone Dental programs. An explicit risk margin of 1.5% is within the reasonable range and deemed to be appropriate for the covered population and covered benefits within this program.

The experience rebate adjustments discussed in Rate Structure section of this Appendix provide some protection to the Commission if actual experience in FY 2023 deviates substantially from projected costs reflected in the capitation rates. Despite the uncertainty regarding the PHE, we do not have material concerns regarding the FY 2023 non-benefit expense assumptions given the existence of broader risk mitigation mechanisms (e.g., the experience rebate adjustments).

APPENDIX C: DENTAL

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 DHMOs 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 do not have any specific observations related to non-benefit expenses for the Dental program.

Recommendations

We note the following recommendation related to the Dental program:

Recommendation #1: Include supporting documentation for the development of the administrative costs
Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids, Dual Demo

As noted above, the administrative costs assumptions applied by the Commission in the FY 2023 capitation rates appear reasonable compared to historical program experience; however, it is not clear how the Commission determined the specific parameters used in the administrative assumption formula. We recommend the Commission expand their documentation to include additional documentation, so that CMS or another actuary could reasonably understand the development of these parameters

APPENDIX C: DENTAL

CMS COMPLIANCE AND DOCUMENTATION

We reviewed the Commission's FY 2023 rate certification for compliance with the CMS 2022-2023 Medicaid managed care rate setting guidance.[11] 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 2022-2023 Medicaid managed care rate setting guidance and provided sufficient documentation to comply with actuarial standards of practice. We reviewed the CMS 2022-2023 Medicaid managed care rate setting guidance and compared them against what the Commission submitted in their Medicaid managed care capitation rate certification for the Dental 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) 2023 CMS Compliance and Documentation

Section I. Medicaid Managed Care Rates

The Commission has answered all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2022-2023 Medicaid managed care rate setting guidance.

Data - The Commission has answered all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2022-2023 Medicaid managed care rate setting guidance.

Projected Benefit Costs and Trends - The Commission has answered all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2022-2023 Medicaid managed care rate setting guidance.

Special Contract Provisions Related to Payment - The Commission has answered 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 2022-2023 Medicaid managed care rate setting guidance.

Projected Non-Benefit Costs - The Commission has answered all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2022-2023 Medicaid managed care rate setting guidance.

Risk Adjustment and Acuity Adjustments - The Commission has answered all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2022-2023 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 available for CMS Compliance and Documentation Review

The Commission provided us with the final FY 2023 rate certification report for the Dental program. We relied on this document, as well as the publicly available CMS 2022-2023 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] 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.

APPENDIX C: DENTAL

REVIEW CONCLUSIONS

We categorize our review conclusions into *observations* and *recommendations*.
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.

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.

Several of our conclusions apply to multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

Observations

We note the following observation related to the Dental program:

Observation #1: Supporting documentation should describe methodology for estimating FY 2023 projected enrollment used in the rate development

Applicable program(s): Dental

Consistent with other Medicaid programs, the Commission used a monthly enrollment file that includes projected FY 2023 enrollment for use in the rate development. However, the Commission did not use this projected enrollment by DHMO and risk group in the final rate development.

The Commission's total projected enrollment in rate development matches the monthly enrollment file for the two DHMOs with base period experience, but the enrollment was redistributed across risk groups using the base period distribution instead of the projected distribution. In addition, the Commission excluded the projected enrollment for the new DHMO. The Commission's redistribution of projected enrollment mix for the two DHMO's with base period experience results decreased the projected FY 2023 program costs in the Commission's rate certification by approximately $16 million. The Commission's projected FY 2023 program costs are understated by an additional $122 million due to the exclusion of projected enrollment for the new DHMO.

The Commission's modifications to the projected enrollment in the monthly enrollment file were not documented in the rate certification.

Recommendations

We note the following recommendation related to the Dental program:

Recommendation #1: Include supporting documentation for the development of the administrative costs

Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids, Dual Demo

The rate certification includes the following information to support the administrative costs included in the FY 2023 capitation rates:

- PMPM administrative cost assumption
- Historical PMPM program administrative costs

The Commission noted in the rate certification that the administrative costs are developed from historical Financial Statistic Reports and the Commission believes the resulting administrative costs for FY 2023 are reasonable compared to historical program experience. However, the rate certification does 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:

- Base period experience
- Trend assumptions
- Population adjustments, if applicable
- Any other adjustments applied
- Changes in methodology from prior rating period

Exhibit C-1
Texas Medicaid Managed Care Rate Review
Dental Program - Base Data Review
Reconciliation Statewide Across All DHMOs

Table 1: Raw Base Period (3/1/2019 - 2/29/2020) Enrollment and Expenditure Data As Reported

Risk Group	Enrollment	Dental_FFS	Other Non-FFS Expenses	Total Benefit Cost
Under Age 1	2,070,851	$21,647,150	-$254,084	$21,393,066
Ages 1-5	9,748,943	$279,376,212	-$156,622	$279,219,590
Ages 6-14	15,842,110	$483,029,771	$797,868	$483,827,639
Ages 15-18	5,384,919	$166,625,573	$477,852	$167,103,424
Ages 19-20	469,096	$9,671,815	$443,638	$10,115,453
Total	**33,515,919**	**$960,350,521**	**$1,308,652**	**$961,659,173**

Table 2: Data Adjustments

Risk Group	Enrollment	Dental_FFS	Other Non-FFS Expenses	Total Benefit Cost
Under Age 1			-$19,248	-$19,248
Ages 1-5			$71,126	$71,126
Ages 6-14			$239,530	$239,530
Ages 15-18			$112,730	$112,730
Ages 19-20			$66,974	$66,974
Total			**$471,113**	**$471,113**

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	2,070,851	$21,647,150	-$273,333	$21,373,818
Ages 1-5	9,748,943	$279,376,212	-$85,496	$279,290,716
Ages 6-14	15,842,110	$483,029,771	$1,037,399	$484,067,170
Ages 15-18	5,384,919	$166,625,573	$590,582	$167,216,155
Ages 19-20	469,096	$9,671,815	$510,613	$10,182,428
Total	**33,515,919**	**$960,350,521**	**$1,779,765**	**$962,130,285**

Footnotes:

1. In Table 1, historical enrollment data was summarized based on the SFY 2023 data book

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 SFY20-21 MCO supplemental data report with runout through February 2022

4. In Table 1, base period non-lag expenditure data was calculated using a composite of the first six-month (3/1/2019-8/31/2019) expenditure data as reported in SFY19-20 (9/1/2018-8/31/2020) MCO supplemental data

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 the UHRIP State directed payments

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 550,000 beneficiaries in FY 2023 at a program cost of roughly $10.5 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 2023 capitation rate development for the STAR+PLUS program by reviewing the actuarial report and rate development model created by the Commission. For a high-level description of the regulatory and policy authority to be followed when designing the rate structure of a program, please see the Review Process section in the Main Report.

Description of State Fiscal Year (FY) 2023 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 2023 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 2023 rates:

- Step One: Develop MCO-specific FY 2023 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 2023 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)

APPENDIX D: STAR+PLUS

A review of the development of directed payment programs is not included in the scope of our review of the FY 2023 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 2023, 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 4.6% of revenues.

Table 1
Texas Medicaid Managed Care Rate Review
STAR+PLUS Program – Rate Structure
FY 2023 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%	0%	100%
> 7% and ≤ 9%	0%	100%
> 9% and ≤ 12%	0%	100%
> 12%	0%	100%

Review Conclusions

In this section we include commentary related to the reasonableness of the resulting rate structure. We further categorize our review conclusions into observations and recommendations.

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.

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.

Several of our conclusions apply to multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

Reasonableness of Resulting Rate Structure

The Commission's STAR+PLUS risk group definitions, which primarily use a combination of Medicare eligibility status and service setting, are in line with commonly seen practices for similar programs in other states. 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.

The following table summarizes average enrollment associated with each risk group and SDA combination.

APPENDIX D: STAR+PLUS

Table 2 Texas Medicaid Managed Care Rate Review STAR+PLUS Program – Rate Structure March 2019 through February 2020 Average Enrollment								
	Medicaid Only - OCC	**Medicaid Only - HCBS**	**Dual Eligible - OCC**	**Dual Eligible - HCBS**	**Medicaid Only - NF**	**Dual Eligible - NF**	**IDD**	**MBCCP**
Bexar	18,445	2,169	16,346	2,764	586	3,245	1,742	362
Dallas	25,435	2,959	20,891	4,437	846	4,604	2,237	487
El Paso	5,872	801	11,794	1,327	85	595	496	277
Harris	40,987	3,244	44,241	5,007	883	5,647	3,787	886
Hidalgo	13,953	2,551	32,310	10,352	243	2,515	963	540
Jefferson	7,601	691	7,004	1,249	204	1,725	377	148
Lubbock	4,677	305	5,220	573	184	1,546	575	115
Nueces	6,831	867	7,917	2,278	189	1,843	469	218
Tarrant	15,919	1,395	13,591	2,280	680	4,394	2,043	382
Travis	9,169	644	9,281	1,551	382	2,994	1,205	262
Central	11,403	650	10,959	1,296	511	4,165	842	172
Northeast	16,891	1,500	15,549	4,066	588	5,456	1,085	269
West	11,122	831	15,432	2,356	494	4,561	1,037	283

Observations

We note the following observation related to the STAR+PLUS program:

Observation #1: LTC rates developed separately for nursing facility and community residents

Applicable program(s): STAR+PLUS

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.

Recommendations

We note the following recommendations related to the STAR+PLUS program:

Recommendation #1: Consider consolidating SDAs for the purpose of rate development

Applicable program(s): STAR, STAR+PLUS, STAR Kids

APPENDIX D: STAR+PLUS

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.

Recommendation #2: Review current structure of patient liability in the capitation rates

Applicable program(s): STAR+PLUS

Another unique aspect of a managed long-term care program is that a material portion of long-term care costs (nursing facility costs in particular) are paid by members out of their own monthly income according to Medicaid post-eligibility-treatment-of-income ("PETI") rules.[7] The member paid portion is typically called patient liability. Based on our experience setting capitation rates for similar programs, the patient liability portion generally accounts for 10% to 20% of total allowable nursing facility cost for dually eligible nursing facility risk groups and the remainder is paid by the MCOs and funded through the capitation rates. Based on a review of nursing facility paid amounts compared to the per diem gross of patient responsibility, we believe that the overall patient liability amount is roughly 16% for the nursing facility members in the STAR+PLUS program.
The Medicaid Rating Checklist, Section AA.3.13[8] 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.

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 Commission's 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 does not 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.

We recommend the rate structure be reviewed to follow one of the two commonly used approaches outlined above based upon the availability of patient liability data. Based on our conversations with the Commission, CMS has not identified the current approach as an issue in past rate reviews, however the Commission exposes itself to a risk that CMS requires the Commission to change approaches in the future by not developing the rates under one of these two approaches.

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[7] 42 CFR § 435.733, Post-eligibility treatment of income of institutionalized individuals in States using more restrictive requirements than SSI: Application of patient income to the cost of care, Retrieved from: 42 CFR § 435.733 - Post-eligibility treatment of income of institutionalized individuals in States using more restrictive requirements than SSI: Application of patient income to the cost of care. | CFR | US Law | LII / Legal Information Institute (cornell.edu).

[8] "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).

Under approach 2, where capitation rates are developed net of patient liability, we are aware of states where CMS has approved not performing a reconciliation between the actual and expected patient liability amounts, however the state first had to perform an analysis to determine the reconciliation would have been immaterial. We recommend that the Commission perform this materiality analysis to determine if the current approach of setting capitation rates net of patient liability without a reconciliation meets the criterion in the CMS guidance.

APPENDIX D: STAR+PLUS

BASE DATA DEVELOPMENT

We gained a detailed understanding of the Commission's FY 2023 base data development approach used for the STAR+PLUS program based on a detailed review and replication of FY 2023 base data development for Bexar, the sample Service Delivery Area ("SDA"), in conjunction with the Commission's responses to our base data review questions. 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 of the Main Report.

Description of State Fiscal Year (FY) 2023 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 2023 capitation rate setting process:

Base Data Selection

- The Commission selected the most recent 12-month period (March 2019 through February 2020) prior to the COVID-19 public health emergency as the base period for both the enrollment data and the service expenditure data. Other than the carve-in of NEMT services as previously provided by MTOs or FFS, the populations and services covered by the STAR+PLUS program during FY 2023 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

  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 2023.

- The Commission reconciled MCO reported supplemental data to the MCO reported Financial Statistical Reports ("FSR") expenditures for overall consistency in aggregate across all risk groups at the MCO and SDA level for the base period (March 2019 through February 2020). 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.[9]

- 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 2019 and FY 2020 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 expenditure" in this report, the Commission made the following explicit adjustments:
  - The paid expenditures as of February 2022 for the base period (March 2019 through February 2020) were adjusted for claims which have been incurred but not reported ("IBNR"). Please note, the IBNR assumption by the Commission is $0 given there are 24 months of additional payment runout in the data.
  - 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.

[9] Medicaid & CHIP Financial Statistical Reports: Fiscal Year 2020: Sept. 1, 2019, to May 31, 2020, 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, including Uniform Hospital Rate Increase Payment ("UHRIP"), Quality Incentive Payment Program ("QIPP"), and Network Access Improvement Program ("NAIP"). The Commission accounted for these payments outside the main capitation rates as special rate adjustments.

  - Pharmacy Benefit Manager ("PBM") discount and rebate settlements were deducted by the Commission in the base data development. These adjustments were not reported through the MCO supplemental data but were based on information provided separately to the Commission.

- 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 TPR was explicitly noted in Part 4 of the FSR. Otherwise, the Commission assumed the reported reimbursement amounts were already included in the claims and other expenses, so the Commission did not offset other expenditures as reported in the MCO supplemental data by the reported reimbursement amounts.

- 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.

- The Commission did not adjust the base data to remove the impact of any changes in eligibility or covered services between the base period and FY 2023. Instead, the Commission reflected the expected impact of these changes on expenditures 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 2023.

Data Available 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 2019 Final (September 2018 through August 2019) with runout through August 2020.
  - FY 2020 Final (September 2019 through August 2020) with runout through August 2021.
- MCO supplemental expenditure data:
  - FY 2019 – FY 2020 (September 2018 through August 2020) with runout through February 2021.
  - FY 2020 – FY 2021 (September 2019 through August 2021) with runout through February 2022.
- The Commission provided summarized monthly enrollment files by each MCO and risk group:
  - Actual enrollment was provided for the period from September 2012 through December 2021.
  - Projected enrollment was provided for the period from January 2022 through August 2027.

- 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 (March 2019 through February 2020).
  - 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 2019 and FY 2020.
- The Commission's documentation of base data development in the FY 2023 actuarial report.
- The Commission's responses to ad hoc questions from Milliman.

Review Conclusions

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.

In this section we include commentary related to the technical accuracy of the base data development. We further categorize our review conclusions into *observations* and *recommendations*.

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.

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.

Several of our conclusions apply to multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

Technical Accuracy

The development of the final medical (acute care and LTC) and pharmacy base period data is technically accurate for each risk group and each MCO in the sample SDA. Using the raw enrollment data as reported by the Commission and the raw expenditure data as reported by the MCOs, Milliman was able to replicate the calculation of the final medical and pharmacy base data using the Commission's approach within a margin of rounding difference at the risk group level for the sample SDA. Please refer to the sample SDA base data reconciliation Exhibit D-1 for details.

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 the most recent pre-COVID period (March 2019 through February 2020) as the base period
- Use of validated MCO self-reported expenditure data as the primary base expenditure data
- Use of the MCO financial data (i.e., FSR) and the encounter data for expenditure data validation
- Assumed $0 adjustment for IBNR, given the significant length of paid data runout included in the base period data
- 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 lag-expenditure and non-lag expenditure data, to the extent applicable

The adjustments made to the service categorization for the reported acute care costs for dually eligible risk groups and the reported LTC costs for the IDD risk group are not commonly seen in other states. However, to the extent that these adjustments are a cost neutral at the risk group level and the intent of these adjustments is to better align the nature of these costs with the service categorization, we have no concerns with this approach.

We note the following observations related to the STAR+PLUS program:

Observation #1: Summary-level enrollment data and expenditure data are gathered from separate sources
Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids

The Commission collected summarized base period enrollment data and expenditure data separately from different entities (e.g., the Commission and the MCOs). 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.

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.

Observation #2: There is not a clear process for the treatment of MCO self-reported TPR data

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

TPR was collected by the Commission as part of the MCO supplemental data as a standalone cost recovery item. In the MCO supplemental data request template and instructions, the Commission did not specifically request information from the MCOs about the nature of these TPRs, and whether the reported reimbursement amounts have already been accounted for in expenditures or recoveries reported in other sections of the MCO supplemental data. For the sample SDA reviewed, the Commission's treatment of MCO reported TPR ranges from being fully reflected in other sections to not being reflected in other sections at all. The Commission explained that the decision to include or exclude TPR from the base data development was primarily based on a manual review of relevant FSR reporting notes in Part 4 and the expenditure comparison between the FSR and MCO supplemental data. In general, the Commission did not use reported TPR for base data development unless TPR was mentioned in the FSR reporting notes in Part 4. Given the self-reporting nature of the FSRs and potential for incomplete notes, this approach can lead to an artificial inflation of base period expenditures to the extent that TPR was not appropriately noted or included in the FSRs. At a minimum, the Commission may consider obtaining explicit clarifications from the MCOs to inform appropriate treatment of MCO-reported TPR amounts in the base data development, or the Commission may consider adding direct questions should be added to the MCO supplemental data collection template to remove the manual nature of this adjustment and obtain consistent information and reporting from all MCOs.

Observation #3: Net reinsurance costs should not be included in the base data

Applicable program(s): STAR, STAR+PLUS, STAR Kids

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 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.

***Observation* #4: 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

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 practice is to re-allocate 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.

Recommendations

We note the following recommendations related to the STAR+PLUS program:

Recommendation #1: Use state encounter data as the primary base data source for expenditure data

Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids

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 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" vs. "non-dual") and risk group assignment changes [other community care ("OCC") vs. home and community-based services ("HCBS") vs. nursing facilities ("NF")]. While encounter data can play a primary role in the base data development, the MCO FSRs and the MCO 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 2022-2023 Medicaid Managed Care Rate Development Guide[10] 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. For the development of the FY 2023 capitation rates, given the base period is March 2019 to February 2020, our understanding is that the detailed encounter data would have been available to use 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 once the Commission returns to using a more recent base period.

Recommendation #2: Use the state capitation payment file as the primary base data source for enrollment data

Applicable program(s): STAR, Dental, STAR+PLUS, STAR Kids

For an established managed care program like STAR+PLUS, 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 capitation payments. When enrollment is provided without the member level details, i.e., how the Commission provided the enrollment file, such consistency will be at risk.

Recommendation #3: Consider the inclusion of patient liability in the base data development

Applicable program(s): STAR+PLUS

A unique aspect of managed LTC programs is that a material portion of LTC costs (nursing facility costs in particular) are paid by members out of their own monthly income under Medicaid post-eligibility-treatment-of-income ("PETI") rules.[11] The member paid portion is typically called patient liability. Based on our experience setting capitation rates for similar programs, the patient liability portion generally accounts for 10% to 20% of total allowable nursing facility cost for dually eligible NF risk groups and the remainder is paid by the MCOs and accounted for in the capitation rates. This unique co-funding dynamic creates an extra pricing risk to the NF risk group due to the leveraged effect as patient liability changes from the base period to the rating period do not always align with nursing facility fee schedule changes. Therefore, the change in MCO paid costs does not always align with nursing facility fee schedule changes. For instance, in CY 2022 Social Security payments, which is the primary source of the income used by the member to pay the patient liability amount, increased 5.9% due to a higher-than-normal cost of living increase.

To accurately project the MCOs' paid cost net of patient liability changes from the base period, the actuary will need to know both the change of patient liability and the change of the fee schedule during the projection period. Therefore, many states collect patient liability amount as part of base data development so they can quantify the leveraged effect of projected changes in patient liability vs. nursing facility costs.

Recommendation #4: 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

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[12] 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

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[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.

[11] 42 CFR § 435.733, Post-eligibility treatment of income of institutionalized individuals in States using more restrictive requirements than SSI: Application of patient income to the cost of care, Retrieved from: 42 CFR § 435.733 - Post-eligibility treatment of income of institutionalized individuals in States using more restrictive requirements than SSI: Application of patient income to the cost of care. | CFR | US Law | LII / Legal Information Institute (cornell.edu).

[12] 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.

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 SDA and then aggregated the costs per member per month weighted by each MCO's projected FY 2023 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. In addition, the Commission explained that the intent of using projected enrolment 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 3, 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.

If the Commission determines it is appropriate to apply an adjustment to reflect changes between the base period and rating period due to changes in the overall provider contracting levels, the Commission may consider applying this adjustment as a programmatic adjustment so that 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 is normalized out of the trend calculations so that the impact is not double counted in the final capitation rates. The current approach introduces the risk of double counting any persistent historical shifts that may also be reflected in trends, as well as removing cost differences beyond provider reimbursement levels (e.g., underlying differences in member demographics or required levels of care).

Table 3
Texas Medicaid Managed Care Rate Review
STAR+PLUS Program – Base Data
Difference in SDA-level PMPMs using Base Period Membership vs. Projected Membership Weighting
Medical + Pharmacy Percentage Difference

SDA	Medicaid Only OCC	Medicaid Only HCBS	Medicaid Only Nursing Facility	Dual Eligible OCC	Dual Eligible HCBS	Dual Eligible Nursing Facility	IDD	MBCCP	Total
Bexar	0.07%	-0.03%	0.10%	-0.05%	-0.23%	0.00%	0.68%	-0.05%	**0.02%**
Dallas	0.19%	0.09%	0.02%	0.42%	-0.11%	-0.01%	-0.12%	-1.45%	**0.08%**
El Paso	-0.09%	-0.18%	-0.67%	-0.01%	0.05%	-0.01%	-0.03%	0.57%	**-0.05%**
Harris	-0.31%	0.55%	-0.07%	-0.22%	0.28%	-0.10%	-0.62%	-0.06%	**-0.12%**
Hidalgo	-0.10%	-0.84%	-0.43%	-0.26%	-0.29%	-0.05%	-2.42%	-1.90%	**-0.32%**
Jefferson	-1.23%	-0.25%	0.06%	2.55%	-0.01%	-0.03%	-3.75%	-0.94%	**-0.46%**
Lubbock	-0.13%	-1.39%	0.03%	-0.03%	-1.30%	0.00%	0.03%	-1.95%	**-0.29%**
MRSA Central	-0.23%	-0.44%	-0.01%	-0.21%	0.47%	0.05%	0.55%	-0.22%	**-0.08%**
MRSA Northeast	-0.43%	-2.54%	-0.03%	-0.27%	0.14%	0.03%	-0.94%	0.05%	**-0.41%**
MRSA West	0.07%	0.02%	0.06%	0.85%	-0.44%	0.01%	0.10%	-1.82%	**0.02%**
Nueces	-0.05%	-0.01%	0.10%	0.42%	-0.23%	-0.08%	0.09%	0.00%	**-0.01%**
Tarrant	0.00%	0.16%	0.00%	-0.11%	-0.06%	0.01%	-0.18%	0.12%	**0.01%**
Travis	0.18%	0.76%	-0.13%	4.50%	-0.37%	-0.05%	0.01%	-0.08%	**0.34%**
Total	**-0.14%**	**-0.18%**	**-0.03%**	**0.08%**	**-0.12%**	**-0.02%**	**-0.36%**	**-0.56%**	**-0.10%**

Recommendation #5: Include supporting documentation for the development of the base period data

Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids

The rate certification includes the following information to support the development of the base period data used for the FY 2023 capitation rates:

- Data sources
- High level information about each of the main three data sources: MCO 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:

- The specific use of each of the three data sources in the base data development
- An overview of the Commission's reconciliation processes between the MCO supplemental data and FSRs and whether a different approach is used for lag vs. 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 experience into overall program experience

APPENDIX D: STAR+PLUS

TREND

We gained a detailed understanding of the Commission's FY 2023 medical and pharmacy trend development approach used for the STAR+PLUS program. We relied on underlying data provided by the Commission, as well as responses to our specific trend review questions.

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 2023 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 Review Process section of the Main Report.

Description of State Fiscal Year (FY) 2023 Trend Development

Our detailed understanding of the trend development for FY 2023 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 2017 through February 2020) 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 2014 through FY 2020, including:

  - Provider reimbursement changes
  - Other programmatic changes

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 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 2023 (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 FFS claim payments amounts were adjusted to reflect managed care pharmacy reimbursement provisions. Historical data and calculations were developed separately by drug type (i.e., brand, generic, and specialty) for utilization and unit cost, but the Commission ultimately used the PMPM level data to develop the selected pharmacy trends.

- Adjustment factors for material preferred drug list (PDL) changes from FY 2018 through FY 2020

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) claims for demand response services[13] (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 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) by risk group for each 12-month period from March 2016 through February 2020.
- The Commission multiplied the statewide incurred pharmacy claims PMPM by the annual PDL adjustment factors. The adjusted PMPMs estimate the 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.

[13] https://www.transit.dot.gov/sites/fta.dot.gov/files/docs/Demand_Response_Fact_Sheet_Final_with_NEZ_edits_02-13-13.pptx

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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 2 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 2019 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	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
MBCCP		
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 trend at the risk group level by weighting the historical annual statewide 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	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
MBCCP		
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

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

  Note that 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:
  - Summarized FY 2017 – FY 2020 managed care PMPM trends
- Trend adjustment factors for the following adjustments:
  - Reimbursement related adjustments
  - Programmatic / benefit related adjustments
- A copy of the Commission's 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 2014 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 2014 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, and
    - For all risk groups combined calibrated to reflect the projected FY 2023 enrollment mix by risk group

  - Calculation of final trends by risk group based on a weighted average of historical annual trends in incurred claims PMPM adjusted for PDL changes

- The Commission's documentation of trend development in the FY 2023 actuarial report

- The Commission's responses to ad hoc questions

Review Conclusions

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 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.

In this section we include commentary related to the appropriateness of resulting trend assumptions. We further categorize our review conclusions into *observations* and *recommendations*.

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.

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.

Several of our conclusions apply to multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

Appropriateness of Resulting Trend Assumptions

LTC Services

The Commission's overall annual prospective LTC services PMPM trend at the program level of 3.0% appears to be somewhat high based on our experience working with other states, especially given that the provider reimbursement and other program changes are not accounted for through this trend assumption. However, the historical trends for LTC services in the STAR+PLUS program were higher than what we have seen in other States for similar programs so the selected trend may be reasonable based on the unique characteristics of the populations and services included in the program. 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.
We asked the Commission to share any analysis they performed to understand the trend drivers and any of their insights about the local market's trend dynamics so we can assess the appropriateness of assuming that the relatively high historical trend will continue for 3.5 years from the base period through the rating period. The Commission explained that historically there have been two major drivers of the observed 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, however we did not perform an independent analysis to confirm these trend drivers.

We also reviewed the stability of the Commission's trend calculation methodology. Table 6 displays the volatility in observed annual trends by risk group in the medical data based on the Commission's development of trend estimates

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Table 6
Texas Medicaid Managed Care Rate Review
STAR+PLUS - 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**	**Total**
9/16 to 8/17	9.3%	6.6%	5.6%	6.4%	1.2%	1.8%	N/A	3.8%
9/17 to 8/18	3.6%	3.8%	2.5%	3.9%	1.8%	2.3%	N/A	1.8%
9/18 to 8/19	4.6%	6.1%	2.0%	4.1%	3.2%	3.2%	42.5%	3.4%
9/19 to 2/20	3.5%	3.1%	0.7%	1.8%	1.7%	2.2%	21.1%	2.8%
Selected Trend	**5.5%**	**5.2%**	**3.0%**	**4.4%**	**2.0%**	**2.4%**	**4.2%**	**3.0%**

We did not evaluate the drivers of the historical 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, new alternative treatments for existing conditions, and changes in average member demographics and acuity. Table 6 is 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 assumption.

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, the Commission's overall annual prospective PMPM trend at the program level of 5.1% per year, included in Table 7 below, 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 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 2023 pharmacy PMPMs were within the range of monthly historical PMPMs for several risk groups. However, the projected FY 2023 pharmacy PMPM was more than 70% higher than any historical pharmacy PMPMs for the MBCCP risk group. The Commission explained that the high historical trends for the MBCCP risk group were primarily driven by the drug Ibrance. The Commission explained that they reviewed Ibrance experience to validate these trends, but the Commission did not affirm that this significant increase driven by Ibrance continued beyond the base period to support using these trends in the projection period. The emerging trends for the MBCCP population in Table 7 below suggest this significant increase driven by Ibrance subsided in more recent years; therefore, the Commission's reliance on the historical trend may not be reasonable for this population.

We also reviewed the stability of the Commission's trend calculation methodology over time. Although the PHE likely had some impact on pharmacy trends during the PHE, the pharmacy experience for populations such as STAR+PLUS has generally been less impacted throughout the PHE for several reasons, including:

- The acuity of these populations has remained more stable due to the eligibility requirements
- Many of the drug costs are attributable to conditions that require timely adherence

Table 7 displays the volatility in observed annual trends by risk group in the pharmacy data provided for our review. The same methodology produces materially different results at a risk group level depending on the years used in the calculation, such as shifting the time periods used as shown in Table 7.

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Table 7 Texas Medicaid Managed Care Rate Review STAR+PLUS Program - Trend Development Historical Annual Trend in Total Pharmacy PMPM (Adjusted for PDL Changes)						
	Risk Groups					
Year Ending	**OCC**	**HCBS**	**IDD**	**NF**	**MBCCP[1]**	**Total[2]**
3/16 to 2/17	6.7%	4.9%	1.4%	-2.2%		6.8%
3/17 to 2/18*	6.5%	6.5%	1.9%	0.9%		7.0%
3/18 to 2/19*	5.1%	3.8%	7.9%	2.2%	34.7%	5.8%
3/19 to 2/20*	3.6%	3.9%	3.9%	-1.0%	14.5%	4.0%
3/20 to 2/21	1.2%	0.1%	4.6%	-6.4%	4.1%	1.3%
3/21 to 2/22	-1.9%	0.6%	6.2%	0.1%	1.4%	-1.1%
Selected Trend	**4.6%**	**4.3%**	**4.9%**	**0.4%**	**21.3%**	**5.1%**
Final Trend if Underlying Years Shift:						
Years of Shift						
1 Year Backward	5.8%	4.9%	4.8%	1.0%		6.3%
1 Year Forward	2.6%	2.0%	4.9%	-3.2%	7.6%	3.0%
2 Years Forward	0.0%	1.0%	5.3%	-2.3%	2.3%	0.5%

** Data included in selected trend.*
[1] Based on 6-month periods from September through February; Final trend based on different weighted average.
[2] Excluding MBCCP risk group.

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 alternative treatments for existing conditions, and changes in average member demographics and acuity.

Depending on expected changes in drug mix and utilization, it may be reasonable for the FY 2023 pharmacy trends to be higher or lower than previous observed pharmacy trends. Table 7 is 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 appropriateness of the final trend assumption.

NEMT Trends

As noted in the Review Process section of the Main Report, 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.

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 the STAR+PLUS program:

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Observation #1: Prospective medical trends are developed using a purely formulaic approach
Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids

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 2023.

Observation #2: Medical trends are not consistently applied to sub-capitated and service coordination cost
Applicable program(s): STAR, STAR+PLUS, STAR Kids

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 2023 rate development.

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.

For service coordination costs, the primary underlying costs are staffing costs for service coordinators, such as wages and benefits. For FY 2023 rate development, the projection period happens to be in a high inflationary environment where wages and other staffing costs increased significantly.

Observation #3: The data source used for quantitative medical trend analysis does not enable more granular analysis
Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

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.

Observation #4: 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, Duals

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 and does not reflect the actual time period of the projection.

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 ten years ending February 2020 (based on this typical approach) is 0.9%. The Commission calculated each month's annual trend for the most recent 120 months 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%.

Additionally, the resulting trend is applied to reflect anticipated CPI changes from the base period (March 2019 to February 2020) to FY 2023. It may be more appropriate to use *actual observed* CPI changes from the base period to present day (i.e., March 2022 when setting FY 2023 rates) and then recently observed averages from present day to FY 2023. This approach would ensure historical periods from 5 to 10 years ago are not used at the expense of recent market conditions.

Recommendations

We note the following recommendations related to the STAR+PLUS program:

Recommendation #1: Develop medical trend assumptions at more detailed service category level

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

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:

- Hospital inpatient services
- Hospital outpatient services
- Emergency room services
- Physician services
- 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 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.

Recommendation #2: Develop medical and pharmacy trend assumptions separately by utilization and unit cost component

Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids

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 help validate how historical provider reimbursement changes (that are separately identified in the prior rate development) compare to historical unit cost trends. Such a comparison will provide insights about the provider contracting dynamics at the major service category level. It will also provide an understanding of the drivers of observed recent 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 an actuarially sound manner in the trend development.

The Commission produced an analysis of historical utilization and unit cost trends for medical and pharmacy services, but this analysis was not explicitly used to develop distinct utilization and unit cost trends for the rate development. Other states often select distinct utilization and unit cost pharmacy trends. A more granular approach for selecting trends allows for drug trends that are better aligned with each population's projected costs and program goals.

Recommendation #3: Apply separate trends to patient liability and remaining net state costs

Applicable program(s): STAR+PLUS

As discussed in the Base Data Development section of this Appendix, managed LTC programs are unique in that a material portion of LTC costs (nursing facility costs in particular) are paid by members out of their own monthly income under Medicaid post-eligibility-treatment-of-income ("PETI") rules. The member paid portion is typically called patient

liability. Based on our experience setting capitation rates for similar programs, the patient liability portion generally accounts for 10% to 20% of total allowable nursing facility cost for dually eligible NF risk groups and the remainder is paid by the MCOs and accounted for in the capitation rates. This unique co-funding dynamic creates an extra pricing risk to the NF risk group due to the leveraged effect as patient liability can change from the base period to the rating period at a different rate than nursing facility fee schedule changes. Therefore, the change in MCO paid costs does not always align with nursing facility fee schedule changes. For instance, CY 2022 Social Security payments, which is the primary source of the income used by the member to pay the patient liability amount, increased 5.9% due to a higher-than-normal cost of living increase.

To accurately project the MCOs' cost net of patient liability from the base period to the rating period, we recommend the Commission modify the trend methodology to calculate the trend in the following step:

- Step 1: The base data for STAR+PLUS is net of patient liability. This first needs to be converted to a gross of patient liability basis by adding the historical patient liability amounts to the base data.
- Step 2: Apply trend assumptions for estimated changes between the base period and rating period to the gross of patient liability amounts.
- Step 3: Apply trend assumptions for estimated changes between the base period and rating period for the patient liability that will be collected from the members. Typically, this is the cost-of-living increases for Social Security payments.
- Step 4: Calculate the trend impact costs on a net of patient liability basis by taking the projected gross costs (Step 2) minus the projected patient liability (Step 3)

Recommendation #4: Do not introduce changes in SDA distribution between Year 1 and Year 2 of the calculation when using statewide trend assumptions

Applicable program(s): STAR, STAR+PLUS, STAR Kids

As described above, the Commission followed a generally accepted process to calculate annual medical PMPM trends for each SDA. The Commission then aggregated these SDA trends into a statewide annual PMPM trend using the year 2 aggregate dollars by SDA. The Commission's calculation approach produced a higher result than weighting the SDA trends by the year 1 costs, which would produce the actual historical statewide PMPM trend (alternatively calculated as the one-year trend in statewide PMPM amounts). The selection of year two aggregate dollars places a larger reliance on SDA trends that are higher than the average statewide trend (i.e., an SDA with a higher than average trend receives additional weight due to having higher costs in year two than in year one) and smaller reliance on SDA trends that are lower than the average statewide trend. As a result, this weighting methodology will always produce a trend that is greater than the actual observed statewide trend unless trends by SDA are identical.

Table 8 summarizes our analysis of the difference between the aggregation approaches (i.e., year 1 costs, year 2 costs) at the risk group level and in total for the STAR program.

Table 8 Texas Medicaid Managed Care Rate Review STAR+PLUS - Trend Development Analysis of Medical Trend Aggregation Approach					
		Annualized Trends			
Risk Group	**Rate Component**	**Aggregated Based on Year 2 Costs (Used for FY 2023 Capitation Rates)**	**Aggregated Based on Year 1 Costs (Actual Historical Statewide Trend)**	**Annual Trend Difference**	**Applied Trend Impact (3.5 years of trend)**
Medicaid Only - OCC	Acute Care	1.5%	1.4%	0.1%	0.4%
Medicaid Only - HCBS	Acute Care	1.5%	1.1%	0.4%	1.4%
Medicaid Only - Nursing Facility	Acute Care	4.1%	3.3%	0.8%	3.1%
IDD	Acute Care	5.2%	4.3%	0.9%	3.5%
MBCCP	Acute Care	9.3%	8.3%	1.0%	4.3%
Medicaid Only - OCC	LTC	5.5%	5.3%	0.2%	0.8%
Medicaid Only - HCBS	LTC	5.2%	5.1%	0.1%	0.4%
Medicaid Only - Nursing Facility	LTC	2.0%	2.0%	0.0%	0.0%
Dual Eligible - OCC	LTC	3.0%	2.9%	0.1%	0.4%
Dual Eligible - HCBS	LTC	4.4%	4.3%	0.1%	0.4%
Dual Eligible - Nursing Facility	LTC	2.4%	2.4%	0.0%	0.0%
MBCCP	LTC	4.2%	4.1%	0.1%	0.4%
All Risk Groups Combined	**Medical**	**3.0%**	**2.9%**	**0.1%**	**0.5%**

As displayed in Table 8, the Commission's aggregation method using year 2 costs for the historical statewide trend calculation results in the overall final prospective annual trend being roughly 0.1% the actual observed historical trend (using year 1 costs). Applying the selected annual trend assumption from the base period (March 2019 through February 2020) to the FY 2023 rating period (i.e., a total of 3.5 years) results in an overall difference of roughly 0.5% between the two aggregation approaches.

We recommend that the Commission composites the trends using the year 1 SDA cost distribution when relying on historical statewide trends to develop prospective trend assumptions. This aggregation methodology will produce the same result as calculating the statewide average historical trend.

Recommendation #5: Develop and apply pharmacy trends by drug type (i.e., Specialty and Non-Specialty)

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

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. Figure 1 shows the historical change in the specialty PMPM included in the trend analysis as a percentage of the total pharmacy PMPM included in the trend analysis (net of the exclusions, noted above).

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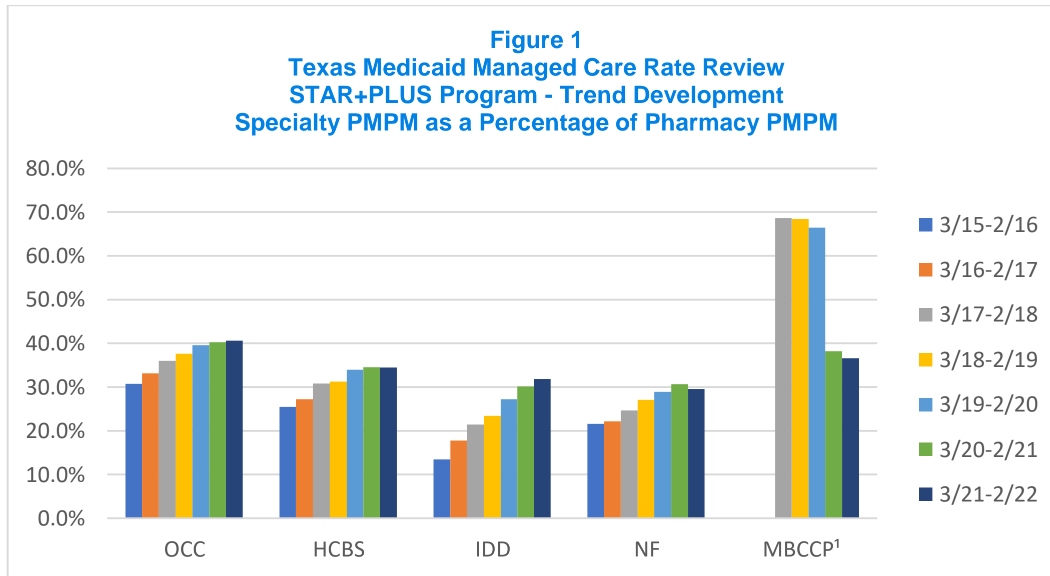

Given the general increase in specialty drug mix in recent years, relying on historical aggregate trends likely understates future trends by undervaluing the impact of higher-than-average specialty drug trends on the current drug mix included in the base period.

To illustrate this, we reviewed the selected FY 2023 pharmacy trends for each risk group relative to estimated one-year trends based on separate specialty / non-specialty trends composited using the base period mix. Table 9 includes the comparison of these two trend approaches.

Table 9
Texas Medicaid Managed Care Rate Review
STAR+PLUS Program - Trend Development
Estimated Impact of Applying Distinct Trends to Specialty and Non-Specialty Pharmacy Costs

Risk Group	Final FY 2023 Trend	Estimated Composite Trend Based on Distinct Trends[1]	(Under) / Over-Statement of Historical Weighted Trend
OCC	4.6%	4.9%	(0.3%)
HCBS	4.3%	4.7%	(0.4%)
IDD	4.9%	5.8%	(0.9%)
NF	0.4%	0.8%	(0.4%)
MBCCP	21.3%	24.4%	(3.1%)

[1] Based on applying the Commission's historical weighing approach to historical specialty and non-specialty trends separately.

Table 9 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.

We note, that 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 these two 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 9, 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 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 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.

Recommendation #6: Consider the impact of recently approved and upcoming pipeline drugs for each population

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

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 2023 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. Examples of some of these drugs that could materially impact program costs include:

- Ubrelvy (approved December 2019) for acute treatment of migraine
- Oxbryta (approved December 2019) to treat sickle cell disease
- Trikafta (approved October 2019) to treat cystic fibrosis

The Commission reimburses the MCOs for certain newly approved drugs through non-risk arrangements, however, the three drugs listed above are not on the non-risk drug payment list[14] as of July 11, 2022 but they are included on either the Texas preferred drug list[15] effective January 27, 2022 or the March 2022 Texas specialty drug list (SDL).[16] Although these drugs were approved during the base period, the base period would reflect a limited amount of claims.

In addition, many oncology drugs have been newly approved or approved for expanded indications since 2019. Each of these drugs alone may not materially impact trends, but the combined impact of these drug approvals has materially increased utilization within the therapeutic class in other states.

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 in the STAR program 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 populations.

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

[14] "Vendor Drug Program, Non-Risk Drugs," Texas Health and Human Services, Retrieved from: https://www.txvendordrug.com/resources/managed-care/non-risk-drugs.
[15] "Vendor Drug Program, Preferred Drugs," Texas Health and Human Services, Retrieved from: https://www.txvendordrug.com/formulary/prior-authorization/preferred-drugs.
[16] "Vendor Drug Program, Specialty Drugs," Texas Health and Human Services, Retrieved from: https://www.txvendordrug.com/formulary/specialty-drugs.

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.

Recommendation #7: Evaluate pharmacy trends at the therapeutic class level

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

In conjunction with the previous recommendation, 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.

APPENDIX D: STAR+PLUS

PROGRAMMATIC ADJUSTMENTS

We gained a detailed understanding of the Commission's FY 2023 programmatic adjustment development approach used for the STAR+PLUS program based on a review and analysis of the FY 2023 programmatic adjustment development, in conjunction with the Commission's responses to our programmatic adjustment review questions. Our review approach varied based on the assessed risk of each adjustment. For a full description of the approach used to review the programmatic adjustments, as well as a high-level description of the regulatory and policy authority to be followed in the development of the programmatic adjustments, please see Review Process section of the Main Report.

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 2023 NEMT programmatic adjustments to become comfortable in the context of overall rate soundness.

Description of State Fiscal Year (FY) 2023 Programmatic Adjustment Development

The Commission developed and applied programmatic adjustments separately for each itemized change as applicable to the FY 2023 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 2023

Programmatic Adjustment Factor Development Approach

The Commission applied 30 programmatic adjustments specific to this program in the FY 2023 capitation rate development, including:

- 20 adjustments to the medical rate component.
- 7 adjustments to the pharmacy rate component.
- 3 adjustments to the NEMT rate component.
- In the development of the community rates, the Commission developed all 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 2023 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 carve-out of certain drugs.
  - Other changes, such as PHE related changes, nursing facility risk group classification change, regulatory required changes (IMD long-stay removal), and targeted managed care efficiency adjustments.

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.
- Medical and pharmacy costs for hemostatic drugs.
- Pharmacy costs for Hepatitis C drugs.

The Commission used different methodologies to address the PHE related cost adjustment, as noted below:

- PHE related cost adjustment (medical (separated between acute care and LTC care) and pharmacy components).
  - The Commission estimated the impact of the PHE on program costs by comparing actual monthly costs per member in March – August 2021 (net of COVID-related costs) to expected costs during that period. The expected costs were calculated by projecting actual March through August 2019 costs forward two years with assumed trend and programmatic adjustments.
  - The Commission compared actual to expected costs for each 3-month period between March and August 2021 and averaged the ratios to derive the impact of the PHE.
  - The Commission dampened the final PHE impact by 75% to account for an assumption that the PHE will end in October 2022 and will affect costs for one quarter (through November 2022).
  - Table 10 provides an example of the PHE adjustment calculation for the acute care services for Medicaid Only – OCC risk group in Bexar.

Table 10
Texas Medicaid Managed Care Rate Review
STAR+PLUS Program - Programmatic Adjustment Development
FY 2023 Public Health Emergency Adjustment Factor Development

	Actual FY 2019 PMPM Trended for 2 years and Adjusted for Programmatic Changes	Actual FY 2021 PMPM	FY 2021 PMPM / Trended and Adjusted FY 2019 PMPM
March through May	$593.21	$564.21	0.9511
June through August	$585.86	$573.28	0.9785
Average			0.9648
PHE Impact		= 1 - 0.9648	3.52%
Dampened PHE Impact		= 3.52% x .25	0.88%
Final PHE Adjustment Factor		= 1 - 0.88%	0.9912

The Commission's PHE adjustment reduced the acute care services component of the projected FY 2023 costs by 0.88% for this sample risk group / SDA combination.

Data Available 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
- 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 2023 actuarial report.
- The Commission's responses to ad hoc questions from Milliman

Review Conclusions

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.

In this section we include commentary related to the appropriateness of resulting programmatic adjustments. We further categorize our review conclusions into *observations* and *recommendations*.

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.

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.

Several of our conclusions apply to multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

Appropriateness of Resulting Programmatic Adjustment Assumptions

Table 11 summarizes the programmatic adjustment factors used by the Commission to develop the FY 2023 STAR+PLUS program rates 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). The adjustment descriptions in Table 11 are consistent with the titles of the Commission's exhibits in Attachments 5 and 6 of the FY 2023 rate certification.

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Table 11
Texas Medicaid Managed Care Rate Review
STAR+PLUS Program - Programmatic Adjustment Development
Summary of FY 2023 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 Adj - Acute Care*	-1.95%	-13.96%	2.73%	16.69%	Methodology Review
DRG Grouper Revisions	1.26%	0.00%	2.90%	2.90%	Reasonableness
PHE Adj – LTC*	-1.18%	-19.27%	20.17%	39.44%	Methodology Review
Nursing Facility Risk Group Adj	1.03%	-4.98%	19.38%	24.36%	Reasonableness
IMD Adjustment - Medical	-1.00%	-2.98%	0.08%	3.06%	Reasonableness
FQHC Wrap Removal	-0.90%	-4.48%	0.00%	4.48%	Reconciliation to MCO submissions
Rural Hospital OP Reimbursement	0.72%	0.00%	3.05%	3.05%	Reasonableness
Nursing Facility Reimbursement	0.71%	0.00%	1.71%	1.71%	Methodology Review
Standard Dollar Amount	0.54%	-0.39%	2.73%	3.12%	Reasonableness
QI - PPR	-0.46%	-0.99%	0.00%	0.99%	Reasonableness
Attendant Care Reimbursement	0.19%	0.00%	0.55%	0.55%	Reasonableness
Non-Rural Lab Reimbursement	-0.19%	-0.31%	0.00%	0.31%	Reasonableness
E&M Reimbursement	0.18%	0.00%	0.34%	0.34%	Reasonableness
Radiology Reimbursement	0.17%	0.00%	0.53%	0.53%	Reasonableness
MAT Reimbursement	0.14%	0.00%	0.79%	0.79%	Reasonableness
OP BH Reimbursement	0.13%	0.00%	0.72%	0.72%	Reasonableness
PPC Reimbursement Reduction	-0.08%	-0.47%	0.29%	0.76%	Reasonableness
Hemostatic Drug Carve-out - Medical	-0.04%	-1.18%	0.00%	1.18%	Reasonableness
Invalid CAD Encounters	-0.02%	-1.23%	0.00%	1.23%	Reasonableness
Vaccine Reimbursement	0.02%	0.00%	0.06%	0.06%	Reasonableness
PPR Reimbursement Reduction	0.01%	-0.14%	0.13%	0.27%	Reasonableness
Therapy Reimbursement	0.01%	0.00%	0.10%	0.10%	Reasonableness
ASC/HASC Reimbursement	0.00%	-0.03%	0.00%	0.03%	Reasonableness
Pharmacy Rate Component Programmatic Adjustments					
Hepatitis C Drug Carve-Out	-2.55%	-4.52%	0.00%	4.52%	Reasonableness
Hemostatic Drug Carve-Out - Rx	-1.70%	-6.69%	0.00%	6.69%	Reasonableness
PHE Related Cost Adj – Rx*	-1.67%	-15.95%	9.54%	25.49%	Methodology Review
PDL Changes	-0.37%	-0.71%	0.16%	0.87%	Reasonableness
NF Eligibility Changes - Rx	0.10%	-4.01%	2.50%	6.51%	Reasonableness
IMD Adjustment - Rx	-0.06%	-0.35%	0.00%	0.35%	Reasonableness
Other NF Risk Group Adj	0.00%	-4.98%	19.38%	24.36%	Reasonableness
NEMT Rate Component Programmatic Adjustments					
PHE Related Cost Adj - NEMT*	-13.91%	-16.73%	-9.40%	7.33%	Reasonableness
Mileage Reimbursement	0.58%	0.00%	6.43%	6.43%	Reasonableness
TNC Adjustment	0.27%	-0.05%	0.61%	0.66%	Reasonableness

** 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.*

Table 11 shows 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 straightforward 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 the STAR+PLUS program. Therefore, we cannot offer a definitive assessment of the programmatic adjustments used by the Commission to develop the FY 2023 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 the programmatic change's impact across risk groups and SDAs

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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
- Use of actual vs expected analysis with emerging FY 2021 data to estimate PHE related impact
- Developing programmatic adjustments at the risk group and SDA level

We note the following observations related to the STAR+PLUS program:

Observation #1: Reimbursement changes are included as programmatic adjustments, regardless of their materiality

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

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. This 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 #2: The FQHC wrap payment removal relies on base data aggregation using projected enrollment

Applicable program(s): STAR, Dental, STAR+PLUS, STAR Kids

As described in the Base Data Development section of this Appendix, the Commission excluded FQHC wrap payment costs from the capitation rate development because MCOs 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, as noted in the Base Data Development section of this Appendix (Recommendation #4). 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 #3: Programmatic adjustments are not developed at a service category level

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

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. 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 is materially different than the service mix at the SDA level, the MCO's projected FY 2023 costs may not accurately reflect the adjustment for a particular programmatic change.

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 section of this Appendix, one of the benefits of introducing this level of granularity in the development of the capitation rates is to help the State and MCOs 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 "Medicaid Only – Nursing Facility" risk group in Bexar, if the trend assumptions and programmatic adjustments are developed and applied at a detailed category of service level, Table 12 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 12
Texas Medicaid Managed Care Rate Review
STAR +PLUS Program - Programmatic Adjustment Development
Illustrative Programmatic vs. Trend Assumptions Granularity
Bexar Medicaid Only – Nursing Facility Risk Group

Scenario 1: Current Approach: Aggregate Trend and Programmatic Assumptions

Category of Service	Base Period PMPM[1]	Annual Trend Assumption	Acute Care - Inpatient	FY 2023 PMPM[4]
Professional	$320.81	1.041	1.0146	$374.64
Emergency Room	$44.65	1.041	1.0146	$52.14
Outpatient Facility	$73.25	1.041	1.0146	$85.55
Inpatient Facility	$720.80	1.041	1.0146	$841.75
Other Acute Care	$164.88	1.041	1.0146	$192.54
Total	$1,324.38			$1,546.62

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]	Acute Care - Inpatient[3]	FY 2023 PMPM[4]	Difference to Scenario 1
Professional	$320.81	1.030	1.0000	$355.78	-$18.86
Emergency Room	$44.65	1.040	1.0000	$51.22	-$0.92
Outpatient Facility	$73.25	1.070	1.0000	$92.82	$7.27
Inpatient Facility	$720.80	1.040	1.0269	$849.10	$7.35
Other	$164.88	1.053	1.0000	$197.70	$5.16
Total	$1,324.38			$1,546.62	$0.00

Illustrative FY 2023 PMPMs = Base Period PMPM x [Annual Trend Assumption Factor ^ 3.5 years] x Acute Care - Inpatient 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 2023.
[3] Removal of Acute Care - Inpatient if the full adjustment is applied to the Inpatient Facility category of service.
[4] Does not include all programmatic adjustments; only reflects Acute Care - Inpatient for illustrative purposes.

Observation #4: The PHE related cost adjustment uses the same formulaic approach across all Medicaid populations, which may not produce reasonable results for all risk groups

Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids

The PHE adjustment applied by the Commission in the development of the FY 2023 capitation rates uses a formulaic approach to review actual versus expected PMPMs from March 2021 to August 2021 at a risk group and SDA level. The Commission calculates the expected PMPM as March 2019 to August 2019 claims trended for two years and adjusted for programmatic changes, as described earlier in this section. Based on this analysis, as well as experience we have observed in other states during the PHE, some populations are more insulated from the impact of the PHE on a PMPM basis due to the underlying acuity of the population or the type of services that these populations utilize.

The overall approach taken by the Commission to estimate the impact on costs during the PHE is reasonable and comparable to how this adjustment has been calculated in other states. Due to the changes in enrollment and service utilization occurring throughout the PHE, the Commission's decision to use the last six months of available experience to evaluate the impact of the PHE for the purpose of projecting its impact to FY 2023 rates is reasonable. However, calculating the adjustment at a risk group and SDA level can introduce normal fluctuations in this more granular level of data, particularly when developing the adjustment using six months of data.

The Commission may consider whether the results from this formulaic adjustment are reasonable based on expected PHE impacts and not inadvertently skewed by observed differences in experience versus assumed trend, programmatic changes, or other non-PHE related variances (e.g., credibility issues due to using only six months of data in smaller SDAs).

Recommendations

We note the following recommendations related to the STAR+PLUS program:

Recommendation #1: 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

In Section 42 CFR § 438.6(e),[17]438.6(e), the State may make a monthly capitation payment to MCOs for a member aged 21 through 64 who receives inpatient treatment at 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.

Recommendation #2: Calculate the nursing facility COVID-19 add-on impact gross of patient liability

Applicable program(s): STAR+PLUS

Annual payment for nursing facility claims for the risk group "dually eligible nursing facility" accounts for about $2 billion dollars under this program during the base period. During the PHE, the State increased the nursing facility daily rate schedule by a uniform add-on amount of $19.63 for all claims, resulting in approximately a $285 million annual increase to nursing facility reimbursement, based on Milliman's calculation using the detailed encounter data provided by the Commission by multiplying reported units in the encounters with the daily add-on amount. The applicable impact to FY 2023 rates for this risk group is about $33 million using the Commission's estimated end of the PHE on October 13, 2022.

APPENDIX D: STAR+PLUS

Based on the working file and explanations provided by the Commission for the calculation of nursing facility reimbursement changes, the calculation assumes that the percentage of costs paid by the MCO will remain the same between the base nursing facility daily rates and the COVID-19 enhanced daily rates. However, even though the gross daily rate paid to the nursing facilities increases each individual's patient liability will not change as their patient liability amount is dependent upon their personal income and not what the nursing facility rates are. Therefore the MCO's costs, the gross nursing facility costs net of patient liability, will not change at the same rate as the daily rates. Table 13 illustrates the difference in approaches assuming a hypothetical gross nursing facility rate of $150 and patient liability equal to 15% of the gross cost.

Table 13
Texas Medicaid Managed Care Rate Review
STAR+PLUS Program - Programmatic Adjustment Development
Illustrative Calculation - Nursing Facility

Nursing Facility Per Diem	$150.00	A
Patient Liability	$22.50	B
Nursing Facility Per Diem, Net of Patient Liability	$127.50	C = A - B
COVID-19 Add-On	$19.63	D
Enhanced Per Diem, Net of Patient Liability	$147.13	E = A + D - B
Appropriate NF Reimbursement Adjustment	1.154	F = E / C
NF Reimbursement Adjustment calculated using the Commission's approach	1.131	G = (A + D) / A

While the dollar impact of this miscalculation is approximately $5 million which might not be significant for FY 2023 rates, since the nursing facility rate increase will be only effective through the expiration date of PHE, which is currently assumed by the Commission to be October 13, 2022, the dollar impact on FY 2023 rates will increase if the PHE is extended.

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NON-BENEFIT EXPENSES

We examined the Commission's FY 2023 non-benefit expense development approach used for the STAR + PLUS program. We relied on 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 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 2023 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 Review Process in the Main Report.

Description of State Fiscal Year (FY) 2023 Non-Benefit Expense Development

Our detailed understanding of the non-benefit expense development for FY 2023 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 14
Texas Medicaid Managed Care Rate Review
STAR+PLUS Program - Non-Benefit Expense
FY 2023 Non-Benefit Expense Assumption Development

Service Grouping	Medical	Pharmacy	NEMT
Administrative Expenses	$12.00 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 $12.00 PMPM medical administrative expense load as follows:

- $10.00 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 Available 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 summary

- 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 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[16] and maintenance taxes.[17]

Review Conclusions

Within the scope of our review, we reviewed 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.

In this section we include commentary related to the appropriateness of resulting non-benefit expense adjustments. We further categorize our review conclusions into observations and recommendations.

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.

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.

Several of our conclusions apply to multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

Reasonableness of Resulting Non-Benefit Expense Assumptions

Per the Commission's administrative expense review, the FY 2023 program-wide administrative allowance (net of taxes and fees) in the capitation rates for medical and pharmacy is $81.00 PMPM, excluding service coordination costs. 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 2023 administrative expense load for the medical and pharmacy components to historical program-wide administrative expenses PMPM reported by the MCOs. The FY 2023 program-wide assumption appears to be generally consistent with average MCO experience from FY 2018 through FY 2019. The administrative expense PMPM decreased in FYs 2020, 2021, and 2022.

MCOs in many states are reporting emerging increases in administrative costs due to increases in wages and general inflation. The Commission noted that the current formula provides a reasonable allowance to address MCO concerns regarding these increasing costs. However, as noted above, the program-wide FY 2023 assumption of $81.00 PMPM is consistent with actual pre-PHE administrative costs, so it may not explicitly account for both an increase in wages and general inflation and the expected reduction in enrollment following the expiration of the PHE. Table 15 below shows the historical administrative expenses PMPM from the Commission's FY 2023 STAR+PLUS program rate certification.

[16] "Insurance Premium Tax (Licensed Insurers)," Texas Comptroller of Public Accounts, Retrieved from: https://comptroller.texas.gov/taxes/insurance/licensed.php.

[17] "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.

Table 15 Texas Medicaid Managed Care Rate Review STAR+PLUS Program - Non-Benefit Expense Development Historical Medical and Pharmacy Administrative Expense PMPM	
FY 2017	$82.39
FY 2018	$84.39
FY 2019	$76.86
FY 2020	$71.17
FY 2021	$75.86
FY 2022	$76.38
6 Year Average	$77.84

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 2021 research report[18] shows the actual administrative PMPMs net of taxes and fees for calendar year 2021 across the country. These PMPMs include all types of managed care programs, including those with lower acuity populations than the STAR+PLUS program population. We would expect the STAR+PLUS program to be near the higher end of the range due to the average expected acuity of enrollees. The actual administrative PMPMs net of taxes and fees for calendar year 2021 for 80% of managed care organizations included in the report (between the 10th and 90th percentiles) were between $24.64 and $55.93.

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 to cover the uncertain costs related to provide defined benefits and administration duties as specified in the MCO contracts under fixed capitation rates. Nationally, the risk margin assumptions range from 1.0% to 2.0% for most comprehensive Medicaid managed care programs. The Commission's explicit risk margin of 1.75% is within the reasonable range and deemed to be appropriate for the covered population and covered benefits within this program.

The experience rebate adjustments discussed in Rate Structure section of this Appendix provide some protection to the Commission if actual experience in FY 2023 deviates substantially from projected costs reflected in the capitation rates. Despite the uncertainty regarding the PHE and current market conditions, we do not have material concerns regarding the FY 2023 non-benefit expense assumptions given the existence of broader risk mitigation mechanisms (e.g., the experience rebate adjustments).

Observations

The following approaches used by the Commission's contracted actuary for the development of prospective non-benefit expense assumptions are consistent with generally accepted 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

[18] "Medicaid Managed Care Financial Results for 2021," Milliman Research Report, Retrieved from: https://jp.milliman.com/-/media/milliman/pdfs/2022-articles/7-8-22_medicaid-managed-care-financial-results-2021.ashx.

APPENDIX D: STAR+PLUS

We note the following observations related to the STAR+PLUS program:

Observation #1: Administrative expense assumptions are developed separately for the medical, pharmacy, and NEMT rate components

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

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.

Observation #2: 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

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 35% 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. 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.

Recommendations

We note the following recommendations related to the STAR+PLUS program:

Recommendation #1: Include supporting documentation for the development of the administrative costs

Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids

As noted above, the administrative costs assumptions applied by the Commission in the FY 2023 capitation rates appear reasonable compared to historical program experience; however, it is not clear how the Commission determined the specific parameters used in the administrative assumption formulas. We recommend the Commission expand their documentation to include additional documentation so that CMS or another actuary could reasonably understand the development of these parameters.

Recommendation #2: Review administrative allocations across risk groups to remove incentives to enroll higher cost risk groups

Applicable program(s): STAR+PLUS

The variable component of general administration accounts for approximately 55% 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. Under the current approach, this component was funded through capitation rates for all risk groups on a uniform percentage. Because capitation rates are significantly higher for NF risk groups as compared to HCBS risk groups, due to the underlying benefit cost differences, this approach results in a significantly higher general administration load on a PMPM basis in the capitation rates for NF risk groups than HCBS risk groups. Similar to the unintended financial incentives created by the funding approach for service coordination, this approach essentially creates an unintended financial mechanism for MCOs to promote institutional placement rather than community placement. While it is commonly seen for general administration to be loaded in the capitation rates using a uniform percentage basis for acute care programs, this approach does not work for long term care program. Based on our experience developing this rate component for other States for similar long term care programs, the common approach is to use a higher percentage for HCBS risk group and a lower percentage for NF risk group in order to remove those unintended financial incentives otherwise introduced under a uniform percentage approach.

APPENDIX D: STAR+PLUS

To better align program goals of promoting community placement and the strategic financial incentives built into the capitation rates, we recommend the Commission revise the administrative cost assumptions to use different variable administrative percentages by risk group resulting in reasonable administrative costs allocations included at a risk group level.

APPENDIX D: STAR+PLUS

CMS COMPLIANCE AND DOCUMENTATION

We reviewed the Commission's FY 2023 rate certification for compliance with the CMS 2022-2023 Medicaid managed care rate setting guidance.[19] 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 2022-2023 Medicaid managed care rate setting guidance and provided sufficient documentation to comply with actuarial standards of practice. We reviewed the CMS 2022-2023 Medicaid managed care rate setting guidance and compared them against what the Commission submitted in their Medicaid managed care capitation rate certification for the STAR+PLUS 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) 2023 CMS Compliance and Documentation

Section I. Medicaid Managed Care Rates

The Commission has answered all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2022-2023 Medicaid managed care rate setting guidance.

Data - The Commission has answered all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2022-2023 Medicaid managed care rate setting guidance.

Projected Benefit Costs and Trends - The Commission has answered all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2022-2023 Medicaid managed care rate setting guidance.

Special Contract Provisions Related to Payment - The Commission has answered 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 2022-2023 Medicaid managed care rate setting guidance.

Projected Non-Benefit Costs - The Commission has answered all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2022-2023 Medicaid managed care rate setting guidance.

Risk Adjustment and Acuity Adjustments - The Commission has answered all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2022-2023 Medicaid managed care rate setting guidance.

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

The Commission has answered all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2022-2023 Medicaid managed care rate setting guidance.

Section III. New Adult Group Capitation Rates

This section is not applicable to the STAR+PLUS program.

Data available for CMS Compliance and Documentation Review

The Commission provided us with the final FY 2023 rate certification report for the STAR+PLUS program. We relied on this document as well as the publicly available CMS 2022-2023 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.

[19] 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.

APPENDIX D: STAR+PLUS

Review Conclusions

We categorize our review conclusions into *observations* and *recommendations*.

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.

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.

Several of our conclusions apply to multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

Observations

We note the following observations related to the *STAR+PLUS* program:

Observation #1: Supporting documentation does not clearly indicate that IMD costs are removed but associated member months remain

Applicable program(s): STAR, STAR+PLUS

In 42 CFR § 438.6(e),[18] 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.

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.

Observation #2: Supporting documentation indicates pharmacy trends are set by drug type, which is inconsistent with the actual methodology used

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

The FY 2023 STAR+PLUS report describes the pharmacy trend development as follows:

> *The STAR+PLUS pharmacy trend assumptions for the period March 2020 through FY2023 were developed by risk group using the following formula. For each risk group / drug type combination, the utilization and cost per service trend assumptions were set equal to one sixth of the experience trend rate for the 12-month period ending February 2018 plus two sixths of the experience trend rate for the 12-month period ending February 2019 plus three sixths of the experience trend rate for the 12-month period ending February 2020. The final cost trend assumptions were then determined by applying the assumed utilization and cost per service trends by individual drug type to actual experience for the 12-month period ending February 2020 and combining the results into a single trend assumption for each risk group.*

[18] 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 Commission developed separate trends at the drug type and utilization / unit cost level, without adjustment for historical PDL changes, and included these calculations in the rate certification. However, these trends were not used to determine the final trend, nor were they used in the final rate development.

The Commission's actual trend development for the FY 2023 capitation rates set the trend assumption by calculating the historical annual PMPM trend for each risk group, adjusted for historical PDL changes. The Commission's final trend assumption for each risk group was set equal to one sixth of the experience PMPM trend rate for the 12-month period ending February 2018 plus two sixths of the experience PMPM trend rate for the 12-month period ending February 2019 plus three sixths of the experience PMPM trend rate for the 12-month period ending February 2020.

As illustrated in the Trend section of this Appendix, the difference between the approach described in the Commission's rate certification and the Commission's actual approach can produce materially different results in some instances, particularly for risk groups where the mix between drug types is shifting. We recommend that the Commission describes the trend development in the rate certification in a manner that is consistent with the actual methodology used to develop the trend assumptions.

Recommendations

We note the following recommendations related to the STAR+PLUS program:

Recommendation #1: Include supporting documentation for the development of the administrative costs
Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids

The rate certification includes the following information to support the administrative costs included in the FY 2023 capitation rates:

- Fixed and variable administrative costs assumptions by rate component (medical, pharmacy, and NEMT)
- The total administrative costs in the total program on a PMPM calculated by adding the amounts for each rate component
- Historical PMPM program administrative costs (excluding NEMT, which was added to the STAR program effective July 1, 2021)

The Commission noted in the rate certification that the administrative costs are developed from historical Financial Statistic Reports and the Commission believes the resulting administrative costs for FY 2023 are reasonable compared to historical program experience. However, the rate certification does 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:

- Base period experience
- Trend assumptions
- Population adjustments, if applicable
- Allocation methodology between fixed and variable administrative costs
- 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

APPENDIX D: STAR+PLUS

Recommendation #2: The Commission should reconcile actual patient liability amounts compared to rating assumptions for each MCO

Applicable program(s): STAR+PLUS

As noted in the Rate Structure section of this Appendix, the Medicaid Rating Checklist, Section AA.3.13[21] 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.

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, there is not 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.

We recommend the rate structure be reviewed to follow one of the two commonly used approaches outlined above based upon the availability of patient liability data.

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

Exhibit D-1
Texas Medicaid Managed Care Rate Review
STAR+PLUS Program - Base Data Review
Reconciliation of Bexar SDA Across All MCOs

Table 1: Raw Base Period (3/1/2019 - 2/29/2020) Enrollment and Expenditure Data As Reported

Risk Group	Enrollment	Acute_FFS	LTC_FFS	Rx_FFS	Capitation	Net Reinsurance	Other Medical Expenditures	Other Pharmacy Expenditures	TPR (Medical)	TPR (Rx)	Total Benefit Costs	TPR Reported But Not Used: TPR - Medical
Dual Eligible - HCBS	33,168	$1,290,734	$58,868,477	$330,525	$15,899	$71	$169,139	-$2,844	-$28,946	-$63,052	$60,613,171	-$380,382
Dual Eligible - OCC	196,154	$1,651,843	$63,881,906	$924,706	$29,457	$398	$582,039	-$3,366	-$86,568	-$309,690	$66,866,879	-$2,746,692
Dual Eligible - Nursing Facility	38,939	$619,508	$148,091,968	$60,853	$20,503	$113	$28,342,818	-$11,716	-$73,643	-$52,597	$177,036,745	-$505,215
IDD >21	20,906	$8,952,763	$148,506	$11,644,533	$61,763	$3,368	$546,966	-$121	-$640	-$49,643	$21,328,401	-$188,645
MBCCP	4,343	$9,479,163	$167,578	$3,017,965	$52,585	$948	$554,723	-$179	-$750	-$9,107	$13,267,268	-$30,852
Medicaid Only - HCBS	26,033	$41,144,408	$45,097,443	$28,296,217	$694,384	$8,996	$1,507,991	-$2,871	-$12,496	-$49,602	$116,710,503	-$207,370
Medicaid Only - OCC	221,343	$142,821,721	$44,866,635	$110,923,713	$3,015,014	$60,058	$9,114,188	-$5,529	-$36,910	-$419,191	$310,561,041	-$2,543,562
Medicaid Only - Nursing Facility	7,029	$11,316,156	$29,988,819	$5,414,271	$22,361	$3,986	$5,907,049	-$2,596	-$12,282	-$10,788	$52,634,005	-$85,305
Total	**547,915**	**$217,276,296**	**$391,111,332**	**$160,612,783**	**$3,911,966**	**$77,939**	**$46,724,913**	**-$29,223**	**-$252,236**	**-$963,672**	**$819,018,012**	**-$6,688,023**

Table 2: Data Adjustments

Risk Group	Enrollment	Acute_FFS	LTC_FFS	Rx_FFS	Capitation	Net Reinsurance	Other Medical Expenditures	Other Pharmacy Expenditures	TPR (Medical)	TPR (Rx)	Total Benefit Costs
Dual Eligible - HCBS		-$1,290,734	$1,310,820	-$330,525	-$11,970	$0	$14,265	$2,844	$17,087	$63,052	-$305,299
Dual Eligible - OCC		-$1,651,843	$1,573,979	-$924,706	-$7,078	$0	$14,615	$3,366	$72,632	$309,690	-$991,667
Dual Eligible - Nursing Facility		-$619,508	$629,730	-$60,853	-$14,306	$0	-$28,208,896	$11,716	$25,307	$52,597	-$28,262,116
IDD >21		-$879,289	-$148,506	$0	-$56,493	$0	-$478,193	-$107,147	$135	-$30,155	-$1,669,628
MBCCP		-$810,613	$0	$0	$117,129	$0	-$688,491	-$22,415	$0	-$7,586	-$1,404,390
Medicaid Only - HCBS		-$5,074,918	$0	$0	-$514,904	$0	-$1,110,341	-$124,037	$515	-$42,391	-$6,824,200
Medicaid Only - OCC		-$19,334,421	$0	$0	-$1,522,063	$0	-$8,768,581	-$1,027,675	$14,252	-$336,106	-$30,652,740
Medicaid Only - Nursing Facility		-$2,023,470	$0	$0	-$18,816	$0	-$5,865,291	-$27,020	$1,338	-$9,770	-$7,934,597
Total		**-$31,684,794**	**$3,366,023**	**-$1,316,084**	**-$2,028,500**	**$0**	**-$45,090,914**	**-$1,290,367**	**$131,266**	**-$668**	**-$78,044,637**

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

Risk Group	Enrollment	Acute_FFS	LTC_FFS	Rx_FFS	Capitation	Net Reinsurance	Other Medical Expenditures	Other Pharmacy Expenditures	TPR (Medical)	TPR (Rx)	Total Benefit Costs
Dual Eligible - HCBS	33,168	$0	$60,179,296	$0	$3,929	$71	$183,404	$0	-$11,859	$0	$60,354,842
Dual Eligible - OCC	196,154	$0	$65,455,886	$0	$22,380	$398	$596,653	$0	-$13,937	$0	$66,061,380
Dual Eligible - Nursing Facility	38,939	$0	$148,721,698	$0	$6,197	$113	$133,922	$0	-$48,335	$0	$148,813,595
IDD >21	20,906	$8,073,474	$0	$11,644,533	$5,270	$3,368	$68,773	-$107,267	-$505	-$79,798	$19,607,848
MBCCP	4,343	$8,668,550	$167,578	$3,017,965	$169,713	$948	-$133,769	-$22,594	-$750	-$16,693	$11,850,949
Medicaid Only - HCBS	26,033	$36,069,490	$45,097,443	$28,296,217	$179,480	$8,996	$397,650	-$126,908	-$11,981	-$91,993	$109,818,394
Medicaid Only - OCC	221,343	$123,487,300	$44,866,635	$110,923,713	$1,492,951	$60,058	$345,607	-$1,033,204	-$22,658	-$755,297	$279,365,104
Medicaid Only - Nursing Facility	7,029	$9,292,686	$29,988,819	$5,414,271	$3,545	$3,986	$41,758	-$29,617	-$10,944	-$20,559	$44,683,946
Total	**547,915**	**$185,591,502**	**$394,477,355**	**$159,296,699**	**$1,883,465**	**$77,939**	**$1,633,999**	**-$1,319,590**	**-$120,970**	**-$964,340**	**$740,556,059**

Footnotes:

1. *In Table 1, enrollment data was calculated based on the March 2022 caseload file as 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_FFS, LTC, FFS and Rx_FFS) was calculated based on the monthly expenditure data as reported in SFY20-21 MCO supplemental data report with runout through February 2022*
4. *In Table 1, base period non-lag expenditure data (Capitation, Net Reinsurance Cost, Other Medical and Pharmacy Expenditures, and TPR) was calculated using a composite of the first six-month (3/1/2019-8/31/2019) expenditure data as reported in SFY19-20 (9/1/2018-8/31/2020) MCO supplemental data report with runout through February 2021 and the second six-month (9/1/2019-2/29/2020) expenditure data as reported in SFY20-21 (9/1/2019-8/31/2021) MCO supplemental data report with runout through February 2022*
5. *In Table 1, 'Other Medical Expenditures' is net of reported quality improvement expenditures to the extent applicable as we reviewed this component with the service coordination component and the administrative cost component of the rates.*
6. *In Table 2, the primary drivers of the data adjustments are UHRIP, UHRIP-QIF, and QIPP State directed payments; FQHC wrap payments; and outpatient pharmacy expenditures for dual members*

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 169,000 beneficiaries in FY 2023 at a program cost of roughly $4.2 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 2023 capitation rate development for the STAR Kids program by reviewing the actuarial report and rate development model created by the Commission. For a high-level description of the regulatory and policy authority to be followed when designing the rate structure of a program, please see the Review Process section in the Main Report.

Description of State Fiscal Year (FY) 2023 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 2023 rates:

- Step One: Develop MCO-specific FY 2023 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 2023 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)

APPENDIX E: STAR KIDS

A review of the development of directed payment programs is not included in the scope of our review of the FY 2023 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 2023, 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 4.6% of revenues.

Table 1
Texas Medicaid Managed
STAR Kids Program – Rate Structure
FY 2023 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%	0%	100%
> 7% and ≤ 9%	0%	100%
> 9% and ≤ 12%	0%	100%
> 12%	0%	100%

Review Conclusions

We categorize our review conclusions into *observations* and *recommendations*.

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.

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.

Several of our conclusions apply to multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

Observations

We note the following observations related to the STAR Kids program:

Observation #1: Rates are developed individually by MCO rather than across all MCOs
Applicable program(s): STAR, STAR Kids

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

The Commission notes this 108% cap is intended to limit the ability of a lower-cost MCOs from benefiting excessively from the higher community rate while still incentivizing the efficient provision of services since those affected MCOs will ultimately receive rates that are approximately eight percent higher than their projected costs. While the intent is understandable, the Commission may consider accomplishing this goal at MCO level through the existing experience rebate mechanism rather than at an individual risk group level, which introduces risks to the actuarial soundness of rates.

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Recommendations

We note the following recommendations related to the STAR Kids program:

Recommendation #1: Consider consolidating SDAs for the purpose of rate development
Applicable program(s): STAR, STAR+PLUS, STAR Kids

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.

Recommendation #2: Consider combining risk groups to enhance credibility and reduce annual volatility
Applicable program(s): STAR Kids

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 as used by 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 program with a total enrollment of around 1.9 million member months (i.e., equivalent to a monthly average of approximately 158,000 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 were developed using likely not fully credible experience, the overall funding risks at program level increased to both the State and the MCOs as community rates developed using not fully credible experience are generally subject to higher pricing risks. In addition, each community rate for this program was first developed at a more granular level as described above (Step one under Rate Development Process) using MCO level experience which has even lower credibility. As a result, additional pricing and funding risks were introduced to both the State and the MCOs for this program.

The following table summarizes the average enrollment associated with each risk group and SDA combination.

Table 2
Texas Medicaid Managed Care Rate Review
STAR Kids Program – Rate Structure
March 2019 through February 2020 Average Enrollment

	MDCP	IDD	YES*	Under Age 1*	Ages 1-5	Ages 6-14	Ages 15-20
Bexar	556	440	107	109	1,425	6,664	4,546
Dallas	918	665	118	181	2,130	10,330	6,772
El Paso	116	92	16	31	571	2,432	1,639
Harris	1,309	1,095	224	304	3,965	17,918	11,816
Hidalgo	250	265	249	88	2,135	11,498	6,907
Jefferson	147	87	65	26	482	2,402	1,646
Lubbock	121	102	20	27	376	1,543	1,043
Nueces	71	106	39	34	528	2,519	1,888
Tarrant	772	609	161	109	1,425	6,501	4,327
Travis	394	473	149	56	741	3,147	2,136
Central	237	181	53	45	849	4,512	2,965
Northeast	407	283	89	51	1,015	5,179	3,519
West	207	206	75	37	701	3,286	2,275

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

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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) 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 (Step one under Rate Development Process) and then aggregating them together using projected enrollment mix across MCOs to create community rate by SDA an risk group (Step two under Rate Development Process), we recommend the use of combined MCO base experience as the base data for community rate development.

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BASE DATA DEVELOPMENT

We gained a detailed understanding of the Commission's FY 2023 base data development approach used for the STAR Kids program based on a detailed review and replication of FY 2023 base data development for Harris, the sample Service Delivery Area ("SDA"), in conjunction with the Commission's responses to our base data review questions. 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 of the Main Report.

Description of State Fiscal Year (FY) 2023 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 2023 capitation rate setting process:

Base Data Selection

- The Commission selected the most recent 12-month period (March 2019 through February 2020) prior to the COVID-19 public health emergency as the base period for both the enrollment data and the service expenditure data. Other than the carve-in of NEMT services as previously provided by MTOs or FFS, the populations and services covered by the STAR Kids program during FY 2023 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

  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 2023.

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- The Commission reconciled MCO reported supplemental data to the MCO reported Financial Statistical Reports ("FSR") expenditures for overall consistency in aggregate across all risk groups at the MCO and SDA level for the base period (March 2019 through February 2020). 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 2019 and FY 2020 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 expenditure" in this report, the Commission made the following explicit adjustments:

  - The paid expenditures as of February 2022 for the base period (March 2019 through February 2020) were adjusted for claims which have been incurred but not reported ("IBNR"). Please note, the IBNR assumption by the Commission is $0 given there is 24 months of additional payment runout in the data.

  - 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.

[3] Medicaid & CHIP Financial Statistical Reports: Fiscal Year 2020: Sept. 1, 2019, to May 31, 2020, Texas Health and Human Services, Retrieved from: Medicaid & CHIP Financial Statistical Reports | Texas Health and Human Services.

    - The Commission capped reported net reinsurance costs to be no greater than $2.00 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, and are therefore, not included in the base data development.

    - Pharmacy Benefit Manager ("PBM") discount and rebate settlements were deducted by the Commission in the base data development. These adjustments were not reported through the MCO supplemental data but were based on information provided separately to the Commission.

- 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 TPR was explicitly noted in Part 4 of the FSR. Otherwise, the Commission assumed the reported reimbursement amounts were already included in the claims and other expenses, so the Commission did not offset other expenditures as reported in the MCO supplemental data by the reported reimbursement amounts.

- 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.

- The Commission did not adjust the base data to remove the impact of any changes in eligibility or covered services between the base period and FY 2023. Instead, the Commission reflected the expected impact of these changes on expenditures 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 2023.

Data Available 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 2019 Final (September 2018 through August 2019) with runout through August 2020.
    - FY 2020 Final (September 2019 through August 2020) with runout through August 2021.

  - MCO supplemental expenditure data:

    - FY 2019 – FY 2020 (September 2018 through August 2020) with runout through February 2021.
    - FY 2020 – FY 2021 (September 2019 through August 2021) with runout through February 2022.

  - The Commission provided summarized monthly enrollment files by each MCO and risk group:
    - Actual enrollment was provided for the period from September 2012 through December 2021.
    - Projected enrollment was provided for the period from January 2022 through August 2027.
- 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 (March 2019 through February 2020).
  - 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 2019 and FY 2020.
- The Commission's documentation of base data development in the FY 2023 actuarial report.
- The Commission's responses to the ad hoc base data review questions from Milliman.

Review Conclusions

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.

In this section we include commentary related to the technical accuracy of the base data development. We further categorize our review conclusions into *observations* and *recommendations*.

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.

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.

Several of our conclusions apply to multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

APPENDIX E: STAR KIDS

Technical Accuracy

The development of the final medical (acute care and LTC) and pharmacy base period data is technically accurate for each risk group and each MCO in the sample SDA. Using the raw enrollment data as reported by the Commission and the raw expenditure data as reported by the MCOs, Milliman was able to replicate the calculation of final base medical and pharmacy base data using the Commission's approach within a margin of rounding difference at the risk group level for the sample SDA. Please refer to the sample SDA base data reconciliation Exhibit E-1 for details.

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 the most recent pre-COVID period (March 2019 through February 2020) as the base period
- Use of validated MCO self-reported expenditure data as the primary base expenditure data
- Use of the MCO financial data (i.e., FSR) and the encounter data for expenditure data validation
- Assumed $0 adjustment for IBNR, given the significant length of paid data runout included in the base period data
- 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 lag-expenditure and non-lag expenditure data, to the extent applicable

We note the following observations related to the STAR Kids program:

Observation #1: Summary-level enrollment data and expenditure data are gathered from separate sources
Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids

The Commission collected summarized base period enrollment data and expenditure data were collected separately from different entities (e.g., the Commission and the MCOs). 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.

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.

Observation #2: There is not a clear process for the treatment of MCO self-reported TPR data
Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

TPR was collected by the Commission as part of the MCO supplemental data as a standalone cost recovery item. In the MCO supplemental data request template and instructions, the Commission did not specifically request information from the MCOs about the nature of these TPRs and whether the reported reimbursement amounts have already been accounted for in expenditures or recoveries reported in other sections of the MCO supplemental data. For the sample SDA reviewed, the three MCOs reported a total of $8.7 million of TPR, but of the Commission did not use any of the $8.7 million to offset the expenditure reported in other sections in the final base calculation. The Commission explained that the decision to include or exclude TPR from the base data development was made based on a manual review of

relevant FSR reporting notes in Part 4 and the expenditure comparison between the FSR and MCO supplemental data. In general, the Commission did not use reported TPR for base data development unless TPR was mentioned in the FSR reporting notes in Part 4. Given the self-reporting nature of the FSRs and potential for incomplete notes, this approach can lead to an artificial inflation of base period expenditures to the extent that TPR was not appropriately noted or included in the FSRs. At a minimum, the Commission may consider obtaining explicit clarifications from the MCOs to inform appropriate treatment of MCO-reported TPR amounts in the base data development, or the Commission may consider adding direct questions to the MCO supplemental data collection template to remove the manual nature of this adjustment and obtain consistent information and reporting from all MCOs.

Observation #3: Net reinsurance costs should not be included in the base data
Applicable program(s): STAR, STAR+PLUS, STAR Kids

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 $2.00 PMPM 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.

Observation #4: 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

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 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.

Recommendations

We note the following recommendations related to the STAR Kids program:

Recommendation #1: Use state encounter data as the primary base data source for expenditure data
Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids

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 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 Kids 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" vs. "non-dual") and risk group assignment changes [other community care ("OCC") vs. home and community-based services ("HCBS") vs. nursing facilities ("NF")]. While encounter data can play a primary role in the base data development, the MCO FSRs and the MCO 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 2022-2023 Medicaid Managed Care Rate Development Guide[4] 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. For the development of the FY 2023 capitation rates, given the base period is March 2019 through February 2020, our understanding is that the detailed encounter data would have been available to use 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 once the Commission returns to using a more recent base period.

Recommendation #2: Use the state capitation payment file as the primary base data source for enrollment data

Applicable program(s): STAR, Dental, STAR+PLUS, STAR Kids

For an established managed care program like STAR Kids, 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 capitation payments. When enrollment is provided without the member level details, i.e., how the Commission provided the enrollment file, such consistency will be at risk.

Recommendation #3: Develop base period for each SDA by weighting each MCO's experience with actual enrollment instead of projected enrollment

Applicable program(s): STAR, Dental, STAR+PLUS, STAR Kids

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[5] 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 reginal 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 2023 enrollment. Based on our understanding from conversations with the Commission, the 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. In addition, the Commission explained that the intent of using projected enrolment 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 3, 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.

If the Commission determines it is appropriate to apply an adjustment to reflect changes between the base period and rating period due to changes in the overall provider contracting levels, the Commission may consider applying this adjustment as a programmatic adjustment so that 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 is normalized out of the trend calculations so that the impact is not double counted in the final capitation rates. The current approach introduces the risk of double counting any persistent historical shifts that may also be reflected in trends, as well as removing cost differences beyond provider reimbursement levels (e.g., underlying differences in member demographics or required levels of care).

[4] "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.

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

Table 3
Texas Medicaid Managed Care Rate Review
STAR Kids Program – Base Data
Difference in SDA-level PMPMs using Base Period Membership vs. Projected Membership Weighting
Medical + Pharmacy Percentage Difference

SDA	Under Age 1	Ages 1-5	Ages 6-14	Ages 15-20	IDD	MDCP	YES	Total
Bexar	-0.74%	-1.25%	-0.03%	-0.09%	-1.50%	0.72%	-1.58%	**-0.03%**
Dallas	0.38%	4.92%	3.95%	1.46%	7.12%	7.11%	6.45%	**4.87%**
El Paso	0.94%	-1.05%	0.08%	0.18%	-3.20%	0.07%	-1.31%	**-0.17%**
Harris	-1.72%	-1.75%	-1.54%	-1.33%	-0.65%	-0.10%	0.35%	**-1.13%**
Hidalgo	0.35%	-0.27%	0.11%	0.03%	-1.48%	4.58%	-0.52%	**0.57%**
Jefferson	2.60%	1.68%	0.06%	-0.94%	0.99%	-0.13%	-0.11%	**0.24%**
Lubbock	15.14%	0.00%	3.71%	-1.61%	-7.28%	1.17%	15.58%	**1.06%**
MRSA Central	5.65%	-0.98%	0.45%	0.24%	-2.66%	-0.20%	2.21%	**-0.08%**
MRSA Northeast	0.22%	-5.59%	-3.76%	-0.09%	-1.59%	-3.36%	-0.63%	**-3.43%**
MRSA West	10.51%	1.39%	-0.10%	0.70%	2.60%	-0.05%	-2.49%	**0.60%**
Nueces	-2.95%	0.43%	0.20%	0.34%	-0.13%	0.49%	0.29%	**0.24%**
Tarrant	-3.82%	2.31%	1.58%	0.51%	-0.35%	0.01%	-0.34%	**0.76%**
Travis	-7.59%	0.40%	-0.10%	-0.03%	-1.18%	-0.05%	-0.46%	**-0.19%**
Total	**-0.50%**	**-0.04%**	**0.12%**	**-0.12%**	**0.24%**	**1.35%**	**0.92%**	**0.38%**

Recommendation #4: Include supporting documentation for the development of the base period data
Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids

The rate certification includes the following information to support the development of the base period data used for the FY 2023 capitation rates:

- Data sources
- High level information about each of the main three data sources: MCO 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:

- The specific use of each of the three data sources in the base data development
- An overview of the Commission's reconciliation processes between the MCO supplemental data and FSRs and whether a different approach is used for lag vs. 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 experience into overall program experience

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TREND

We gained a detailed understanding of the Commission's FY 2023 medical and pharmacy trend development approach used for the STAR Kids program. We relied on underlying data provided by the Commission, as well as responses to our specific trend review questions.

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 2023 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 Review Process section of the Main Report.

DESCRIPTION OF STATE FISCAL YEAR ("FY") 2023 TREND DEVELOPMENT

Our detailed understanding of the trend development for FY 2023 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 years of FFS data prior to the beginning of the STAR Kids program in November 2016 (September 2014 through August 2016) and the 2.5 years of STAR Kids program experience prior to the beginning of the COVID-19 PHE (September 2018 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 2014 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 risk group and month, excluding the following costs:

  - Drugs carved out of managed care for FY 2023 (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 FFS claim payments amounts were adjusted to reflect managed care pharmacy reimbursement provisions. Historical data and calculations were developed separately by drug type (i.e., brand, generic, and specialty) for utilization and unit cost, but the Commission ultimately used the PMPM level data to develop the selected pharmacy trends.

- Adjustment factors for material preferred drug list (PDL) changes from FY 2018 through FY 2020.

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NEMT Trends

- Historical PMPM NEMT managed transportation organization (MTO) claims for demand response services[4] (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 2014 through FY 2016 (prior to transitioning to managed care), FY 2018 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) by risk group for each 12-month period from March 2016 through February 2020.
- The Commission multiplied the statewide incurred pharmacy claims PMPM by the annual PDL adjustment factors. The adjusted PMPMs estimate the 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.

[4] https://www.transit.dot.gov/sites/fta.dot.gov/files/docs/Demand_Response_Fact_Sheet_Final_with_NEZ_edits_02-13-13.pptx

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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 2 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 2019 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 4
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	28.57% = 12 / 42 months
FY 2015	FY 2016	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 trend at the risk group level by weighting the historical annual statewide trends for each risk group as follows:

Table 5
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	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

[1] FFS experience prior to November 2016 was adjusted to reflect managed care pharmacy reimbursement provisions

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 Available for Trend Review

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

- Historical medical claim experience for September 2017 through February 2022 by risk group, SDA and month:
  - Incurred claims in total and PMPM
- Historical pharmacy claim experience for September 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 medical trend development working files for all risk group and SDA combinations:
  - Summarized FY 2014 – FY 2016 FFS PMPM trends (prior to transitioning to managed care)
  - Summarized FY 2018 – FY 2020 managed care PMPM trends
- Trend adjustment factors for the following adjustments:
  - Reimbursement related adjustments
  - Programmatic/benefit related adjustments
- A copy of the Commission's 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 2014 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 2014 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, and
    - For all risk groups combined calibrated to reflect the projected FY 2023 enrollment mix by risk group
  - Calculation of final trends by risk group based on a weighted average of historical annual trends in incurred claims PMPM adjusted for PDL changes
- The Commission's documentation of trend development in the FY 2023 actuarial report.
- The Commission's responses to ad hoc questions

APPENDIX E: STAR KIDS

Review Conclusions

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 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.

In this section we include commentary related to the reasonableness of resulting trend assumptions. We further categorize our review conclusions into *observations* and *recommendations*.

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.

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.
Several of our conclusions apply to multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

Reasonableness of Resulting Trend Assumptions

Medical Trends

The Commission's overall annual prospective PMPM trend at the program level of 6.9% appears to be somewhat high based on our experience working with other states, especially given that the provider reimbursement and other program changes are not accounted for through this trend assumption. 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, so the selected trend may be reasonable based on the unique characteristics of the populations and services included in the program. 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.

We asked the Commission to share any analysis they performed to understand the trend drivers and any of their insights about the local market's trend dynamics so we can assess the appropriateness of assuming that the relatively high historical trend will continue for 3.5 years from the base period through the rating period. The Commission explained that historically there have been two major drivers of the observed 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, however we did not perform an independent analysis to confirm these trend drivers.

We also reviewed the stability of the Commission's trend calculation methodology. Table 6 displays the volatility in observed annual trends by risk group in the medical data based on the commission's development of trend estimates. In general for credible risk groups, the observed annual trends for the time periods included in the trend calculation are consistent and reasonable to use in the analysis.

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Table 6
Texas Medicaid Managed Care Rate Review
STAR Kids - Trend Development
Historical Annual Trend in Total Medical PMPM (Adjusted for Programmatic Changes)

		Risk Groups							
Program	**Year Ending**	**MDCP**	**IDD**	**YES**	**Newborns**	**Ages 1-5**	**Ages 6-14**	**Ages 15-20**	**Total**
FFS	9/13 through 8/14	8.8%	0.6%	96.6%	9.7%	11.7%	8.3%	-6.2%	7.7%
FFS	9/14 through 8/15*	8.3%	11.8%	-7.4%	2.1%	6.2%	4.3%	2.3%	5.8%
FFS	9/15 through 8/16*	5.4%	9.8%	21.6%	3.9%	8.4%	8.9%	3.2%	7.1%
Managed Care	9/17 through 8/18	15.0%	3.6%	-10.5%	28.4%	2.2%	8.3%	5.1%	4.8%
Managed Care	9/18 through 8/19*	10.5%	9.7%	25.2%	42.4%	4.9%	2.6%	8.0%	7.1%
Managed Care	9/19 through 2/20*	8.6%	7.1%	6.1%	-12.3%	9.5%	5.0%	9.9%	8.4%
	Selected Trend	**8.1%**	**10.0%**	**12.1%**	**12.1%**	**6.9%**	**5.2%**	**5.3%**	**6.9%**

**Data included in selected trend*

We did not evaluate the drivers of the historical 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, new alternative treatments for existing conditions, and changes in average member demographics and acuity. Table 6 is 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 assumption.

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, the Commission's overall annual prospective PMPM trend at the program level of 3.8% per year, included in Table 7 below, 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 2023 pharmacy PMPMs were more than 10% higher than any historical pharmacy PMPMs for the MCDP and IDD risk groups, and they were more than 10% lower than any historical pharmacy PMPMs for the YES risk group. The Commission's rate certification and the work files do not include any explanation to support the FY 2023 pharmacy PMPMs for some risk groups being materially higher or lower than historical experience.

We also reviewed the stability of the Commission's trend calculation methodology over time. Although the PHE likely had some impact on pharmacy trends during the PHE, the pharmacy experience for populations, such as STAR Kids have generally been less impacted throughout the PHE for several reasons, including:

- The acuity of these populations has remained more stable due to the eligibility requirements
- Many of the drug costs are attributable to conditions that require timely adherence

Table 7 displays the volatility in observed annual trends by risk group in the pharmacy data provided for our review. The same methodology produces materially different results at a risk group level depending on the years used in the calculation, such as shifting the time periods used as shown in Table 7.

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Table 7 Texas Medicaid Managed Care Rate Review STAR Kids Program - Trend Development Historical Annual Trend in Total Pharmacy PMPM (Adjusted for PDL Changes)								
	Risk Groups							
Year Ending	**MDCP**	**IDD**	**YES**	**Newborns**	**Ages 1-5**	**Ages 6-14**	**Ages 15-20**	**Total**
3/16 through 2/17	6.3%	2.7%	-16.3%	2.5%	10.3%	0.0%	-5.0%	1.1%
3/17 through 2/18*	11.1%	5.1%	-5.8%	41.3%	11.8%	4.7%	9.8%	7.3%
3/18 through 2/19*	21.4%	6.7%	0.0%	3.9%	9.8%	2.4%	5.4%	6.0%
3/19 through 2/20*	4.4%	9.1%	-2.9%	-14.5%	-5.0%	-1.3%	2.2%	1.0%
3/20 through 2/21	8.9%	3.6%	-12.0%	-5.6%	-8.9%	-4.1%	2.6%	0.2%
3/21 through 2/22	12.2%	3.4%	3.0%	34.2%	2.7%	6.1%	0.0%	3.4%
Selected Trend	10.6%	5.9%	-6.5%	6.5%	6.5%	1.4%	3.0%	3.8%
Final Trend if Underlying Years Shift:								
Years of Shift								
1 Year Backward	15.4%	5.5%	-4.7%	16.1%	10.6%	2.7%	5.1%	5.6%
1 Year Forward	9.5%	6.0%	-7.0%	-7.0%	-4.5%	-2.1%	2.9%	1.5%
2 Years Forward	9.8%	4.4%	-3.0%	12.9%	-2.4%	1.5%	1.2%	1.9%

**Data included in selected trend*

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 alternative treatments for existing conditions, and changes in average member demographics and acuity.

Depending on expected changes in drug mix and utilization, it may be reasonable for the FY 2023 pharmacy trends to be higher or lower than previous observed pharmacy trends. Table 7 is 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 appropriateness of the final trend assumption.

NEMT Trends

As noted in the Review Process section of the Main Report, 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.

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 the STAR Kids program:

Observation #1: Prospective medical trends are developed using a purely formulaic approach
Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids

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 2023.

Observation #2: Medical trends are not consistently applied to sub-capitated and service coordination cost

Applicable program(s): STAR, STAR+PLUS, STAR Kids

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 2023 rate development.

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.

For service coordination costs, the primary underlying costs are staffing costs for service coordinators, such as wages and benefits. For FY 2023 rate development, the projection period happens to be in a high inflationary environment where wages and other staffing costs increased significantly

Observation #3: The data source used for quantitative medical trend analysis does not enable more granular analysis

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

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.

Observation #4: 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, Duals

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 and does not reflect the actual time period of the projection.

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 ten years ending February 2020 (based on this typical approach) is 0.9%. The Commission calculated each month's annual trend for the most recent 120 months 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%.

Additionally, the resulting trend is applied to reflect anticipated CPI changes from the base period (March 2019 to February 2020) to FY 2023. It may be more appropriate to use *actual observed* CPI changes from the base period to present day (i.e., March 2022 when setting FY 2023 rates) and then recently observed averages from present day to FY 2023. This approach would ensure historical periods from 5 to 10 years ago are not used at the expense of recent market conditions.

APPENDIX E: STAR KIDS

Recommendations

We note the following observations related to the STAR Kids program:

Recommendation #1: Develop medical trend assumptions at more detailed service category level
Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

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:

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

In the capitation rate setting, 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 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 keep 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.

Recommendation #2: Develop medical and pharmacy trend assumptions separately by utilization and unit cost component
Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids

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 help validate how historical provider reimbursement changes (that are separately identified in the prior rate development) compare to historical unit cost trends. Such a comparison will provide insights about the provider contracting dynamics at the major service category level. It will also provide an understanding of the drivers of observed recent 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 an actuarially sound manner in the trend development.

The Commission produced an analysis of historical utilization and unit cost trends for pharmacy services, but this analysis was not explicitly used to develop distinct utilization and unit cost trends for the rate development. Other states often select distinct utilization and unit cost pharmacy trends. A more granular approach for selecting trends allows for drug trends that are better aligned with each population's projected costs and program goals.

Recommendation #3: Do not introduce changes in SDA distribution between Year 1 and Year 2 of the calculation when using statewide trend assumptions
Applicable program(s): STAR, STAR+PLUS, STAR Kids

As described above, the Commission followed a generally accepted process to calculate annual medical PMPM trends for each SDA. The Commission then aggregated these SDA trends into a statewide annual PMPM trend using the year 2 aggregate dollars by SDA. The Commission's calculation approach produced a higher result than weighting the SDA trends by the year 1 costs, which would produce the actual historical statewide PMPM trend (alternatively calculated as the one-year trend in statewide PMPM amounts). The selection of year two aggregate dollars places a larger reliance on SDA trends that are higher than the average statewide trend (i.e., an SDA with a higher than average trend receives additional weight due to having higher costs in year two than in year one) and smaller reliance on SDA trends that are

lower than the average statewide trend. As a result, this weighting methodology will always produce a trend that is greater than the actual observed statewide trend unless trends by SDA are identical.

Table 8 summarizes our analysis of the difference between the aggregation approaches (i.e., year 1 costs, year 2 costs) at the risk group level and in total for the STAR program.

Table 8
Texas Medicaid Managed Care Rate Review
STAR Kids - Trend Development
Analysis of Medical Trend Aggregation Approach

	Annualized Trends			
Risk Group	**Aggregated Based on Year 2 Costs (Used for FY 2023 Capitation Rates)**	**Aggregated Based on Year 1 Costs (Actual Historical Statewide Trend)**	**Annual Trend Difference**	**Applied Trend Impact (3.5 years of trend)**
MDCP	8.1%	7.9%	0.2%	0.8%
IDD	10.0%	8.5%	1.5%	6.5%
YES	12.1%	6.6%	5.5%	24.1%
Newborns	12.1%	3.6%	8.5%	36.0%
Ages 1-5	6.9%	6.4%	0.5%	2.1%
Ages 6-14	5.2%	4.9%	0.3%	1.2%
Ages 15-20	5.3%	4.4%	0.9%	3.5%
All Risk Group Combined	**6.9%**	**6.1%**	**0.7%**	**3.0%**

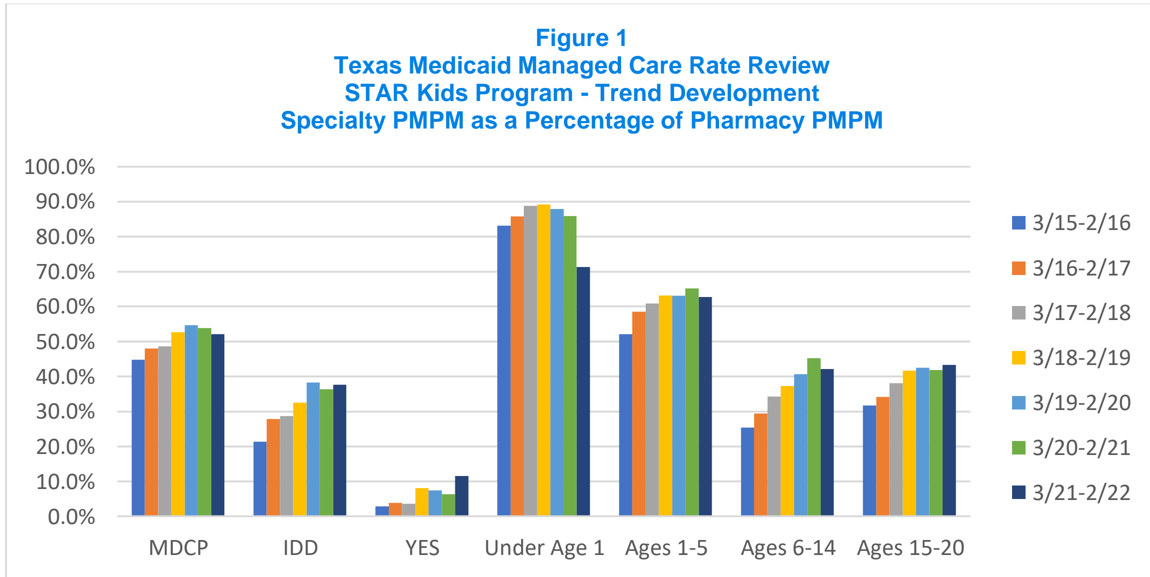
As displayed in Table 8, the Commission's aggregation method (using year 2 costs for the historical statewide trend calculation) results in the overall final prospective annual trend being roughly 0.7% higher than the actual observed historical trend (using year 1 costs). Applying the selected annual trend assumption from the base period (March 2019 through February 2020) to the FY 2023 rating period (i.e., a total of 3.5 years) results in an overall difference of roughly 3.0% between the two aggregation approaches.

We recommend that the Commission composites the trends using the year 1 SDA cost distribution when relying on historical statewide trends to develop prospective trend assumptions. This aggregation methodology will produce the same result as calculating the statewide average historical trend.

Recommendation #4: Develop and apply pharmacy trends by drug type (i.e., Specialty and Non-Specialty)

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

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. Figure 1 shows the historical change in the specialty PMPM included in the trend analysis as a percentage of the total pharmacy PMPM included in the trend analysis (net of the exclusions noted above).



Given the general increase in specialty drug mix in recent years, relying on historical aggregate trends likely understates future trends by undervaluing the impact of higher-than-average specialty drug trends on the current drug mix included in the base period.

To illustrate this, we reviewed the selected FY 2023 pharmacy trends for each risk group relative to estimated one-year trends based on separate specialty / non-specialty trends composited using the base period mix. Table 9 includes the comparison of these two trend approaches.

Table 9
Texas Medicaid Managed Care Rate Review
STAR Kids Program – Trend Development
Estimated Impact of Applying Distinct Trends to Specialty and Non-Specialty Pharmacy Costs

Risk Group	Final FY 2023 Trend	Estimated Composite Trend Based on Distinct Trends[1]	(Under) / Over-Statement of Historical Weighted Trend
MDCP	11.2%	11.7%	(0.5%)
IDD	7.7%	9.0%	(1.3%)
YES	-2.4%	-1.3%	(1.1%)
Under Age 1	0.9%	1.1%	(0.2%)
Ages 1-5	2.7%	2.8%	(0.1%)
Ages 6-14	0.9%	1.7%	(0.8%)
Ages 15-20	4.5%	4.9%	(0.4%)

[1] Based on applying the Commission's historical weighing approach to historical specialty and non-specialty trends separately

Table 9 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.

We note that 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 these two 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 9, 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 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 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.

Recommendation #5: Consider the impact of recently approved and upcoming pipeline drugs for each population

Applicable program(s): STAR, Star Health, STAR+PLUS, STAR Kids

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 2023 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. Examples of some of these drugs that could materially impact program costs include:

- Ubrelvy (approved December 2019) for acute treatment of migraine
- Oxbryta (approved December 2019) to treat sickle cell disease
- Trikafta (approved October 2019) to treat cystic fibrosis

The Commission reimburses the MCOs for certain newly approved drugs through non-risk arrangements, however, the three drugs listed above are not on the non-risk drug payment list[6] as of July 11, 2022 but they are included on either the Texas preferred drug list[7] effective January 27, 2022 or the March 2022 Texas specialty drug list (SDL).[8] Although these drugs were approved during the base period, the base period would reflect a limited amount of claims.

In addition, many oncology drugs have been newly approved or approved for expanded indications since 2019. Each of these drugs alone may not materially impact trends, but the combined impact of these drug approvals has materially increased utilization within the therapeutic class in other states.

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 in the STAR program 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 populations.

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[6] "Vendor Drug Program, Non-Risk Drugs," Texas Health and Human Services, Retrieved from: https://www.txvendordrug.com/resources/managed-care/non-risk-drugs.
[7] "Vendor Drug Program, Preferred Drugs," Texas Health and Human Services, Retrieved from: https://www.txvendordrug.com/formulary/prior-authorization/preferred-drugs.
[8] "Vendor Drug Program, Specialty Drugs," Texas Health and Human Services, Retrieved from: https://www.txvendordrug.com/formulary/specialty-drugs.

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.

Recommendation #6: Evaluate pharmacy trends at the therapeutic class level

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

In conjunction with recommendation #5, 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.

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PROGRAMMATIC ADJUSTMENTS

We gained a detailed understanding of the Commission's FY 2023 programmatic adjustment development approach used for the STAR Kids program based on a review and analysis of the FY 2023 programmatic adjustment development, in conjunction with the Commission's responses to our programmatic adjustment review questions. Our review approach varied based on the assessed risk of each adjustment. For a full description of the approach used to review the programmatic adjustments, as well as a high-level description of the regulatory and policy authority to be followed in the development of the programmatic adjustments, please see Review Process section of the Main Report.

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 2023 NEMT programmatic adjustments to become comfortable in the context of overall rate soundness.

Description of State Fiscal Year (FY) 2023 Programmatic Adjustment Development

The Commission developed and applied programmatic adjustments separately for each itemized change as applicable to the FY 2023 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 2023

Programmatic Adjustment Factor Development Approach

The Commission applied 23 programmatic adjustments specific to this program in the FY 2023 capitation rate development, including:

- 16 adjustments to the medical rate component.
- 4 adjustments to the pharmacy rate component.
- 3 adjustments to the NEMT rate component.
- For the purpose of community rate development, the Commission developed all 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 2023 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 carve-out of certain drugs
  - Other changes, such as PHE related changes and targeted managed care efficiency adjustments

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.
- Medical and pharmacy costs for hemostatic drugs.
- Pharmacy costs for Hepatitis C drugs.

The Commission used different methodologies to address the PHE related cost adjustment, as noted below:

- PHE related cost adjustment (medical and pharmacy components).
  - The Commission estimated the impact of the PHE on program costs by comparing actual monthly costs per member in March through August 2021 (net of COVID-related costs) to expected costs during that period. The expected costs were calculated by projecting actual March through August 2019 costs forward two years with assumed trend and programmatic adjustments.
  - The Commission compared actual to expected costs for each 3-month period between March and August 2021 and averaged the ratios to derive the impact of the PHE.
  - The Commission dampened the final PHE impact by 75% to account for an assumption that the PHE will end in October 2022 and will affect costs for one quarter (through November 2022).
  - Table 10 provides an example of the PHE adjustment calculation for the Ages 6-14 risk group in Bexar.

Table 10
Texas Medicaid Managed Care Rate Review
STAR Kids Program – Programmatic Adjustment Development
FY 2023 Public Health Emergency Adjustment Factor Development

	Actual FY 2019 PMPM Trended for 2 years and Adjusted for Programmatic Changes	Actual FY 2021 PMPM	FY 2021 PMPM / Trended and Adjusted FY 2019 PMPM
March through May	$793.13	$724.41	0.9134
June through August	$842.92	$673.55	0.7991
Average			0.8562
PHE Impact		= 1 – 0.8562	14.38%
Dampened PHE Impact		= 14.38% x .25	3.59%
Final PHE Adjustment Factor		= 1 – 3.59%	0.9641

The Commission's PHE adjustment reduced the projected FY 2023 costs by 3.59% for this sample risk group / SDA combination.

Data Available 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 (included with the trend 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 2023 actuarial report.
- The Commission's responses to ad hoc questions from Milliman.

Review Conclusions

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.

In this section we include commentary related to the reasonableness of resulting programmatic adjustments. We further categorize our review conclusions into *observations* and *recommendations*.

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.

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.

Several of our conclusions apply to multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

Reasonableness of Resulting Programmatic Adjustment Assumptions

Table 11 summarizes the programmatic adjustment factors used by the Commission to develop the FY 2023 STAR Kids program rates 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). The statewide adjustments are included for the Under Age 1 and YES risk groups since the SDA detail level was not used in the final capitation rates. The adjustment descriptions in Table 11 are consistent with the titles of the Commission's exhibits in Attachments 4 and 5 of the FY 2023 rate certification.

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Table 11 Texas Medicaid Managed Care Rate Review STAR Kids Program – Programmatic Adjustment Development Summary of FY 2023 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 Adj*	-4.51%	-13.53%	10.47%	24.00%	Methodology Review
DRG Grouper Revisions	0.75%	0.00%	2.48%	2.48%	Reasonableness
Standard Dollar Amount	-0.69%	-2.11%	0.44%	2.55%	Reasonableness
Therapy Reimbursement	0.52%	0.02%	1.27%	1.25%	Reasonableness
PDN Reimbursement	0.40%	0.00%	0.89%	0.89%	Reasonableness
Removal of FQHC Wrap	-0.38%	-2.72%	0.00%	2.72%	Reconciliation to MCO submissions
QI – PPR Reduction	-0.18%	-0.82%	0.00%	0.82%	Reasonableness
PPR Reduction	-0.13%	-0.56%	0.27%	0.83%	Reasonableness
Hemostatic Drug Carve-out	-0.10%	-2.34%	0.00%	2.34%	Reasonableness
Non-Rural Clinical Lab Reimbursement	-0.09%	-0.32%	-0.01%	0.31%	Reasonableness
Rural Hospital OP Reimbursement	0.08%	0.00%	1.54%	1.54%	Reasonableness
OP BH Reimbursement	0.07%	0.00%	0.44%	0.44%	Reasonableness
E&M Reimbursement	0.06%	0.01%	0.19%	0.18%	Reasonableness
Attendant Care Reimbursement	0.05%	0.00%	0.15%	0.15%	Reasonableness
Invalid CAD Encounters	-0.04%	-5.03%	0.00%	5.03%	Reasonableness
Radiology Reimbursement	0.03%	0.00%	0.20%	0.20%	Reasonableness
PPR Reimbursement	0.02%	-0.09%	0.35%	0.44%	Reasonableness
Vaccine Reimbursement	0.02%	0.00%	0.06%	0.06%	Reasonableness
ASC\HASC Reimbursement Adjustment	0.00%	0.00%	0.04%	0.04%	Reasonableness
Pharmacy Rate Component Programmatic Adjustments					
Hemostatic Drug Carve-out	-9.97%	-32.24%	0.00%	32.24%	Reasonableness
PDL Changes	1.00%	-0.41%	4.20%	4.61%	Methodology review
PHE Related Cost Adj*	-0.91%	-9.09%	14.00%	23.09%	Methodology review
Hepatitis C Drug Carve-out	-0.01%	-0.16%	0.00%	0.16%	Reasonableness
NEMT Rate Component Programmatic Adjustments					
PHE Related Cost Adj*	-14.35%	-18.61%	-7.66%	10.95%	Reasonableness
Mileage Reimbursement	2.68%	0.62%	6.81%	6.19%	Reasonableness
TNC Adjustment	0.06%	0.00%	0.26%	0.26%	Methodology 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.*

Table 11 shows 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 straightforward to isolate and measure. Although some of these adjustments can be material at the risk group level, they have small 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 the STAR Kids program. Therefore, we cannot offer a definitive assessment of the programmatic adjustments used by the Commission to develop the FY 2023 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 the programmatic change's impact across risk groups and SDAs (e.g., the adjustment factor for the Rural Hospital Outpatient should disproportionately impact SDAs in more rural areas of the state)

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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
- Use of actual vs. expected analysis with emerging FY 2021 data to estimate PHE related impact
- Developing programmatic adjustments at the risk group and SDA level

We note the following observations related to the STAR Kids program:

Observation #1: Reimbursement changes are included as programmatic adjustments, regardless of their materiality

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

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. This 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 #2 The FQHC wrap payment removal relies on base data aggregation using projected enrollment

Applicable program(s): STAR, Dental, STAR+PLUS, STAR Kids

As described in the Base Data Development section of this Appendix, the Commission excluded FQHC wrap payment costs from the capitation rate development because MCOs 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 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, as noted in the Base Data Development section of this Appendix (Recommendation #3). 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 #3: Programmatic adjustments are not developed at a service category level

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

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. 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 is materially different than the service mix at the SDA level, the MCO's projected FY 2023 costs may not accurately reflect the adjustment for a particular programmatic change.

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 section of this Appendix, one of the benefits of introducing this level of granularity in the development of the capitation rates is to help the State and MCOs 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 "Ages 15-20" risk group in Bexar, if the trend assumptions and programmatic adjustments are developed and applied at a detailed category of service level, Table 12 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 12
Texas Medicaid Managed Care Rate Review
STAR Kids Program - Programmatic Adjustment Development
Illustrative Programmatic vs. Trend Assumptions Granularity
Bexar Ages 15-20 Risk Group

Scenario 1: Current Approach: Aggregate Trend and Programmatic Assumptions

Category of Service	Base Period PMPM[1]	Annual Trend Assumption	Acute Care Inpatient	FY 2023 PMPM[4]
Professional	$101.38	1.053	0.9909	$120.36
Emergency Room	$13.68	1.053	0.9909	$16.24
Outpatient Facility	$53.26	1.053	0.9909	$63.23
Inpatient Facility	$132.36	1.053	0.9909	$157.14
Other	$86.83	1.053	0.9909	$103.08
Total	$387.50			$460.05

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]	Acute Care Inpatient[3]	FY 2023 PMPM[4]	Difference to Scenario 1
Professional	$101.38	1.060	1.0000	$124.31	$3.95
Emergency Room	$13.68	1.040	1.0000	$15.69	-$0.55
Outpatient Facility	$53.26	1.070	1.0000	$67.49	$4.26
Inpatient Facility	$132.36	1.040	0.9722	$147.61	-$9.53
Other	$86.83	1.056	1.0000	$104.95	$1.87
Total	$387.50			$460.05	$0.00

Illustrative FY 2023 PMPMs = Base Period PMPM x [Annual Trend Assumption Factor ^ 3.5 years] x Acute Care Inpatient 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 2023.
[3] Acute Care - Inpatient if the full adjustment is applied to the Inpatient Facility category of service.
[4] Does not include all programmatic adjustments; only reflects Acute Care - Inpatient for illustrative purposes.

Observation #4: The PHE related cost adjustment uses the same formulaic approach across all Medicaid populations, which may not produce reasonable results for all risk groups

Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids

The PHE adjustment applied by the Commission in the development of the FY 2023 capitation rates uses a formulaic approach to review actual versus expected PMPMs from March 2021 to August 2021 at a risk group and SDA level. The Commission calculates the expected PMPM as March 2019 to August 2019 claims trended for two years and adjusted for programmatic changes, as described earlier in this section. Based on this analysis, as well as experience we have observed in other states during the PHE, some populations are more insulated from the impact of the PHE on a PMPM basis due to the underlying acuity of the population or the type of services that these populations utilize.

The overall approach taken by the Commission to estimate the impact on costs during the PHE is reasonable and comparable to how this adjustment has been calculated in other states. Due to the changes in enrollment and service utilization occurring throughout the PHE, the Commission's decision to use the last six months of available experience

to evaluate the impact of the PHE for the purpose of projecting its impact to FY 2023 rates is reasonable. However, calculating the adjustment at a risk group and SDA level can introduce normal fluctuations in this more granular level of data, particularly when developing the adjustment using six months of data.

The Commission may consider whether the results from this formulaic adjustment are reasonable based on expected PHE impacts and not inadvertently skewed by observed differences in experience versus assumed trend, programmatic changes, or other non-PHE related variances (e.g., credibility issues due to using only six months of data in smaller SDAs).

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

Applicable program(s): STAR, STAR Kids

As shown in Table 11, 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.

- Hemostatic and Hepatitis C carve-outs: These adjustments primarily vary by risk group. Although we did not review drug-level detail, the impact by risk group is reasonable.

Recommendations

We do not have any specific recommendations related to programmatic adjustments for the Star Kids program.

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NON-BENEFIT EXPENSES

We examined the Commission's FY 2023 non-benefit expense development approach used for the STAR Kids program. We relied on 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 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 2023 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 Review Process section in the Main Report.

Description of State Fiscal Year (FY) 2023 Non-Benefit Expense Development

Our detailed understanding of the non-benefit expense development for FY 2023 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 13.

Table 13
Texas Medicaid Managed Care Rate Review
STAR Kids Program - Non-Benefit Expense
FY 2023 Non-Benefit Expense Assumption Development

Service Grouping	Medical	Pharmacy	NEMT
Administrative Expenses	\$15.00 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 \$15.00 PMPM medical administrative expense load as follows:

- \$12.00 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 Available 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 summary
- 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 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[9] and maintenance taxes.[10]

Review Conclusions

Within the scope of our review, we reviewed 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.

In this section we include commentary related to the reasonableness of resulting non-benefit expense adjustments. We further categorize our review conclusions into observations and recommendations.

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.

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.

Several of our conclusions apply to multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

Reasonableness of Resulting Non-Benefit Expense Assumptions

Per the Commission's administrative expense review, the FY 2023 program-wide administrative allowance (net of taxes and fees) in the capitation rates for medical and pharmacy is $172.00 PMPM. 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 2023 administrative expense load for the medical and pharmacy components to historical program-wide administrative expenses PMPM reported by the MCOs. The FY 2023 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 and FY 2022, which is consistent with the increase in enrollment during the PHE that resulted in fixed costs being spread over many more members.

MCOs in many states are reporting emerging increases in administrative costs due to increases in wages and general inflation. The Commission noted that the current formula provides a reasonable allowance to address MCO concerns regarding these increasing costs. However, as noted above, the program-wide FY 2023 assumption of $172.00 PMPM is consistent with the total five year average administrative costs, so it may not explicitly account for both an increase in wages and general inflation and the expected reduction in enrollment following the expiration of the PHE. Table 14 below shows the historical administrative expenses PMPM from the Commission's FY 2023 STAR Kids program rate certification.

[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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Table 14 Texas Medicaid Managed Care Rate Review STAR Kids Program - Non-Benefit Expense Development Historical Medical and Pharmacy Administrative Expense PMPM	
FY 2018	$182.00
FY 2019	$179.62
FY 2020	$179.02
FY 2021	$157.01
FY 2022	$164.25
5 Year Average	$172.38

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 2021 research report[11] shows the actual administrative PMPMs net of taxes and fees for calendar year 2021 across the country. These PMPMs include all types of managed care programs, including those with lower acuity populations than the STAR Kids program population. It is not unreasonable that the STAR Kids program's administrative expenses 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.. The actual administrative PMPMs net of taxes and fees for calendar year 2021 for 80% of managed care organizations included in the report (between the 10th and 90th percentiles) were between $24.64 and $55.93.

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 to cover the uncertain costs related to provide defined benefits and administration duties as specified in the MCO contracts under fixed capitation rates. Nationally, the risk margin assumptions range from 1.0% to 2.0% for most comprehensive Medicaid managed care programs. The Commission's explicit risk margin of 1.75% is within the reasonable range and deemed to be appropriate for the covered population and covered benefits within this program.

The experience rebate adjustments discussed in Rate Structure section of this Appendix provide some protection to the Commission if actual experience in FY 2023 deviates substantially from projected costs reflected in the capitation rates. Despite the uncertainty regarding the PHE and current market conditions, we do not have material concerns regarding the FY 2023 non-benefit expense assumptions given the existence of broader risk mitigation mechanisms (e.g., the experience rebate adjustments).

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

[11] "Medicaid Managed Care Financial Results for 2021," Milliman Research Report, Retrieved from: https://jp.milliman.com/-/media/milliman/pdfs/2022-articles/7-8-22_medicaid-managed-care-financial-results-2021.ashx.

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We note the following observations related to the STAR Kids program:

Observation #1: Administrative expense assumptions are developed separately for the medical, pharmacy, and NEMT rate components

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

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.

Observation #2: 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

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 38% 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. 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.

Observation #3: Final non-benefit expense assumptions are not clearly identified

Applicable program(s): STAR, STAR Kids

The Commission's final capitation rates paid to MCOs for the medical and pharmacy service groupings are based on the lesser of 108% of the individual MCO experience rate or the risk-adjusted community rate. The Commission does not indicate how the 108% factor or the risk adjustment factor are 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.

Recommendations

We note the following recommendation related to the STAR Kids program:

Recommendation #1: Include supporting documentation for the development of the administrative costs

Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids, Dual Demo

As noted above, the administrative costs assumptions applied by the Commission in the FY 2023 capitation rates appear reasonable compared to historical program experience; however, it is not clear how the Commission determined the specific parameters used in the administrative assumption formulas. We recommend the Commission expand their documentation to include additional documentation, so that CMS or another actuary could reasonably understand the development of these parameters.

APPENDIX E: STAR KIDS

CMS COMPLIANCE AND DOCUMENTATION

We reviewed the Commission's FY 2023 rate certification for compliance with the CMS 2022-2023 Medicaid managed care rate setting guidance.[12] 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 2022-2023 Medicaid managed care rate setting guidance and provided sufficient documentation to comply with actuarial standards of practice. We reviewed the CMS 2022-2023 Medicaid managed care rate setting guidance and compared them against what the Commission submitted in their Medicaid managed care capitation rate certification for the STAR Kids 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) 2023 CMS Compliance and Documentation

Section I. Medicaid Managed Care Rates

The Commission has answered all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2022-2023 Medicaid managed care rate setting guidance.

Data - The Commission has answered all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2022-2023 Medicaid managed care rate setting guidance.

Projected Benefit Costs and Trends - The Commission has answered all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2022-2023 Medicaid managed care rate setting guidance.

Special Contract Provisions Related to Payment - The Commission has answered 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 2022-2023 Medicaid managed care rate setting guidance.

Projected Non-Benefit Costs - The Commission has answered all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2022-2023 Medicaid managed care rate setting guidance.

Risk Adjustment and Acuity Adjustments - The Commission has answered all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2022-2023 Medicaid managed care rate setting guidance.

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

The Commission has answered all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2022-2023 Medicaid managed care rate setting guidance.

Section III. New Adult Group Capitation Rates

This section is not applicable to the STAR Kids program.

Data available for CMS Compliance and Documentation Review

The Commission provided us with the final FY 2023 rate certification report for the STAR Kids program. We relied on this document as well as the publicly available CMS 2022-2023 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.

Review Conclusions

We categorize our review conclusions into *observations* and *recommendations*.

[12] 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.

APPENDIX E: STAR KIDS

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.

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.

Several of our conclusions apply to multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

Observations

We note the following observations related to the STAR Kids program:

Observation #1: Supporting documentation indicates pharmacy trends are set by drug type, which is inconsistent with the actual methodology used.

Applicable program(s): STAR, STAR Health, STAR+PLUS, STAR Kids

The FY 2023 STAR Kids report describes the pharmacy trend development as follows:

> *The STAR Kids pharmacy trend assumptions for the period March 2020 through FY2023 were developed by risk group using the following formula. For each risk group / drug type combination, the utilization and cost per service trend assumptions were set equal to one sixth of the experience trend rate for the 12-month period ending February 2018 plus two sixths of the experience trend rate for the 12-month period ending February 2019 plus three sixths of the experience trend rate for the 12-month period ending February 2020. The final cost trend assumptions were then determined by applying the assumed utilization and cost per service trends by individual drug type to actual experience for the 12-month period ending February 2020 and combining the results into a single trend assumption for each risk group.*

The Commission developed separate trends at the drug type and utilization / unit cost level, without adjustment for historical PDL changes, and included these calculations in the rate certification. However, these trends were not used to determine the final trend, nor were they used in the final rate development.

The Commission's actual trend development for the FY 2023 capitation rates set the trend assumption by calculating the historical annual PMPM trend for each risk group, adjusted for historical PDL changes. The Commission's final trend assumption for each risk group was set equal to one sixth of the experience PMPM trend rate for the 12-month period ending February 2018 plus two sixths of the experience PMPM trend rate for the 12-month period ending February 2019 plus three sixths of the experience PMPM trend rate for the 12-month period ending February 2020.

As illustrated in Trend section of this Appendix, the difference between the approach described in the Commission's rate certification and the Commission's actual approach can produce materially different results in some instances, particularly for risk groups where the mix between drug types is shifting. We recommend that the Commission describes the trend development in the rate certification in a manner that is consistent with the actual methodology used to develop the trend assumptions.

Recommendations

Recommendation #1: Include supporting documentation for the development of the administrative costs

Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids, Dual Demo

The rate certification includes the following information to support the administrative costs included in the FY 2023 capitation rates:

- Fixed and variable administrative costs assumptions by rate component (medical, pharmacy, and NEMT)
- 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 (excluding NEMT, which was added to the STAR Kids program effective July 1, 2021)

The Commission noted in the rate certification that the administrative costs are developed from historical Financial Statistic Reports and the Commission believes the resulting administrative costs for FY 2023 are reasonable compared to historical program experience. However, the rate certification does 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:

- Base period experience
- Trend assumptions
- Population adjustments, if applicable
- Allocation methodology between fixed and variable administrative costs
- 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

Exhibit E-1
Texas Medicaid Managed Care Rate Review
STAR Kids Program - Base Data Review
Reconciliation of Harris SDA Across All MCOs

											TPR Reported But Not Used
Table 1: Raw Base Period (3/1/2019 - 2/29/2020) Enrollment and Expenditure Data As Reported											
Risk Group	Enrollment	Medical_FFS	Rx_FFS	Capitation	Net Reinsurance	Other Medical Expenditures	Other Pharmacy Expenditures	TPR (Medical)	TPR (Rx)	Total Benefit Cost	TPR-Medical and Rx Combined
MDCP	15,706	$165,944,080	$17,312,421	$31,470	$4,110	-$968,433	-$274,172	-$459,068	-$2,102	$182,049,477	-$461,170
IDD	13,140	$30,093,502	$6,413,146	$28,731	$3,043	$476,101	-$135,896	-$2,006,145	-$2,071	$36,878,626	-$2,008,216
YES	2,686	$2,537,549	$776,197	$25,899	$650	$377,399	-$6,099	-$1,373,776	-$438	$3,711,594	-$1,374,214
Under Age 1	3,650	$16,546,261	$1,470,126	$23,539	$774	-$224,751	-$7,833	-$100,442	-$611	$17,808,116	-$101,053
Age 1-5	47,585	$143,356,332	$12,709,056	$92,009	$11,531	$114,083	-$28,310	-$411,181	-$5,627	$156,254,700	-$416,808
Age 6-14	215,010	$169,469,599	$53,149,613	$390,346	$47,778	$2,900,904	-$113,309	-$1,653,083	-$28,950	$225,844,931	-$1,682,032
Age 15-20	141,794	$81,129,772	$34,715,977	$233,385	$27,271	$2,749,114	-$101,887	-$1,353,077	-$23,436	$118,753,631	-$1,376,513
Total	**439,571**	**$609,077,094**	**$126,546,536**	**$825,377**	**$95,156**	**$5,424,416**	**-$667,505**	**-$8,613,386**	**-$63,236**	**$741,301,075**	**-$8,676,622**

Table 2: Data Adjustments

Risk Group	Enrollment	Medical_FFS	Rx_FFS	Capitation	Net Reinsurance	Other Medical Expenditures	Other Pharmacy Expenditures	TPR (Medical)	TPR (Rx)	Total Benefit Cost
MDCP		$27,989		-$1,563		$316,503	-$1	$459,068	$2,102	$342,928
IDD		$594,522		-$5,225		-$484,692	-$17	$2,006,145	$2,071	$104,588
YES		$791,959		-$20,990		-$363,303	-$6	$1,373,776	$438	$407,660
Under Age 1		$14,215		-$17,301		$232,479	$6	$100,442	$611	$229,399
Age 1-5		$303,419		-$4,650		-$6,320	-$9	$411,181	$5,627	$292,440
Age 6-14		$3,708,076		-$12,107		-$2,267,132	-$270	$1,653,083	$28,950	$1,428,567
Age 15-20		$3,026,552		-$1,040		-$2,452,953	-$94	$1,353,077	$23,436	$572,465
Total		**$8,466,731**		**-$62,877**		**-$5,025,418**	**-$390**	**$7,356,771**	**$63,236**	**$3,378,046**

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

Risk Group	Enrollment	Medical_FFS	Rx_FFS	Capitation	Net Reinsurance	Other Medical Expenditures	Other Pharmacy Expenditures	TPR (Medical)	TPR (Rx)	Total Benefit Cost
MDCP	15,706	$165,972,069	$17,312,421	$29,908	$4,110	-$651,930	-$274,173	$0	$0	$182,392,405
IDD	13,140	$30,688,024	$6,413,146	$23,505	$3,043	-$8,591	-$135,913	$0	$0	$36,983,214
YES	2,686	$3,329,508	$776,197	$4,909	$650	$14,096	-$6,105	$0	$0	$4,119,254
Under Age 1	3,650	$16,560,476	$1,470,126	$6,238	$774	$7,727	-$7,827	$0	$0	$18,037,514
Age 1-5	47,585	$143,659,751	$12,709,056	$87,358	$11,531	$107,763	-$28,319	$0	$0	$156,547,140
Age 6-14	215,010	$173,177,675	$53,149,613	$378,239	$47,778	$633,773	-$113,579	$0	$0	$227,273,498
Age 15-20	141,794	$84,156,324	$34,715,977	$232,344	$27,271	$296,161	-$101,980	$0	$0	$119,326,096
Total	**439,571**	**$617,543,825**	**$126,546,536**	**$762,501**	**$95,156**	**$398,998**	**-$667,895**	**$0**	**$0**	**$744,679,121**

Footnotes:

1. In Table 1, enrollment data was calculated based on the March 2022 caseload file as 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 (Med_FFS and Rx_FFS) was calculated based on the monthly expenditure data as reported in SFY20-21 MCO supplemental data report with runout through February 2022
4. In Table 1, base period non-lag expenditure data (Capitation, Net Reinsurance Cost, Other Medical and Pharmacy Expenditures, and TPR) was calculated using a composite of the first six-month (3/1/2019-8/31/2019) expenditure data as reported in SFY19-20 (9/1/2018-8/31/2020) MCO supplemental data report with runout through February 2021 and the second six-month (9/1/2019-2/29/2020) expenditure data as reported in SFY20-21 (9/1/2019-8/31/2021) MCO supplemental data report with runout through February 2022
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 1, Medical TPR was reported on an SDA wide level by one of the participating health plans. Due to TPR being reported at the SDA level by one health plan, the totals and the sum of each risk group will not tie for Medical TPR or the combined Medical/Rx TPR fields.
7. FQHC wrap payments in "Other Medical Expenditures" were reported as positive figures but included here as negative amounts to reflect the intent of being recoveries.
8. In Table 2, the primary drivers of the data adjustments are FQHC wrap payments

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 36,000 beneficiaries in FY 2023 at a program cost of roughly $513 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 2023 capitation rate development for the Dual Demonstration program. For a high-level description of the regulatory and policy authority to be followed when designing the rate structure of a program, please see the Review Process section in the Main Report.

Description of State Fiscal Year (FY) 2023 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 2023 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 2023 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 from managed transportation organizations (MTOs), 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 2023 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.

  - Quality Incentive Payment Program for Nursing Facilities (QIPP)

  A review of the development of directed payment programs is not included in the scope of our review of the FY 2023 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.

Review Conclusions

In this section we include commentary related to the reasonableness of the resulting rate structure. We further categorize our review conclusions into observations and recommendations.

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.

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.

Several of our conclusions apply across multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

APPENDIX F: DUAL DEMONSTRATION

Reasonableness of Resulting Rate Structure

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, documented in Appendix D, 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.

Observations

We do not have any specific observations related to rate structure for the Dual Demonstration program.

Recommendations

We do not have any specific recommendations related to rate structure for the Dual Demonstration program.

APPENDIX F: DUAL DEMONSTRATION

BASE DATA DEVELOPMENT

The base data used by the Commission to develop the Dual Demonstration FY 2023 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. 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.

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) 2023 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 2023 capitation rate setting process:

Base Data Selection

- The Commission selected the most recent 12-month period (March 2019 through February 2020) prior to the COVID-19 public health emergency (PHE) 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 six experience periods from March 2013 through December 2019. 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 six 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 Available 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 2020 by risk group.

APPENDIX F: DUAL DEMONSTRATION

Review Conclusions

We summarize our review conclusions into *observations* and *recommendations*.

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.

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.

Several of our conclusions apply across multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

Technical Accuracy

Unlike the other programs where we replicated the base data development for a sample service delivery area, we did not perform this technical check for the Dual Demonstration program given the reliance upon STAR+PLUS data.

Observations

We note the following observation related to the Dual Demonstration program:

Observation #1: Member selection adjustment does not capture current duration of members
Applicable program(s): Dual Demo

The use of historical data to review acuity differences between the members that remained in the STAR+PLUS program and those that moved to the Dual Demonstration program is a reasonable approach to develop a member selection adjustment to apply to the STAR+PLUS base data when developing Dual Demonstration capitation rates. In addition, given the number of members upon which the analysis is performed, it is reasonable to review multiple years of experience and blend the results together to improve the credibility of the data underlying the adjustment.

Lastly, the Commission did not apply the member selection adjustment at the county and risk group level in cases where they determined the resulting member selection adjustment was not credible or the results of the analysis did not indicate a material difference in acuity between the two populations (i.e., close to a 1.00 ratio between the costs of each population). Based on our review, the Commission's decisions to use a statewide average or not apply the member selection adjustment appear reasonable.

However, the Commission may consider performing a durational analysis to understand the make-up of the current Dual Demonstration individuals based on the year they entered the program compared to the underlying distribution of membership used to weight together the six experience periods in the member selection calculation. Currently, the highest weight is placed upon the oldest data, due to the nature of the largest membership shift from the STAR+PLUS program to the Dual Demonstration program occurring when the program was first established. However, it is unlikely that the membership for FY 2023 still has this same distribution. This introduces risk into the member selection calculation when the results of the analysis vary by experience period – potentially resulting in a selected overall adjustment that is not indicative of the projected FY 2023 membership.

As an example, using the LTC services in the OCC risk group, Table 1 displays the membership and acuity factor for each of the six experience periods reviewed and the overall weighted average member selection adjustment applied in the base period development. As shown in Table 1, the projected membership for FY 2023 is approximately 50% of the total member months included in the analysis from 2014 to 2019. In the analysis approximately 70% of membership is in 2014, which generally has a lower member selection adjustment than the weighted average in subsequent years. Given it is likely the projected FY 2023 membership is more heavily weighted in those subsequent years than 2014 membership included in the analysis, the member selection adjustment used in the capitation rates may be overstated (i.e., the member selection adjustment may be too high).

APPENDIX F: DUAL DEMONSTRATION

Table 1
Texas Medicaid Managed Care Rate Review
Dual Demonstration Program
Member Selection Adjustments for OCC Risk Group, LTC Services

	Member Months								
County	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**Total 2014 to 2019**	**Projected FY 2023**	**FY 2023 Percentage of Total**
Bexar	86,324	4,649	13,946	4,846	4,591	4,669	119,025	56,625	48%
Dallas	80,814	4,587	14,471	7,135	6,499	6,367	119,873	56,972	48%
El Paso	66,801	3,139	9,215	3,034	3,193	2,447	87,829	36,366	41%
Harris	163,584	7,048	31,421	11,508	11,280	11,304	236,145	91,428	39%
Hidalgo	94,544	6,169	11,143	7,177	9,057	5,038	133,128	67,703	51%
Tarrant	43,807	2,250	9,062	3,493	3,350	3,509	65,471	33,137	51%

	Member Selection Adjustment								
County	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**Total 2014 to 2019**	**Post 2014**	**Difference between Post 2014 and Total**
Bexar	0.848	0.812	0.712	0.777	0.777	0.758	0.822	0.751	(0.070)
Dallas	0.715	0.693	0.682	0.589	0.827	0.697	0.708	0.693	(0.015)
El Paso	0.851	0.881	0.734	0.604	0.833	0.524	0.822	0.728	(0.094)
Harris	0.695	0.616	0.587	0.561	0.673	0.470	0.660	0.581	(0.079)
Hidalgo	0.812	0.777	0.912	0.703	0.884	0.690	0.814	0.816	0.003
Tarrant	0.703	1.010	0.566	0.710	0.830	0.681	0.700	0.695	(0.005)

Recommendations

We do not have any specific recommendations related to base data development for the Dual Demonstration program. However, given the reliance upon the STAR+PLUS base data, the recommendations included in the STAR+PLUS program are also applicable to the Dual Demonstration program.

APPENDIX F: DUAL DEMONSTRATION

TREND

We gained a detailed understanding of the Commission's FY 2023 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.

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 2023 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) 2023 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 2
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	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

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 relies upon the analysis performed by the Commission for the STAR+PLUS program described in Appendix D.

Review Conclusions

We summarize our review conclusions into *observations* and *recommendations*.

APPENDIX F: DUAL DEMONSTRATION

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.

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.

Several of our conclusions are consistent across multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

Reasonableness of Resulting Trend Assumptions

Acute Care

The annual acute care trend of approximately 3.5% appears to be somewhat high compared to similar programs in other states, driven by a higher-than-normal trend in the second experience period in the analysis, as shown in Table 3.

Table 3
Texas Medicaid Managed Care Rate Review
Dual Demonstration Program
Historical Annual Acute Care Trend (Adjusted for Programmatic Changes)

	Risk Group		
Year Ending	**OCC**	**HCBS**	**Nursing Facility**
3/17 through 2/18	2.90%	3.23%	1.94%
3/18 through 2/19	7.09%	5.24%	2.37%
3/19 through 2/20	3.30%	2.19%	-0.74%
Selected Trend	**4.50%**	3.40%	0.70%

In addition, the acute care trends used for the Medicaid Only populations in the STAR+PLUS program, as shown in Table 4, are materially lower than the trends used for dual eligible OCC and HCBS risk groups in the Dual Demonstration program. Most acute care costs paid by Medicaid for dual eligible members is the member cost sharing that Medicare does not cover, which it 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 4
Texas Medicaid Managed Care Rate Review
Dual Demonstration Program
Acute Care Trend Assumptions

Risk Group	Dual Demo	STAR+PLUS Medicaid Only
OCC	4.5%	1.5%
HCBS	3.4%	1.5%
Nursing Facility	0.7%	4.1%

However, the historical trends for the populations reviewed have been high in the few years prior to the PHE. Without more granular data, we do not have insight into the drivers of those trends to evaluate whether they are likely to persist.

Pharmacy Services

Within the scope of our review, we did not obtain the claim detail necessary to independently develop pharmacy trends for the Dual Demonstration program. Therefore, we cannot offer a definitive assessment of the pharmacy trends selected by the Commission to develop the FY 2023 capitation rates. However, 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.

APPENDIX F: DUAL DEMONSTRATION

Observations

We do not have any specific observations related to trend for the Dual Demonstration program. However, given the reliance upon the STAR+PLUS trend analyses, the observations included in the STAR+PLUS program are also applicable to the Dual Demonstration program.

Recommendations

We do not have any specific recommendations related to trend for the Dual Demonstration program. However, given the reliance upon the STAR+PLUS trend analyses, the recommendations included in the STAR+PLUS program are also applicable to the Dual Demonstration program.

APPENDIX F: DUAL DEMONSTRATION

PROGRAMMATIC ADJUSTMENTS

Description of State Fiscal Year (FY) 2023 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.

Review Conclusions

We summarize our review conclusions into *observations* and *recommendations*.

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.

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.

Several of our conclusions apply across multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

Observations

We do not have any specific observations for the Dual Demonstration program, however given the reliance upon the STAR+PLUS programmatic adjustments, the observations included in the STAR+PLUS program are also applicable to the Dual Demonstration program.

Recommendations

We do not have any specific recommendations for the Dual Demonstration program, however given the reliance upon the STAR+PLUS programmatic adjustments, the recommendations included in the STAR+PLUS program are also applicable to the Dual Demonstration program.

APPENDIX F: DUAL DEMONSTRATION

NON-BENEFIT EXPENSES

We examined the Commission's FY 2023 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.

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 2023 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) 2023 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 5.

Table 5
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.

Review Conclusions

We summarize our review conclusions into *observations* and *recommendations.*

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.

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.

Several of our conclusions apply across multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

APPENDIX F: DUAL DEMONSTRATION

Observations

We note the following observation related to the Dual Demonstration program:

Observation #1: The non-benefit expense PMPM for pharmacy services in the Dual Demo program is from 2015 without trend applied

Applicable program(s): Dual Demo

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 2023.

Recommendations

We do not have any specific recommendations related to programmatic adjustments for the Dual Demonstration program. However, given the reliance upon the STAR+PLUS non-benefit expenses, the recommendations included in the STAR+PLUS program are also applicable to the Dual Demonstration program.

APPENDIX F: DUAL DEMONSTRATION

CMS COMPLIANCE AND DOCUMENTATION

We reviewed the Commission's FY 2023 rate certification for compliance with the CMS 2022-2023 Medicaid managed care rate setting guidance.[10] 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 2022-2023 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 2022-2023 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) 2023 CMS Compliance and Documentation

Section I. Medicaid Managed Care Rates

The Commission has answered all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2022-2023 Medicaid managed care rate setting guidance.

Data - The Commission has answered all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2022-2023 Medicaid managed care rate setting guidance.

Projected Benefit Costs and Trends - The Commission has answered all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2022-2023 Medicaid managed care rate setting guidance.

Special Contract Provisions Related to Payment - The Commission has answered 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 2022-2023 Medicaid managed care rate setting guidance.

Projected Non-Benefit Costs - The Commission has answered all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2022-2023 Medicaid managed care rate setting guidance.

Risk Adjustment and Acuity Adjustments - The Commission has answered all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2022-2023 Medicaid managed care rate setting guidance.

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

The Commission has answered all portions of the (A) Rate Development Standards section and (B) the Appropriate Documentation section in the CMS 2022-2023 Medicaid managed care rate setting guidance.

Section III. New Adult Group Capitation Rates

This section is not applicable to the Dual Demonstration program.

Data available for CMS Compliance and Documentation Review

The Commission provided us with the final FY 2023 rate certification report for the Dual Demonstration program. We relied on this document, as well as the publicly available CMS 2022-2023 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.

APPENDIX F: DUAL DEMONSTRATION

Review Conclusions

We summarize our review conclusions into *observations* and *recommendations*.

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.

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.

Several of our conclusions are consistent across multiple Texas Medicaid managed care programs within the scope of our review, as noted for each observation and recommendation below.

Observations

We do not have any specific observations related to compliance and documentation for the Dual Demonstration program.

Recommendations

We note the following recommendations related to the Dual Demonstration program:

Recommendation #1: Include supporting documentation for the development of the administrative costs
Applicable program(s): STAR, STAR Health, Dental, STAR+PLUS, STAR Kids, Dual Demo

The rate certification includes the following information to support the administrative costs included in the FY 2023 capitation rates:

- Fixed and variable administrative costs assumptions by rate component (medical, pharmacy, and NEMT)
- The total administrative costs in the total program on a PMPM calculated by adding the amounts for each rate component
- Historical PMPM program administrative costs (excluding NEMT, which was added to the STAR program effective July 1, 2021)

The Commission noted in the rate certification that the administrative costs are developed from historical Financial Statistic Reports and the Commission believes the resulting administrative costs for FY 2023 are reasonable compared to historical program experience. However, the rate certification does 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:

- Base period experience
- Trend assumptions
- Population adjustments, if applicable
- Allocation methodology between fixed and variable administrative costs
- 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

APPENDIX F: DUAL DEMONSTRATION

Recommendation #2: The Commission should reconcile actual patient liability amounts compared to rating assumptions for each MMP

Applicable program(s): STAR+PLUS, Dual Demo

As noted in the Rate Structure section of the STAR+PLUS Appendix D, the Medicaid Rating Checklist, Section AA.3.13[11] 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 MMPs 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.

1) Gross of patient liability: Capitation rates are developed gross of patient liability, and the State adjusts capitation rates paid to the MMPs 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 MMP 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, which the Dual Demo program relies upon, is net of patient liability, which results in capitation rates being net of patient liability, consistent with approach 2 above. However, there is not 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 MMP due to the mix of members they enroll with unique patient liability amounts.

We recommend the rate structure be reviewed to follow one of the two commonly used approaches outlined above based upon the availability of patient liability data.

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

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Attachment 2

Response from the Health and Human Services Commission to the Milliman Report

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 FY2023 capitation rating process, titled "Review of FY 2023 Texas Medicaid Managed Care Capitation Rate Development Process." Comments from the report from SAO and its contracted actuaries, Milliman, are in italicized and bolded text while HHSC and Rudd and Wisdom responses are in plain text.

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…" 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." 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.

RECOMMENDATIONS (As presented in Exhibit 1)

Rate Structure

A. *Consider consolidating SDAs for the purpose of rate development*

Management Response:

Rudd and Wisdom and HHSC have analyzed the makeup of SDAs several times over the years and the existing SDAs are the result of many hours of collaboration, deliberation and research. 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.

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.

Responsible Manager: Chief Actuary, HHSC Actuarial Analysis

B. *Review current structure of patient liability in the capitation rates (STAR+PLUS only)*

Management Response:

The current methodology excludes patient liability from the base data and therefore from the development of all trend and adjustment factor assumptions and the rate development. The actuarially sound premium rates paid to the MCOs are net of patient liability since the MCOs are not at risk for this portion of the total cost. We believe any changes will not have a material impact on the premium rates as the rating methodology, net of patient liability, used to determine the premium rates for the nursing facility populations has

been approved by CMS in prior years and has remained consistent for many years.

Action Plan:

HHSC Actuarial Analysis and Rudd and Wisdom will evaluate the availability of credible patient liability data for the STAR+PLUS program and determine if adjustments to the current rating methodology are appropriate.

Responsible Manager: Chief Actuary, HHSC Actuarial Analysis

C. Consider combining risk groups to enhance credibility and reduce annual volatility (STAR Kids only)

Management Response:

Currently, YES and Under Age 1 risk group rates are set on a statewide basis due to the relatively small enrollment of these groups by SDA and the volatility of the average cost for these groups. While an argument could be made that the enrollment of the MDCP and IDD risk groups for certain SDAs are lower than the threshold for full credibility, the consistency of the average cost must also be considered.

For example, the MDCP risk group in the Lubbock SDA has averaged 133 members during FY2019 through FY2021. While this is a relatively small risk group, the annual average medical cost PMPM has ranged from $6,200 to $7,200 demonstrating consistent, stable growth each year. While there may be individual months with larger or smaller average costs than expected, these variations are minimal. Using a statewide rating approach for this risk group would result in a premium for the Lubbock SDA that is over 50% larger than the actual historical experience for this SDA.

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.

Consolidating the risk groups would be budget neutral as the rates are a function of the cost of the managed care program and combining risk groups does not impact the cost but merely aggregates the cost across a larger population. The current methodology does not create any additional funding risk as theorized in the report as any adjustment or consolidation of risk groups would be done on a budget neutral basis meaning the aggregate premium paid by the state would be unchanged.

In addition, please note that adjusting the risk group definitions would be budget neutral for HHSC but would create winners and losers among the participating MCOs.

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.

Responsible Manager: Chief Actuary, HHSC Actuarial Analysis

Base Data Development

D. Use state encounter data as the primary base data source for expenditure data

Management Response:

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

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

- Volume analysis based on service category
- Data validity and completeness analysis
- Pharmacy encounter analysis

- Consistency analysis between encounter data and the data reported in the MCO's FSR by service area

The encounter data that the MCOs submit to ICHP does not include risk group. As a result, ICHP's encounter data to FSR reconciliation is done at an aggregate level by Medicaid program, service area and MCO. The ICHP certification is performed for each fiscal year using approximately three months of run-out.

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. A sample of the reconciliation was provided to Milliman on May 3, 2022. 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 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 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. In the case of the base data used for the FY2023 rate development, the base data includes 18 months of runout.

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.

Responsible Manager: Chief Actuary, HHSC Actuarial Analysis

E. Use the state capitation payment file as the primary base data source for enrollment data

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 0.003% for all Medicaid programs. 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: Chief Actuary, HHSC Actuarial Analysis

F. Consider the inclusion of patient liability in the base data development (STAR+PLUS only)

Management Response:

The current methodology excludes patient liability from the base data and therefore from the development of all trend and adjustment factor assumptions and the rate development. The actuarially sound premium rates paid to the MCOs are net of patient liability since the MCOs are not at risk for this portion of the total cost.

Action Plan:

Rudd and Wisdom and HHSC Actuarial Analysis will evaluate the availability of credible patient liability data for the STAR+PLUS program and determine if adjustments to the current rating methodology are appropriate.

Responsible Manager: Chief Actuary, HHSC Actuarial Analysis

G. Develop base period for each SDA by weighting each MCO's experience with actual enrollment instead of projected enrollment

Management Response:

Our 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 projected enrollment. The report states "If the Commission determines it is appropriate to apply an adjustment to reflect changes between the base period and the rating period due to changes in the overall provider contracting levels, the Commission may consider applying this adjustment as a programmatic adjustment so that 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." However, this mischaracterizes the calculation being performed. The application of the projected enrollment as the weights reflects the changing enrollment patterns within each SDA between the base period and the rating period and the impact that the varying average costs of each MCO have on the overall SDA average cost. Using historical base period enrollment as the weight, as suggested in the report, results in community rates that do not reflect emerging enrollment distribution and the varying cost profiles of the participating MCOs. If a different weighting were applied, the SDA level premiums would not equal the sum of the individual MCO calculated premiums.

We disagree with this recommendation as any change to the weighting would violate the budget neutral nature of the rate development.

Action Plan: N/A

Responsible Manager: N/A

H. ***Include supporting documentation for the development of the base data***

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.

Action Plan:

HHSC Actuarial Analysis and Rudd and Wisdom will expand the documentation in future rate developments to provide additional information on which the base period data is developed and validated. We will clearly identify the data sources and analyses used to reconcile the differences amongst the multiple data sources and ensure the accuracy of the selected base period.

I. ***Include new DHMO in projected FY 2023 membership and expenditures***

Management Response:

Dentaquest and MCNA were the only two DHMOs participating in the Medicaid dental program during the base period. Effective September 1, 2020, United began participation in the dental program, for a total of three DHMOs operating statewide. The rating analysis only includes experience for Dentaquest and MCNA because they were the only two DHMOs participating in the program during the base period. This approach ensures the statewide community rates are budget neutral in comparison to the individually calculated rates. If United's projected enrollment had been included, then the statewide level premiums would not equal the sum of the individual DHMO calculated premiums. Please note, including projected enrollment for United would not have any impact on the capitation rates developed.

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.

Responsible Manager: Chief Actuary, HHSC Actuarial Analysis

Trend Assumptions

J. Develop medical trend assumptions at more detailed service category level

Management Response:

Although the medical trends were reviewed by component (professional, outpatient, inpatient, etc.), a single trend assumption was selected and applied in aggregate. The MCO is paid a single capitation rate that does not vary by medical component. Splitting the analysis into separate components does not add any additional accuracy to the analysis but could increase distortions in the projection due to reporting differences among fiscal years, small sample sizes in a given category of service, or variations in the trend projections that could emerge for a category. There is significant interaction among all categories of service as MCOs may shift cost away from inpatient toward

outpatient and looking at an individual category in isolation could lead to overgeneralizations. The aggregate analysis performed takes into consideration all service categories and their interactions with one another without sacrificing accuracy. Use of the aggregate trend captures all interactions between categories of service, including the ongoing shifts that occur, and is reflective of the expected level of trend in future periods.

Action Plan:

HHSC Actuarial Analysis and Rudd and Wisdom will continue to evaluate the trends by component in order to determine if there are underlying issues that require further investigation and analysis.

Responsible Manager: Chief Actuary, HHSC Actuarial Analysis

K. *Develop medical and pharmacy trend assumptions separately by utilization and unit cost component*

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.

Pharmacy experience is analyzed separately by utilization and unit cost components and by drug type (brand, generic, specialty). However, for the past several years the assumed pharmacy trends have been developed based on the overall experience trend. The reason for this change is that 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. As our PDL adjustment analysis does not lend itself to separate factors by drug type, we have been using overall experience in developing our pharmacy trends for the past several rating cycles.

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: Chief Actuary, HHSC Actuarial Analysis

L. Apply separate trends to patient liability and remaining net state costs (STAR+PLUS only)

Management Response:

The current methodology excludes patient liability from the base data and therefore from the development of all trend and adjustment factor assumptions and the rate development. The actuarially sound premium rates paid to the MCOs are net of patient liability since the MCOs are not at risk for this portion of the total cost.

Action Plan:

HHSC Actuarial Analysis and Rudd and Wisdom will evaluate the availability of credible patient liability data for the STAR+PLUS program and determine if adjustments to the current rating methodology are appropriate.

Responsible Manager: Chief Actuary, HHSC Actuarial Analysis

M. Do not introduce changes in SDA distribution between Year 1 and Year 2 of the calculation when using statewide trend assumptions

Management Response:

There are numerous methods that could reasonably be used to composite the SDA trends into a single statewide assumption. The current approach uses the projected incurred claims during the trend measurement period in order to weight the SDA-specific trends. The purpose of this approach is to most closely

align the statewide trends, which include changes in the distribution across SDAs, with those that would be calculated on an SDA-specific basis. The table below presents the relative difference between the current methodology and the SDA-specific trend methodology:

STAR: +0.04%
STAR+PLUS: -0.14%
STAR Kids: +0.36%

In other words, the current methodology produces projected claims for the STAR program that are 0.04% higher ($3.1 million out of more than $10 billion) than the methodology in which the trends are applied on an SDA-specific basis without the need for composite weighting. The STAR+PLUS claims are 0.14% lower ($11.3 million out of more than $7.5 billion) under the current approach than the SDA-specific approach. The STAR Kids claims are 0.36% higher ($10 million out of more than $3.1 billion) under the current methodology. Table 8 in Appendices A, D and E is misleading in that it calculates the weighted average trends using a different approach: Year 1 incurred claims, without considering the relationship between the observed SDA-specific trends and their application in the rate development. The tables below provide the corrected comparison between the statewide trend comparison and the SDA-specific trend comparison for each program.

Annualized Trend – STAR				
Risk Group	**Aggregate Based on Year 2 Costs (Used for FY2023 Capitation Rates)**	**Average Based on Application of SDA-Specific Trends**	**Annualized Difference**	**Applied Trend Impact (3.5 years of Trend)**
Under Age 1	5.1%	5.1%	0.05%	0.18%
Ages 1-5	4.4%	4.4%	0.00%	-0.02%
Ages 6-14	5.3%	5.3%	0.04%	0.13%
Ages 15-20	5.3%	5.3%	-0.04%	-0.13%
TANF Adult	5.3%	5.3%	0.03%	0.09%
Pregnant Women	0.6%	0.6%	0.01%	0.02%
AAPCA	6.0%	6.4%	-0.36%	-1.24%
Total	4.3%	4.3%	0.01%	0.04%

Annualized Trend – STAR+PLUS					
Risk Group		**Aggregate Based on Year 2 Costs (Used for FY2023 Capitation Rates)**	**Average Based on Application of SDA-Specific Trends**	**Annualized Difference**	**Applied Trend Impact (3.5 years of Trend)**
Medicaid Only – OCC	Acute	1.5%	1.5%	0.01%	0.03%
Medicaid Only – HCBS	Acute	1.5%	1.5%	0.00%	-0.01%
Medicaid Only – NF	Acute	4.1%	4.0%	0.12%	0.43%
IDD	Acute	5.2%	4.9%	0.27%	0.93%
MBCCP	Acute	9.3%	10.4%	-0.98%	-3.37%
Medicaid Only – OCC	LTC	5.5%	5.7%	-0.23%	-0.79%
Medicaid Only – HCBS	LTC	5.2%	5.2%	0.01%	0.03%
Medicaid Only – NF	LTC	2.0%	2.0%	0.01%	0.03%
Dual Eligible – OCC	LTC	3.0%	3.1%	-0.10%	-0.36%
Dual Eligible – HCBS	LTC	4.4%	4.4%	0.01%	0.04%
Dual Eligible – NF	LTC	2.4%	2.4%	-0.01%	-0.03%
MBCCP	LTC	4.2%	4.2%	0.00%	0.00%
Total		3.0%	3.1%	-0.04%	-0.14%

	Annualized Trend – STAR Kids			
	Aggregate Based on Year 2 Costs (Used for FY2023 Capitation Rates)	**Average Based on Application of SDA-Specific Trends**	**Annualized Difference**	**Applied Trend Impact (3.5 years of Trend)**
MDCP	8.1%	8.1%	0.02%	0.06%
IDD	10.0%	10.2%	-0.22%	-0.77%
YES	12.1%	7.0%	5.06%	18.85%
Under Age 1	12.1%	6.5%	5.55%	20.81%
Ages 1-5	6.9%	7.5%	-0.62%	-2.17%
Ages 6-14	5.2%	5.2%	0.01%	0.05%
Age 15-20	5.3%	5.1%	0.22%	0.78%
Total	6.9%	6.8%	0.10%	0.36%

Action Plan:

While HHSC Actuarial Analysis and Rudd and Wisdom will update the trend analysis and the approach to utilizing a statewide trend versus SDA-specific trends, we do not believe any changes will result in a material impact to the actuarially sound rates. Furthermore, we will continue to ensure that the approach is unbiased and if statewide trends are used, we will apply a weighting methodology that most closely matches aggregate projected expenditures to the sum of projected expenditures using an SDA-specific approach.

Responsible Manager: Chief Actuary, HHSC Actuarial Analysis

N. *Develop and apply pharmacy trends by drug type (i.e. Specialty and Non-Specialty)*

Management Response:

Pharmacy experience is analyzed separately by utilization and unit cost components and by drug type (brand, generic, specialty). However, for the past several years the assumed pharmacy trends have been developed based on the overall experience trend. The reason for this change is that 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. As our PDL adjustment analysis does not lend itself to separate factors by drug type, we have been using overall experience in developing our pharmacy trends for the past several rating cycles.

Action Plan:

HHSC Actuarial Analysis and Rudd and Wisdom will consider amending this approach in future rate development cycles based on the impact of PDL revisions.

Responsible Manager: Chief Actuary, HHSC Actuarial Analysis

O. *Consider the impact of recently approved and upcoming pipeline drugs for each population*

Management Response:

HHSC and Rudd and Wisdom will monitor upcoming pipeline drugs. For new orphan drugs, HHSC provides the projected fiscal impact by fiscal year, including rebates and estimated population to be served. New orphan drugs with material fiscal impact are considered for non-risk status. Adulhelm is the most recent drug added to non-risk status based on HHSC fiscal analysis.

For the three example drugs listed in the report, we were provided fiscal estimates and determined the following:

1) Ubrelvy – This drug had a low fiscal estimate and did not warrant a specific adjustment. In addition, Ubrelvy will change to non-preferred status July 1, 2022.
2) Oxbryta – This drug is under consideration for non-risk status.
3) Trikafta – Orkambi and Symdeco are other drugs used to treat cystic fibrosis and are included in the capitation rates. The increase in utilization for Trikafta will be offset by decreased utilization for Orkambi and Symdeco.

In addition to new brand drugs, 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 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: Chief Actuary, HHSC Actuarial Analysis

P. Evaluate pharmacy trends at the therapeutic class level

Management Response:

The historical pharmacy trends were analyzed by utilization and inflation and by drug type (brand, generic, specialty). In our development of the cost impact of periodic changes to the Preferred Drug List (PDL), we analyze the cost at the therapeutic class level. 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.

Action Plan:

Please note that HHSC and Rudd and Wisdom closely monitor the cost at the therapeutic class and drug level to determine cost drivers and top drug spend for each program.

In addition, in accordance with Senate Bill 8, 83rd Texas Legislature, Medicaid and CHIP Data Analytics (MCDA), a team within the Office of Data, Analytics and Performance (DAP), has developed an Anomaly Tracking System to monitor variations and trends in the Medicaid and CHIP service utilization data and present their findings to us to consider in the rate development.

Responsible Manager: Chief Actuary, HHSC Actuarial Analysis

Programmatic Adjustment

Q. Remove member months periods for members ages 21 through 64 who have an IMD stay in excess of 15 days during any month (STAR and STAR+PLUS)

Management Response:

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 FY2023 rate development the number of member months meeting these criteria were:

- STAR: 87 member months, .0003% of the 34.5 million total member months
- STAR+PLUS: 1,719 member months, 0.027% of the 6.3 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: Chief Actuary, HHSC Actuarial Analysis

R. Calculate the nursing facility COVID-19 add-on impact gross of patient liability (STAR+PLUS)

Management Response:

The current methodology excludes patient liability from the base data and therefore from the development of all trend and adjustment factor assumptions and the rate development. The actuarially sound premium rates paid to the MCOs are net of patient liability since the MCOs are not at risk for this portion of the total cost.

Action Plan:

HHSC Actuarial Analysis and Rudd and Wisdom will evaluate the availability of credible patient liability data for the STAR+PLUS program and determine if adjustments to the current rating methodology are appropriate.

Responsible Manager: Chief Actuary, HHSC Actuarial Analysis

S. Evaluate the impact of medical service utilization differences in the recently extended eligibility period for pregnant women (STAR)

Management Response:

HHSC and Rudd and Wisdom performed an extensive analysis of the expected impact on per-capita cost from the implementation of HB133 which included an expansion of Pregnant Women eligibility from the current two months postpartum to six months postpartum. Our analysis was based on actual postpartum experience for Medicaid women since the federally-mandated extension of eligibility under the PHE. Our analysis is available for review.

Our STAR medical capitation rates for Pregnant Women are separated in two pieces – (i) a delivery supplemental payment which covers the delivery cost and (ii) an adjusted rate which covers all other medical expenses. The adjusted rate is determined by subtracting projected delivery costs from total costs. The PHE and its resulting increase in postpartum enrollment have changed the composition of the Pregnant Women risk group. While the number of deliveries has remained steady, the total number of eligible members has grown dramatically. The enrollment mix change has required us to develop a new Delivery Mix Adjustment factor which includes the impact from the implementation of HB133.

Our methodology for recognizing the impact from HB133 differs between the medical component and the pharmacy and NEMT components of the STAR Pregnant Women rates because the issue created by separating the rate into two pieces (delivery/other) does not exist for the pharmacy and NEMT components.

Action Plan:

HHSC Actuarial Analysis and Rudd and Wisdom will include additional information and documentation in future rate development cycles regarding this adjustment for medical services.

Responsible Manager: Chief Actuary, HHSC Actuarial Analysis

T. Evaluate the impact of the recently extended eligibility period for pregnant women (STAR Health)

Management Response:

Delivery expenses account for less than 0.35% of total medical expenses in the STAR Health program. Given the immaterial size of pregnancy-related expenses within this program, we believe any adjustment would be immaterial and have no impact on the actuarially sound capitation rate.

Action Plan:

HHSC Actuarial Analysis and Rudd and Wisdom will continue to evaluate the extension of eligibility for pregnant women on an ongoing basis, but it is likely to have little to no impact on this population.

Responsible Manager: Chief Actuary, HHSC Actuarial Analysis

<u>Non-Benefit Expense</u>

U. Include supporting documentation for the development of the administrative cost

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.

Action Plan:

HHSC Actuarial Analysis and Rudd and Wisdom will expand the documentation in future rate developments to provide additional information on which the administrative cost assumption is developed. We will clearly identify the historical time periods and data points used in the assumption development and provide additional comparison statistics for informational purposes.

Responsible Manager: Chief Actuary, HHSC Actuarial Analysis

V. ***Review administrative allocations across risk groups to remove incentives to enroll higher cost risk groups (STAR+PLUS)***

Management Response:

The administrative cost assumptions are reviewed annually based on the most recent information reported in the audited FSRs. While uniform assumptions are applied to all risk groups within the STAR+PLUS program ($12 PMPM fixed + 5.25% of premium) for medical services, we could consider adjusting the formula for each risk group individually; however, this would not impact the aggregate administrative expense dollars included in the capitation rate across all risk groups. In other words, such an approach would shift administrative expenses from one risk group to another through a rebalancing of the assumptions. Over the past 6 years, the average STAR+PLUS administrative cost as reported in the audited FSRs has ranged from $71-84 PMPM. The FY2023 STAR+PLUS rates include an average of $81 PMPM. If the decision was made to allocate fewer administrative dollars to the higher cost risk groups, the aggregate administrative expense assumption would be reduced below the actuarially sound level unless an offsetting increase to the lower cost risk groups was also applied.

In addition, HHSC Actuarial Analysis and Rudd and Wisdom believe the current methodology that applies the administrative cost assumptions uniformly across the STAR+PLUS risk groups is appropriate due to the fact that the enrollment distribution by risk group has remained very consistent for each STAR+PLUS MCO for many years. For example, Dual-eligible Nursing Facility enrollment as a percentage of total enrollment has ranged from 6.9-8.2% from September 2018 through December 2021 and has been steadily declining during this period. Although an incentive to enroll the higher cost risk groups may exist, at least in theory, it has not played out in practice as the enrollment distribution has declined over time for all MCOs.

Any shift in the administrative cost allocation would be done on a budget neutral basis and would have no net impact on the aggregate premiums paid across all risk groups.

Action Plan:

HHSC Actuarial Analysis and Rudd and Wisdom will continue to monitor this issue and determine if further adjustments are necessary.

Responsible Manager: Chief Actuary, HHSC Actuarial Analysis

<u>CMS Compliance</u>

W. Include supporting documentation for the development of the administrative costs

Management Response:

Please see our response to Recommendation Item U above.

X. Enhance supporting documentation to describe the methodology for estimating FY2023 projected enrollment used in the rate development.

Management Response:

Dentaquest and MCNA were the only two DHMOs participating in the Medicaid dental program during the base period. Effective, September 1, 2020, United began participation in the dental program, for a total of three DHMOs operating statewide. The rating analysis only includes experience for Dentaquest and MCNA because they were the only two DHMOs participating in the program during the base period. The addition of a new plan between the base and rating period required several manual adjustments.

1) The rating analysis excludes United's experience given it did not participate in the program during the base period. The projected enrollment only includes enrollment for MCNA and Dentaquest. This approach ensures the statewide community rates are budget neutral in comparison to the individually calculated rates. If United's projected enrollment had been included, then the statewide level premiums would not equal the sum of the individual DHMO calculated premiums. Please note, including projected enrollment for United would not have any impact on the PMPM premium rates developed.

2) The total projected enrollment for MCNA and Dentaquest did not change. However, the projected enrollment by risk group for each DHMO was adjusted in order for the distribution by risk group to be the same as during the base period. This adjustment is necessary in order to remove the impact United had on the distribution of membership for the projected enrollment.

Action Plan:

HHSC Actuarial Analysis and Rudd and Wisdom will include additional information and documentation in future rate development cycles regarding this manual adjustment.

Responsible Manager: Chief Actuary, HHSC Actuarial Analysis

Y. The Commission should reconcile actual patient liability amounts compared to rating assumptions for each MCO

Management Response:

The current methodology excludes patient liability from the base data and therefore from the development of all trend and adjustment factor assumptions and the rate development. The actuarially sound premium rates paid to the MCOs are net of patient liability since the MCOs are not at risk for this portion of the total cost.

Action Plan:

HHSC Actuarial Analysis and Rudd and Wisdom will evaluate the availability of credible patient liability data for the STAR+PLUS program and determine if adjustments to the current rating methodology are appropriate.

Responsible Manager: Chief Actuary, HHSC Actuarial Analysis

OBSERVATIONS (As presented in Exhibit 2)

Rate Structure

A. *Rates are developed individually by MCO rather than across all MCOs*

Management Response:

The use of MCO 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 of 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 FY2023 by $34.1 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.

B. *LTC rates developed separately for nursing facility and community residence*

Management Response:

Effective March 1, 2015, HHSC carved nursing facility services into the STAR+PLUS and Dual Demonstration programs. Given the significant concerns from the nursing facility community, a concession was made to set the rates on an unblended basis. This unblended rating structure has been maintained but is currently under evaluation per the direction of House Bill 2658 from the 87th Legislative Session. Based on the results of this evaluation and direction from the legislature, the approach may be adjusted in future rating periods.

Base Data Development

C. Summary-level enrollment data and expenditure data are gathered from separate sources

Management Response:

The rating analysis primarily relies on the three data sources for enrollment - i) the Financial Statistical Report (FSR), ii) summary-level enrollment 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 0.003% for all Medicaid programs.

D. There is not a clear process for the treatment of MCO self-reported TPR data

Management Response:

Self-reported TPR data is treated in exactly the same manner as any other non-claim lag expense such as capitated expenses and direct service expenses. These items are compared to the audited FSRs and included based on an understanding of which expenses, including TPR amounts, are included in the claim lag information. TPR reporting varies on whether the MCOs net TPR out of their claim expenses as negative amounts or as counter expense items outside of the claims lag information. Our detailed analysis of the base data and reconciliation between the MCO reported data submission, audited FSRs and encounter data allow us to accurately identify which TPR data must be separately accounted for and those that are already included in the claims lag submission or other expense information. All valid expense and counter-expense information has been accounted for in the FY2023 rate development and any adjustments to the process would have no impact on the actuarially sound premium rates.

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

Management Response:

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	0.23	0.092%
STAR+PLUS	0.03	0.002%
STAR Kids	0.52	0.025%

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

Management Response:

Certain 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.

G. *Member selection adjustment does not capture current duration of members*

Management Response:

The Commission will consider performing the recommended durational analysis in future Dual Demonstration rate setting projects.

Trend Assumptions

H. *Prospective medical trends are developed using a purely formulaic approach*

Management Response:

It is correct that the medical trends are developed by a purely formulaic approach; however, the formula is evaluated for reasonableness and developed in a manner such that the trend calculations are transparent, verifiable and objective. All trends are based solely on the populations being rated and based on historical data within the Texas Medicaid programs. 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.

In our opinion, the medical cost and trend in other states is not appropriate to use for the Texas program. We believe that Texas historical trends provide the best indicator of future trends and have developed a formula, which is

updated annually, to objectively select the trend assumptions for medical services. 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" but rather acknowledges that historical experience of the exact population being rated is the best indicator of future experience.

I. *Medical trends are not consistently applied to sub-capitated and service coordination cost*

Management Response:
These items 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: 1.4%
STAR+PLUS: 0.5%
STAR Kids: 0.1%
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: 3.5%
STAR Kids: 3.7%
STAR Health: 0.0%

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.

J. *The data source used for quantitative medical trend analysis does not enable more granular analysis*

Management Response:

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 includes 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.

K. Historical CPI trend used for NEMT trends does not reflect actual time period of projection

Management Response:
The historical CPI inflation trend was determined based on the 12-month percent change for each month. The inflation component of the trend was determined using the average 12-month percent change for each month for the 10-year period March 2010 through February 2020.

Programmatic Adjustment

L. Reimbursement changes are included as programmatic adjustments, regardless of their materiality

Management Response:

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.

M. The FQHC wrap payment removal relies on base data aggregation using projected enrollment

Management Response:

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 as 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. In order to avoid ambiguity in future rate development, the individual MCO adjustment factors will be included in addition to the SDA community adjustment factors.

The issues presented in Recommendation G are the same as those presented in this observation. Please see Recommendation G for additional information.

N. Programmatic adjustments are not developed at a service category level

Management Response:

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.

O. The PHE related cost adjustment uses the same formulaic approach across all Medicaid populations, which may not produce reasonable results for all risk groups

Management Response:

The PHE related cost adjustment has been applied uniformly to all risk groups and SDAs by comparing actual claims during the second half of fiscal year 2021 to expected claims during this same time period. While rare, there are occasions where the actual average costs were higher than expected for certain risk groups. While these rare increases are likely not a direct result of the pandemic and more likely due to other factors, they were observed in practice. It would be inappropriate to ignore the small number of positive adjustments while only applying the negative adjustments when the intent is to account for the change in cost versus expectations from the base period to the rating period.

P. Some programmatic adjustments vary by at least 5% among risk group / SDA combinations but appear reasonable

Management Response:

Certain adjustment factors have larger impacts than others and can vary significantly by SDA and risk group. For example, the Hemostatic carve-out adjustment was determined by identifying all hemostatic drugs and removing the cost from the base period. The adjustment can vary from 0% to -30% for the STAR Kids program depending on actual hemostatic utilization by SDA and risk group.

Non-Benefit Expense

Q. Administrative expense assumptions are developed separately for medical, pharmacy, and NEMT rate components

Management Response:

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.

R. 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

Management Response:

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 which 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.

S. Final non-benefit expense assumptions are not clearly identified

Management Response:

The administrative expense assumptions are provided in Section IV of the actuarial certification. This section clearly defines the fixed and variable amounts of the administrative cost applicable to the medical component of the rate, the fixed amount applicable to the pharmacy component and the fixed and variable amounts applicable to the NEMT components.

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

Management Response:

The Medicaid pharmacy benefit rating model for the Dual Demonstration program includes a provision for administrative expenses of $0.29 PMPM. 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. The pharmacy administrative expense provision for the other Medicaid programs has been reduced somewhat during the interim. We have made no such change to the Dual Demonstration cost as such a change was deemed immaterial.

CMS Compliance

U. *Supporting documentation does not clearly indicate that IMD costs are removed but associated member months remain*

Management Response:

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: 87 member months, .0003% of the 34.5 million total member months
- STAR+PLUS: 1,719 member months, 0.027% of the 6.3 million total member months

V. *Supporting documentation indicates pharmacy trends are set by drug type, which is inconsistent with the actual methodology used*

Management Response:

The historical pharmacy trends were analyzed by utilization and inflation and by drug type. However, the final trend assumption was not developed at the drug type level. We used the overall incurred claims PMPM and applied the PDL adjustment factors. We used the method described in the report for many years (and still perform the analysis) but made a change to the methodology to address several recent PDL revisions which had a significant impact on drug costs and trends. PDL changes for drugs that do not have a brand/generic equivalent were assumed to shift to preferred drugs in the class, which contains both brand and generic drugs. Our methodology does not determine how much of the utilization actually shifted to brand vs. generics. The methodology determines the cost impact by comparing the per unit cost immediately preceding implementation, to that immediately after implementation for each impacted drug class. Our PDL trend adjustment analysis does not lend itself to separate factors by drug type.

W. Supporting documentation should describe methodology for estimating FY2023 projected enrollment used in the rate development

Management Response:

The actuarial certification includes the following statement regarding projected FY2023 enrollment:

> Monthly enrollment by SDA and risk group for each health plan. This includes historical enrollment since September 2017 and a projection of future enrollment through August 2023. These projections were prepared by HHS Forecasting staff. The HHS Forecasting division is a team of experienced, professional demographers who are responsible for all agency caseload forecasts. See response to Recommendation I. If a similar adjustment is deemed necessary in future rate development additional documentation will be included.

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